

***“By Providing Excellence in Eye Health Care & Optimizing Your Vision Skills,
We Enhance Your Quality of Life”***

Name: _____ **Date:** _____

Address: _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Reason for today’s visit? Glasses ___ **Contacts** ___ **Medical** ___ **Other?** _____

Lifestyle Visual Needs Questionnaire

What activities do you engage in when eye safety might be at risk?

Please describe your occupation & work-day tasks:

Occupation: _____

Commute driving time each way: _____

Computer use- # hours: _____ steady or on and off ? (please circle)

Bookkeeping or other detailed viewing?

Technical manuals or blueprint reading?

Equipment repair or mechanical testing?

Please describe your hobbies and other visual demands: (please circle)

Water Sports or Fishing: _____

Musical instruments: _____

Golf Yardwork Other outdoor activities: _____

Arts, crafts or sewing

Reading

Playing cards or Board games: _____

Gym activities: Aerobics Weight Lifting Racket sports

What would you like to improve about your vision?

Are you satisfied with your night vision? _____

Are you satisfied with your distance and reading vision? _____

Do you wear sunglasses? _____

Do both your primary glasses and sunglasses have 100% UVA protection?

When are you bothered most by glare? (please circle)

Night, day, driving, by water, off paper surfaces, on computer screens,
overhead or Fluorescent lights, reflections off your glasses, other:

What frame features are most important to you? (please circle)

Lightweight, durable, hypoallergenic, style, warranties

Reminders:

- *It IS important to optimize your visual abilities! Approximately 80% of brain activity is influenced by vision.*
- *Flexible Spending Account (FSA) monies can be used for all services and eyewear we provide. Will you need a receipt to submit today’s visit to your FSA account for reimbursement?*

WELCOME TO ADVANCED EYECARE & VISION GALLERY

We provide the highest quality professional eye and vision care for our patients. In return for our uncompromising standards and service, we ask that our patients keep their accounts current. Please read, initial and sign the following **FINANCIAL POLICY**. If you have any questions please feel free to ask us.

Patients are expected to pay in full at the time services are rendered, or eye wear is ordered. We do accept Visa and MasterCard to aid in your budgeting of expenses. After 30 days, balances are considered delinquent, and are subject to a billing charge (\$15) each time we are required to send you a statement. We appreciate your notifying us at least 48 hours in advance if you should need to change your appointment with us. Appointments missed without a minimum of 24 hours advance notice are subject to a \$95 missed appointment fee. _____

Initial

We are happy to help you with your insurance. Please be aware that if you are using insurance for today's visit, your insurance coverage is a contract between you and your insurance company – *Not Us*. Please enter your credit card # _____ and expiration date _____. We will keep this information on file for your convenience. If your insurance company has not reimbursed our office within the allotted 60-day time period, we will utilize this information to process your balance. _____

Initial

If you have **vision coverage** for **routine** eye examinations or **medical coverage** for problem visits with a company with which we have an agreement (**Vision Service Plan, QualCare, Aetna, CIGNA, BCBS**) AND you bring us a current insurance card on the day of your visit, we will gladly accept contracted payments from your plan directly. Routine eye examinations result in prescriptions for eyeglasses; contact lens examinations incur additional fees, and are not usually covered by insurance. Corneal topography is a required procedure for all contact lens patients. The \$65 charge will be itemized on your receipt. Likewise, medical conditions such as "lazy eye," diabetes or headaches, may necessitate additional medical tests beyond the scope of your vision coverage or initial referral form. Copayments and overages are due on the day services are received and materials ordered. If you notify us *after* services are received, we will supply you with a coded receipt you can submit to receive reimbursement directly from your plan. However, be aware that if we are not notified when services are rendered, your insurance company may only send you a partial reimbursement for services received. _____

Initial

When a health condition exists, the fees for medical testing can be submitted to your **Major Medical** insurance or Medicare. (Major Medical and Medicare will not usually cover *routine* examinations, nor measurements taken for eye wear unless you have vision coverage.) If your visit might be covered under major medical, we will give you a coded receipt you can mail to your insurance company for reimbursement. (For Medicare, we submit the forms for you.) The insurance company will reimburse *you* directly, not us, unless you are in a contracted plan listed above. **Please remember it is your responsibility to ensure all referral and certification procedures are followed.** These procedures may require a referral from your primary care physician, in which case *you must bring the referral form, and your current insurance card on the day services are received*, and pay any applicable copayments. We have tried, but unfortunately we cannot do this for you, as it comes from the office of your primary care physician. Without your insurance card and forms, you may receive only a partial reimbursement, or no coverage at all. _____

Initial

The **Health Insurance Portability & Accountability Act of 1996 ("HIPPA")** is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. As required by "HIPPA", we have prepared a "**Notice of Privacy Practices Policy**". This explains how we are required to maintain the privacy of your health information and how we may use and disclose your health information. A copy of this policy is available to you at your request and on our website. _____

Initial

Communication is the key to good relationships. Please feel free to ask any questions you have and we will be happy to help you.

The Staff and Doctors of Advanced Eyecare & Vision Gallery.

The Doctors or staff may discuss my situation or condition with the following individual(s).

Name _____ Relationship _____

Name _____ Relationship _____

Please sign below: With this signature on file, I also permit the office staff to submit my charges to my insurance company for reimbursement.

Signature: _____ Date: _____