ANGEL EYES VISION

We see you, so you see better.

Treatment Consent & Understanding of Financial Responsibility

By signing this form, I consent to treatment for myself and/or the minor or dependent whom the attached information describes. I give permission for the doctor and staff to examine, diagnose, and initiate treatment as they deem appropriate, and in consultation with me.

I furthermore agree that I am financially responsible for the value of the services and treatments the doctor and staff provide, according to Angel Eyes Vision's established service menu.

If I am a member of a medical or vision insurance program accepted by Angel Eyes Vision, I understand that Angel Eyes Vision will attempt to bill my insurance provider, or providers, for the services I receive; but I also understand such coverage may be denied, in which case I am solely responsible for paying for the goods, services, and treatments I receive.

I understand that either my medical or vision insurance benefits might be most applicable to my visit. If my diagnoses or treatments with Angel Eyes Vision are applicable to medical insurance coverage — such as if I have diabetes or another chronic condition — Angel Eyes Vision will likely by default first attempt to bill my medical coverage. I understand that if I have a preference on how my insurance benefits are billed, I should consult with the appropriate Angel Eyes representative prior to check out.

Angel Eyes Vision Standard Fee Schedule:

Comprehensive Eye Exam with Refraction: $80
Retinal Imaging or Dilation: $20
Contact Lens Fittings: $35 - $55
Medical Office Visit: $25 - $45

Not all of the above costs are required for your visit today. Your charges will reflect the services you receive, according to the above menu. If you have any questions, please do not hesitate to ask. Angel Eyes requires all patients receive a retinal scan. **This scan is rarely covered by insurance.** (See the attached consent form.)

_____
Print Patient's Name

_____ _____
Patient's Signature Date

_____ _____
Legal Guardian's Signature, if Patient is a Dependent Date

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Retinal Imaging Scan

Angel Eyes Vision is proud to provide the latest technology in delivering to you top-flight eye and health care.

As a part of our commitment to excellent service, we now offer digital retinal imaging as a counterpart of our comprehensive eye examinations. The retinal scan allows a detailed review of the back of your eye — the retina — without sacrificing your time or comfort through a traditional dilation process.

The retinal scan produces a recordable image of the back of your eye. The doctor will use it to confirm your eye is healthy. The image might also help detect disease without the use of dilation drops. It does this by producing a map of the retina, giving your doctor a wider and more-detailed view of your eye than what is typically possible through other methods. By examining this image and recording and tracking changes over time, your doctor can potentially identify even small shifts in eye health and function. The image also gives you and your doctor a chance to see and talk about your eye health and discuss potential problems. (Dilation may sometimes be necessary after a retinal image if your doctor suspects some types of eye pathology.)

Even if you see clearly now, your eyes may not be healthy. They may also already show the early, unnoticeable signs of common diseases such as glaucoma, diabetes, hypertension, macular degeneration, retinal tears, or even some forms of cancer. That is why your doctor recommends, and requires, you document your eye health today through a retinal image. Because of the benefits of a retinal image and the side effects of dilation that include light sensitivity and blurry vision, especially for close-up vision, your doctor believes retinal imaging is a crucial and convenient method for ensuring your eye function and your overall health.

Angel Eyes Vision requires all patients receive a retinal scan to document the health of your eyes.

Your medical and vision insurance rarely cover this procedure.

In recognition of the requirement and the added financial obligation, Angel Eyes Vision has discounted the retinal imaging service to $20.00 from its standard $40.00 level.

Please do not hesitate to ask Angel Eyes Vision staff any questions you may have about the retinal image.

_____

Print Patient's Name

_____ _____

Patient's Signature Date

_____ _____

Legal Guardian's Signature, if Patient is a Dependent Date

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We see you, so you see better.

Today's Date:_____

Patient Information & Medical History

Patient Name:_____ Date of Birth:_____

Social Security:_____ Sex: M F Occupation:_____

Street Address:_____ City, State, Zip:_____

Cell Phone:_____ Email:_____

How Did You Hear About Us:_____

Insurance Information

☐ I want to use insurance ☐ I do not want to use insurance

Vision Insurance Company:_____ Member ID:_____

Medical Insurance Company:_____ Member ID:_____

Medical Information

☐ I currently wear glasses ☐ I currently wear contact lenses

Reason for Today's Visit:_____ ☐ I am interested in contact lenses

Last Eye Exam:_____ Last Medical Exam:_____

List Any Medications You Take:_____

List Any Allergies You Have:_____

Is There Anything Else We Should Know?_____

Do you or your immediate family have any of these conditions?

	Self	Family		Self	Family
Cancer	☐	☐	Diabetes, Type 1	☐	☐
Epilepsy	☐	☐	Diabetes, Type 2	☐	☐
Migraines	☐	☐	High Cholesterol	☐	☐
Depression/Psychiatric	☐	☐	Thyroid Condition	☐	☐
High Blood Pressure	☐	☐	Arthritis	☐	☐
Stroke	☐	☐	Lupus/Autoimmune Dis.	☐	☐
Heart Disease	☐	☐	Cataracts	☐	☐
Blood Disorders	☐	☐	Macular Disease	☐	☐
Asthma	☐	☐	Glaucoma	☐	☐
Hepatitis	☐	☐	Retinal Detachment	☐	☐
Emphysema	☐	☐	Eye Surgery	☐	☐
HIV/AIDS	☐	☐	Blindness or Vision Loss	☐	☐
Gonorrhea	☐	☐	Poor Color Vision	☐	☐
Syphilis	☐	☐	Crossed or Lazy Eye(s)	☐	☐

Do you have these concerns?

	Yes	No
Blurry Vision	☐	☐
Eye Strain or Fatigue	☐	☐
Eye Pain	☐	☐
Sensitivity to Light	☐	☐
Headache	☐	☐
Poor Night Vision	☐	☐
Itchy Eyes	☐	☐
Dry Eyes	☐	☐
Double Vision	☐	☐
Floaters or Flashes	☐	☐
Halos	☐	☐
Seizures	☐	☐
Eye Infection/Injury	☐	☐
Pregnant or Nursing?	☐	☐

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HIPAA Privacy Practices

My signature below acknowledges that I have been presented with the option to receive Angel Eyes Vision's "Notice of Patient Privacy Policy," describing my rights under the Health Insurance Portability and Accountability Act. I may receive such policy in its entirety by asking any staff member for a copy.

I furthermore agree that Angel Eyes Vision may responsibly use and disclose my personal and health-related information to process any necessary corrective vision or device order, and to communicate with me in relation to my visit, including exam reminders, post-appointment followup, and product and service updates. I understand that Angel Eyes Vision may send me patient education and marketing emails and text messages. If I choose to opt out of such communications, I will notify the appropriate Angel Eyes Vision representative.

Should I wish to use my medical insurance or managed vision benefits, I authorize Angel Eyes Vision to share my health information, as necessary and appropriate, with carrier for authorization and payment of such claims. This will provide me with my insurance benefits and/or place a claim with the insurance carrier for payment on my behalf.

I have read and understand this form. I am voluntarily signing this form and authorize use and disclosure of my personal and health information as described above.

_____

Print Patient's Name

_____ _____

Patient's Signature Date

_____ _____

Legal Guardian's Signature, if Patient is a Dependent Date

Please list any family members or other individuals whom Angel Eyes Vision may inform about or communicate with to discuss your medical conditions, diagnosis, treatment, and payment. These individuals may also pick up any product orders on your behalf.

_____

_____ _____

Patient or Legal Guardian Signature Date