LUMINOUS OPTOMETRY

SEE CLEARLY, LIVE FREELY

PATIENT INFORMATION

Name (Last, First) ______________________________ DOB:_____/_____/_______ Age: ______ ☐M ☐F Date: ____/_____/_______
Address ____ City:____________________ State: ______ Zip Code:________________
Primary Phone #: (____) _____-________ Secondary Phone #: (____) _____-________ Email: ________________________________

INSURANCE

Person responsible for account (Last, First) ____ Relation to Patient: _____________________
Insurance Name: ______________________ Member ID: _______________________ Member's DOB: ______/_______/__________

EYE HEALTH HISTORY

Last Eye Exam: ___________ Year(s) Name of Doctor/Office:____
Any eye diseases, injuries, or surgeries in the past? ☐Yes ☐No ***If Yes***, what is it and when it was diagnosed? ________________________
Do you wear glasses currently? ☐Yes ☐No ***If Yes***, how often? ☐All the time ☐Occasionally ☐For Distance ☐For Near ☐Both
Do you wear contacts currently? ☐Yes ☐No ***If Yes***, what brand? _______________________________ ☐Dailies ☐Bi-weekly ☐Monthly
Any problems with your contacts? ☐Yes ☐No ***If Yes,*** what is it? ☐Dryness ☐Rips Easily ☐Uncomfortable by the end of the day
Are you interested in vision correction through Contact Lens (Ortho-K)? ☐Yes ☐No

Please check all symptoms you are currently experiencing:

☐Blurry Vision-Distance	☐Double Vision	☐Watery	☐Headaches	☐Dryness/Sandy	☐Flashes	☐Other________
☐Blurry Vision-Near	☐Itchy Eyes	☐Eyestrain	☐Discharge	☐Light Sensitivity	☐Floaters	

MEDICAL HEALTH HISTORY

Name of Primary Care Physician: ______________________________________ Date of Last Physical Exam: ________________________

Do **YOU** or any **BLOOD RELATIVES** have any of the following conditions?

	Self	Relatives		Self	Relatives		Self	Relatives		Self	Relatives
AIDS/HIV	☐	☐	Diabetes	☐	☐	Lupus	☐	☐	Stroke	☐	☐
Arthritis	☐	☐	Emphysema	☐	☐	Migraines	☐	☐	Thyroid	☐	☐
Asthma	☐	☐	Hepatitis	☐	☐	Retinal Disease	☐	☐	Tuberculosis	☐	☐
Cancer	☐	☐	Kidney Disease	☐	☐	Shingles	☐	☐	Other_________	☐	☐

Please list medications you are currently taking, including eye drops:
MEDICATIONS
☐Metformin ☐Glipizide ☐Insulin ☐Lisinopril ☐Atenolol
☐Atorvastatin ☐Simvastatin ☐Gabapentin ☐Amlodipine ☐Levothyroxine
☐Other: ____

Please list your allergies to medications or other substances:
ALLERGIES
☐Penicillin ☐Sulfa Drugs
☐Other: ____

SOCIAL HISTORY

Do you play any sports? ☐No ☐Yes _____________________________
Do you (check all that apply) ☐Smoke ☐Drink ☐Use Recreational Drugs
Do you have any hobbies? ☐No ☐Yes ______________________
Hours spent on ____☐TV _____☐Computer _____☐Video Games

ASSIGNMENT AND RELEASE

I certify that, I and/or my dependents (s), have insurance coverage with ______________________(name of insurance) and assign directly to Luminous Optometry all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature:____ Date: ____
Patient | Parent | Guardian | Personal Representative

Print Name: ____ Date: ____
Patient | Parent | Guardian | Personal Representative

RETURN POLICIES

PROFESSIONAL SERVICES
Professional fees (examination, refraction, contact lens fitting/evaluation, or any services performed "by the doctor") are **NOT** refundable

FRAMES
Select frames have a limited, one-year manufacturer's defect warranty. Any alterations or gluing of frames will void the warranty. Please note, due to insurance regulations, frame exchange is not allowed. Please be aware, if the lenses are already made with the frame you chose, choosing a different frame will mean you need to pay to have the lenses be remade into the new frame. Medi-Cal frames are **NOT** under warranty.

SUNGLASSES
All **non-prescription** sunglasses may be exchanged within **14** days of purchase. They must be returned in new condition and with the original case. Full credit will be applied to the patient's account to be used toward future purchases. Unfortunately, **NO** refunds can be issued.

LENSES
All lenses are custom made. Therefore, we **CANNOT** accept any cancellation or offer any refund once the order for the lenses is placed.

If progressive lenses have been ordered and you cannot adapt to them, we will have them remade to single vision, bifocal or trifocal lenses at no additional costs (**1 time only**). However, you will **NOT** get a refund due to the expenses incurred by the laboratory.

Within **30** days, if you are not satisfied with your prescription or lenses, please call the office and speak with an optician to help you with this matter.

CONTACT LENSES
Unopened, undamaged, unmarked, and unexpired contact lens boxes may be exchanged or returned for full credit toward the purchase of contact lenses or eyewear within **30** days from the date of purchase.

PROMOTIONAL PACKAGE
- Professional fees (examination, refraction, contact lens fitting/ evaluation, or any services performed "by the doctor") are **NOT** refundable.
- Frames are **NOT** refundable or exchangeable unless it is a manufacturer defect.
- Lenses can be remade **once** if the prescription is not correct (non-adaptation issue). You will **NOT** get a refund due to the expenses incurred by the laboratory.

We offer unlimited cleanings and adjustments for any glasses purchased in our office at no extra charge

My signature below attests that I have received, read, and agree to these return policy terms:

Signature:____ Date:___________________________

Patient | Parent | Guardian | Personal Representative

. HIPAA
CONSENT OF DISCLOSURE

I hereby give consent to Luminous Optometry to use and disclose my protected health information for the purposes of treatment, payment, and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your own behalf, and delivered to the address on the bottom of this form. This may be delivered in person or by mail, but it will only be effective when we actually receive it. Your cancellation will not be effective to the extent that we or others have acted in reliance upon this consent.

You have the right to request a restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment, or health care operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

Our posted privacy policy provides more detailed information about the usage and disclosures of your protected health care information. You have the right to review our posted privacy policy before you sign this consent.

We reserve the right to amend the terms of our posted privacy policy. You may obtain a copy of this current policy at our office any time or by calling **(714) 542-2226.**

CONSENT	CANCELLATION
Date: __________________________	Date: __________________________
Print Name of Patient: ____________________________________	I, ___________________________ hereby void the consent given above
Signature of patient: ____________________________________	Signature of patient: ____________________________________
Patient's Representative: __________________________________	Patient's Representative: __________________________________
Relationship to Patient: ___________________________________	Relationship to Patient: ___________________________________
	Your cancellation will be effective upon receipt at Radiant Optometry