Doc Vision
Eye Care Centers

"We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as thoroughly as you can. If you have any questions, we will be glad to help you."

PATIENT INFORMATION

Last Name _____ **First Name** _____ **Middle Name** _____

Social Security Number _____-_____-_____ **Date of Birth** _____ /_____ /_____

Address _____ City _____ State _____ Zip Code _____

Telephone: Cell (_____) _____ Home (_____) _____

Email Address _____

Gender: ☐ Female ☐ Male **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Occupation _____ Employer/ School_____

Spouse or Parent (if a minor) _____ Phone (_____) _____

Person to contact in case of emergency _____

Relationship to Patient _____ Phone (_____) _____

Who may we thank for referring you to us? _____

INSURANCE INFORMATION

Medical Insurance _____ Vision Insurance _____

If the patient is not the primary insured, please fill out the following information:

Name of Insured _____

Relationship of patient: ☐ Spouse ☐ Child ☐ Other _____

Social Security # _____-_____-_____ Date of Birth _____/_____/_____

Name of Employer _____

Employer's Address _____ City _____ State _____ Zip Code _____

FINANCIAL ASSIGNMENT AND AGREEMENT

I request that payment of authorized insurance benefits be made on my behalf for any services furnished to me. I understand that I am financially responsible for all charges whether or not paid by said insurance. I authorize the use of my signature on all my insurance submissions. **There will be NO SHOW fee of $35 if you did not cancel or reschedule appointment 24 hours before your appointment time. Initials** _____

PRIVACY PRACTICES OR HEALTH INFORMATION

I hereby authorize Doc Vision Eye Care Centers, LLC to release any medical or incidental information that maybe necessary for medical benefit or to obtain payment for services. This includes but is not limited to vision plans or medical insurances. I also have received the Notice of Privacy Practices and I have been provided an opportunity to review it. **Initials** _____

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Patient Consent and Waiver Form

_____ Permission to bill my Vision/Medical Insurance Plan Directly:

Initials I authorized my insurance company to release payment directly to Doc Vision Eye Care Centers, LLC or its doctors. I understand that I am financially responsible for charges not covered by my vision or medical insurance.

_____ Release of my Patient and Health Information to my Vision/Medical Insurance Plan:

Initials I authorize **Doc Vision Eye Care Centers, LLC** to provide my insurance company with any information in my medical record. The notice of Privacy Practices is available to be read both on the website at **www.DocVisionEyeCareCenters.com** and in the waiting room and I have the opportunity to read and consider the contents of this consent form. I understand that by initialing this form, I consent to the use and disclosure if my protected information to carry our treatment, payment activities, and all healthcare operations.

Doctor Prefers to Dilate.

When indicated, pupillary dilation improves the doctor's ability to examine the internal structures of the eye for signs of disease, which is important for your health and well-being. Normal side-effects usually last 3 to 5 hours, and they include sensitivity to bright light (for which disposable eye shades are provided upon request) and difficulty focusing on near objects. Normally, your distance vision is not affected too much (that is, if you are wearing fairly up-to-date prescription eyeglasses or contact lenses), and although it is possible to drive legally after dilation, we suggest that you take caution or have someone drive you home.

Patients may refuse.

Patients reserve the right to refuse any test or diagnostic procedure recommended. If a patient refuses, however, he or she assumes all of the risk for potentially not detecting, and thereby treating in a timely manner, any serious eye conditions that can lead to blindness or even death due to cancerous growths.

Patients may reschedule.

Some patients prefer to reschedule their dilated retinal exam for a different day and time to minimize visual side-effects upon their return to work or school. We will be happy to schedule a second appointment at a later time for this purpose, privately charging an additional fee of $60. for the doctor's extra time. There is absolutely NO ADDITIONAL CHARGE if we complete the dilated retinal exam during your initially scheduled comprehensive eye examination.

☐ **I ACCEPT** to have a dilated exam. Initials _____

☐ **I DECLINE** to have a dilation exam and assume all risks. Initials _____

☐ **I ACCEPT** to have the dilation RESCHEDULED for an additional fee of $60. Initials _____

Visual Field Test.

A critical part of comprehensive eye care is a Visual Field. We highly recommend this test which gives a computerized examination of your side (peripheral) vision. Many diseases revealed by a visual field are undetectable in an eye examination and may only be diagnosed with a visual field test. Some of the diseases that a visual field test may detect are **GLAUCOMA, RETINAL DISEASE, BRAIN TUMORS,** and many other disorders relating to the eye and brain. The addition fee for a visual field test is $40, which is NOT covered by insurance.

☐ **I ACCEPT** to have a visual field test for an additional fee of $40. Initials _____

☐ **I DECLINE** to have a visual field test. Initials _____

I understand that I am responsible for all fees, co-pay deductibles and non-covered services if NOT paid by my Vision/Medical Insurance Plan. If my account becomes delinquent in payment, I agree to pay all cost of collection agency including attorney fees.

The following signature applies to all consents and understanding of the information above:

_____	_____	_____	_____
Date	**Patient Name**	**Signature (adult 18+)**	**Name of parent/guardian**