



PATIENT REGISTRATION FORM

Patient Information

Last Name: _____ First Name: _____ MI _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____
(please include Apt #)

Birth Date: _____ Home or Cell# _____ Work # _____

Employer: _____ Occupation: _____

Gender: _____ MALE _____ FEMALE Marital Status: _____

Email Address: _____

How did you learn about our office? _____

Emergency Contact: _____ Phone # _____ Relationship: _____

If patient is under 18 years of age:

Name of parent / Legal guardian: _____ Phone # _____

Insurance Information

Primary Insurance Name _____ Policy # _____

Policy Holder Name: _____ Birth Date: _____ SS# _____

Relationship to Patient _____

PAYMENT FOR THE DOCTOR IS REQUIRED AT THE TIME OF SERVICE.

If you are paying by check, we do require a valid driver's license. Returned checks and withdrawn credit card transactions will be assessed a \$35.00 service charge.

I certify that the above information is true and accurate. I hereby assign or transfer payments benefits made to me and my behalf to St Cloud Eye Care for any services furnished to me by this physician/supplier. I further agree that I am responsible for payment or charges incurred by me that are not covered by my insurance or for which my insurance has paid me. I understand that professional services are not refundable.

Patient/Legal Representative (Print): _____

Patient/Legal Representative Signature: _____

Relationship to patient (If Minor): _____ Date: _____



MEDICAL QUESTIONNAIRE / EYE HISTORY

Reason for this visit: Routine exam for glasses Routine exam for glasses and contact lens
 Eye infection Eye injury
 Other: _____

Last eye exam: _____ Doctor's Name: _____

Have you ever had any injury or surgery to or around your eyes? _____ If yes, please describe _____

Last physical exam: _____ Doctor's Name: _____

Please list any and all medications you may be taking including eye drops, hormones and birth control (If you don't know the name of the medication, please list the reason for the medication): _____

Please list any medication allergies: _____

Have you ever suffered from the following (please check yes or no):

	Yes	No		Yes	No		Yes	No
Glaucoma	___	___	Kidney/Liver Disorder	___	___	High Cholesterol	___	___
Cataracts	___	___	Arthritis	___	___	Thyroid Disorder	___	___
Lazy Eye	___	___	Fainting/Dizziness	___	___	Asthma/Bronchitis	___	___
Blindness	___	___	Cancer (type)	___	___	Diabetes	___	___
Allergies	___	___	High Blood Pressure	___	___	If yes how long?	___	___
Retinal Disorder	___	___	Heart/Vascular Disorder	___	___	Other Condition	___	___
Color Blindness	___	___	Neurological Disorder	___	___			

Is there any family history of any conditions listed above? Please list relative for the condition. _____

Tobacco Use: No Former Smoker Every day Smoker Some day smoker Smokeless Tobacco

Alcohol use: No Social Use 1-2 drinks a day Above average use Alcohol Dependence

Dilation: It is our goal to provide you a complete and thorough comprehensive eye examination. This will require placing drops in your eyes, which will open the pupil (black spot) and allow a better view of the inside of your eye.

As with many medications, there are some side effects of the drops used to dilate the pupil. These include sensitivity to light and blurred reading vision (in most cases the distance vision will not be affected). Please use caution when driving. The side effects last several hours and in some cases may last as long as 24 hours.

While we believe dilation is an important part of the eye examination process, we understand that you may want to defer or omit this procedure.

I certify that the above information is true and accurate.

Patient/Legal Representative Signature: _____ Date: _____



Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a means by which a third-party payer can verify that services billed were actually provided
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been offered a copy of the *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing except to the extent that the organization has already taken action in reliance thereon.

Patient/Legal Representative Signature: _____ Date: _____

*Thank you for your confidence in our professional services and practice.
We look forward to serving you.*

Office Policies

1. **Professional Services Are Non-Refundable**
2. All completed orders should be picked up within 3 months following notification, If not picked up; the material(s) will be disposed of.
3. We are not responsible for glasses or contacts that are not picked up within 90 days. **Payments or deposits will not be refunded.**
4. Contact lens fitting/evaluation has to be done within **60 days** of the routine examination. Otherwise additional fees will apply. Any evaluation over 6 months from routine examination will require whole new exam in addition to the contact lens fitting/evaluation.
5. Once contact lenses are finalized by the doctor, **no changes can be made** to the powers or brand of the contacts.
6. All contact lens follow-ups within 2 months of a contact lens exam will be at no charge. However, **any follow-up visits after 2 months from the date of the contact lens exam will be charged the regular fitting fee.** Anything over 6 months will require a new exam fee in addition to the fit.
7. Only boxes that are unopened in resalable condition-free of markings, dents, or damages will be exchanged or refunded. **NO EXCEPTIONS**
8. Prescription re-checks within 90 days of exam date will be at no charge. **All re-checks more than 90 days after the date of exam, but not more than 6 months, will be charged a refraction fee.** Thereafter, a new exam is required.
9. We do require a deposit of 50% for all orders and all balances must be paid in full when picking up material(s).
10. Patients may use own frames for orders, however for all orders of patients own frames, **we are NOT** responsible financially if the glasses break going through the lab, are stolen, or are lost during the process of completing the order.
11. Often we have little to no control over the amount of time it will take to manufacture the eyewear order. The average turnaround time is 14 business days but rest assured we will call you as soon as your order is received.
12. **Prescription glasses are made to fit your needs only, they are a custom-made medical device. NO returns will be permitted.**

By signing below, you are acknowledging and accepting our office policies. If you have any questions regarding this form, please speak with one of our associates before signing.

Thank You

Signature _____ Date _____

OFFICE CANCELLATION POLICY

This policy has been established to better serve our patients needs.

It is necessary for us to make appointments in order to see our patients as efficiently as possible. When an appointment is made it takes that time slot away from another patient. No shows and late cancellations delay the delivery of our services to our other patients.

A “no show” is missing a scheduled appointment. A “late cancellation” is cancelling an appointment without calling 24 hours in advance.

We do understand that there are times when you must miss an appointment due to emergencies, obligations from work or family. However, when you do not call to cancel an appointment in advance, you are preventing another patient from being seen.

IF AN APPOINTMENT IS NOT CANCELLED 24 HOURS IN ADVANCE YOU WILL BE CHARGED A TWENTY-FIVE DOLLARS (\$25.00) FEE; THIS WILL NOT BE COVERED UNDER YOUR INSURANCE.

PRINT PATIENT NAME

SIGNATURE PATIENT/GUARDIAN

DATE

Child Medical Consent

Patient name: _____ **Date of Birth:** _____

We understand there are times when the parent or legal guardian cannot be present to bring the child to his/her appointment. Unfortunately, without parental consent your child will not be seen at our facility. In the event of an emergency, where for one reason or another you the parent cannot be present, who do you authorize and give consent to bring your child into our facility?

Name: _____ Phone number: _____

Address: _____

Date of Birth: _____ Relationship to patient: _____

Name: _____ Phone number: _____

Address: _____

Date of Birth: _____ Relationship to patient: _____

Name: _____ Phone number: _____

Address: _____

Date of Birth: _____ Relationship to patient: _____

BY SIGNING BELOW, YOU ARE GIVING CONSENT FOR THE INDIVIDUALS LISTED ABOVE TO BRING YOUR CHILD AND MAKE ANY MEDICAL DECISIONS ON YOUR BEHALF AND THAT OF YOUR CHILD. PLEASE UNDERSTAND IF ANYONE NOT LISTED BRINGS YOUR CHILD TO OUR FACILITY, YOUR CHILD WILL NOT BE SEEN. YOU HAVE THE RIGHT TO REVOKE ANY INDIVIDUAL AT ANY TIME. WE WILL NEED A LETTER STATING THAT IF IT OCCURS. LEGAL FORM OF IDENTIFICATION IS REQUIRED BY ALL INDIVIDUALS AT THE TIME OF VISIT.

Patient/Legal Representative (Print): _____

Patient/Legal Representative Signature: _____

Relationship to patient: _____ Date: _____

Release Form

In order to help us stay within the guidelines of HIPAA, please list below any person/persons that you authorize us to disclose your Protected Health Information with, including billing information and dispensing of prescriptions. Please provide all information requested.

Name: _____ Phone number: _____

Date of Birth: _____ Relationship to patient: _____

Name: _____ Phone number: _____

Date of Birth: _____ Relationship to patient: _____

Name: _____ Phone number: _____

Date of Birth: _____ Relationship to patient: _____

(Patient Information)

Patient Name: _____ Date of birth: _____

SSN: _____ Phone number: _____

This authorization will continue until it is withdrawn, by me (the patient), in writing.

Patient Signature: _____ **Date:** _____

(Office use only)

Use this space for consent withdraws only: Need written letter from patient.

Date consent revoked

Staff Signature