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 000 -00-_____ **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_____

Person to contact in case of emergency _____ Phone (___)_____

Who may we thank for referring you to us? _____

Receive Text or Email (Example for:- Glasses or Contacts ready, Due for Exam, Your Rx or Medical record)

☐ **Yes** **NO** ☐

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 _____

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 $75 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, Waiver & Optional Treatments

Permission to bill my Vision/Medical Insurance Plan Directly:

Initials: I authorize my vision and/or medical insurance to send payment directly to Doc Vision Eye Care Centers, LLC. I understand that I am responsible for any charges not covered by my plan.

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

Initials: I consent to the release of necessary health information to my insurance provider for the purposes of treatment, billing, and healthcare operations. I acknowledge that I have reviewed the Notice of Privacy Practices, available both online and in the clinic.

Doctor Recommendation – Dilation:

Dilated retinal exams help detect internal eye diseases. Side effects may include light sensitivity and blurred near vision lasting 3–5 hours. You may drive legally after, but caution is advised.

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

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

☐ I PREFER to reschedule. (A $60 fee may apply if completed during a separate visit.) Initials: _____

Your Rights: You may refuse any test or procedure. Refusal implies responsibility for any delayed diagnosis or treatment

☐ **Eye Exam for Glasses.** ☐ **Eye Exam for Glasses & Contacts lenses.** ☐ **Eye problem (Medical).**

Contacts Exam :- A $65 fee applies for each additional visit after the first, which includes one follow-up. A full exam fee is required if more than 2 months have passed.

Visual Field Test.

This test checks your side (peripheral) vision and can detect serious conditions like **glaucoma, retinal disease, or brain-related issues** that may not show up in a regular eye exam. It is highly recommended. The additional 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: _____

Optional Dry Eye Questionnaire:

Do you experience dry, burning, gritty, watery eyes or Eye redness or irritation?

☐ **Yes** ☐ **No**

How often do these symptoms occur? ☐ Occasionally ☐ Daily ☐ Constantly

Do your symptoms worsen in any of these situations?

☐ After screen time. ☐ In dry or windy environments. ☐ While reading or driving.

Would you like to learn more about available treatments?

☐ Yes, I am interested in solutions. ☐ No, not at this time.

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**