NEW ALBANY VISION CLINIC

PATIENT INFORMATION

(PLEASE USE BLACK OR BLUE INK ONLY)

PATIENT'S NAME: (FIRST, MIDDLE, LAST) CIRCLE ONE: **Mr. Mrs. Ms. Miss**

_____

NAME PATIENT PREFERS TO BE CALLED: _____

HOME ADDRESS: _____

PO BOX (IF APPLICABLE): _____

CITY: _____ STATE: _____ ZIP: _____

CIRCLE ONE: **MALE FEMALE** CIRCLE ONE: **MARRIED DIVORCED WIDOWED SINGLE OTHER**

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY NUMBER: _____

EMAIL ADDRESS: _____

EMPLOYER: _____ OCCUPATION: _____

HOME PHONE: _____ OK TO LEAVE A MESSAGE? YES NO

WORK PHONE: _____ OK TO LEAVE A MESSAGE? YES NO

CELL PHONE: _____ OK TO LEAVE A MESSAGE OR TEXT? YES NO

PLEASE LIST INSURANCE INFORMATION. **WE REQUIRE A COPY OF YOUR CARD AND PHOTO ID BEFORE WE WILL FILE.**

NAME OF PRIMARY INSURANCE COMPANY POLICY NUMBER

_____

POLICYHOLDER'S NAME DOB SSN

_____

NAME OF SECONDARY OR SUPPLEMENT INSURANCE COMPANY POLICY NUMBER

_____

POLICYHOLDER'S NAME DOB SSN

_____

_____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE RELATIONSHIP TO PATIENT

****PT 18 YEARS OR OLDER MUST SIGN PAPERWORK****

IF PATIENT IS A MINOR CHILD (17 YRS OLD OR YOUNGER), PLEASE COMPLETE THE FOLLOWING INFORMATION
IF YOU ARE A LEGAL GUARDIAN INSTEAD OF PARENT, YOU WILL BE ASKED FOR PROOF OF GUARDIANSHIP.

FATHER'S (OR LEGAL GUARDIAN'S) NAME DOB SSN

_____

MOTHER'S (OR LEGAL GUARDIAN'S) NAME DOB SSN

_____

PAYMENT EXPECTED AT TIME SERVICES ARE RENDERED

PATIENT NAME: _____

DATE: _____

EYE HISTORY

DO YOU CURRENTLY WEAR GLASSES?	Y / N
DO YOU CURRENTLY WEAR CONTACTS?	Y / N
ARE YOU INTERESTED IN CONTACTS?	Y / N
DO YOU HAVE VISUAL DIFFICULTY WHEN READING?	Y / N
DO YOU HAVE VISUAL DIFFICULTY WHEN DRIVING?	Y / N

Have you or a family member experienced or been treated for any of the following. Circle all that apply.

CATARACTS	SELF	FAMILY
CROSSED EYES	SELF	FAMILY
GLAUCOMA	SELF	FAMILY
LASER SURGERY	SELF	FAMILY
LAZY EYE	SELF	FAMILY
MACULAR DEGENERATION	SELF	FAMILY
RETINAL DETACHMENT	SELF	FAMILY

☐ **NO KNOWN OCULAR HISTORY SELF OR FAMILY**

Are you currently or have you ever experienced any of the following.

☐ BLURRY VISION (NEAR)	CURRENT	PAST
☐ BLURRY VISION (DISTANCE)	CURRENT	PAST
☐ BURNING	CURRENT	PAST
☐ DISCHARGE	CURRENT	PAST
☐ DOUBLE VISION	CURRENT	PAST
☐ DROOPING EYELID	CURRENT	PAST
☐ DRYNESS	CURRENT	PAST
☐ EXCESS TEARING/WATERING	CURRENT	PAST
☐ EYE INFECTION	CURRENT	PAST
☐ EYE PAIN OR SORENESS	CURRENT	PAST
☐ FLOATERS OR SPOTS	CURRENT	PAST
☐ FOREIGN BODY SENSATION	CURRENT	PAST
☐ HALOS	CURRENT	PAST
☐ HEADACHES	CURRENT	PAST
☐ ITCHING	CURRENT	PAST
☐ LIGHT FLASHES	CURRENT	PAST
☐ LIGHT SENSITIVITY	CURRENT	PAST
☐ REDNESS	CURRENT	PAST
☐ SANDY OR GRITTY FEELING	CURRENT	PAST

History of any eye surgery. Y / N (if yes, please explain)

_____

MEDICAL HISTORY

Have you or a family member experienced or been treated for any of the following. Circle all that apply.

AIDS/HIV	SELF	FAMILY
ALLERGIES	SELF	FAMILY
ARTHRITIS **(RHEUMATOID)**	SELF	FAMILY
ASTHMA	SELF	FAMILY
BLOOD/LYMPH DISORDER	SELF	FAMILY
CANCER	SELF	FAMILY
DIABETES	SELF	FAMILY
EARS, NOSE, THROAT CONDITIONS	SELF	FAMILY
GASTROINTESTINAL CONDITIONS	SELF	FAMILY
HEART DISEASE	SELF	FAMILY
HIGH BLOOD PRESSURE	SELF	FAMILY
HIGH CHOLESTEROL	SELF	FAMILY
KIDNEY DISEASE	SELF	FAMILY
LUPUS	SELF	FAMILY
NEUROLOGICAL CONDITIONS	SELF	FAMILY
PSYCHIATRIC DISORDER	SELF	FAMILY
SEIZURES	SELF	FAMILY
SKIN CONDITIONS	SELF	FAMILY
STROKE	SELF	FAMILY
THYROID DYSFUNCTION	SELF	FAMILY

☐ **NO KNOWN MEDICAL HISTORY SELF OR FAMILY**

CURRENT MEDICATIONS

(Please list prescription and over-the-counter)

_____

_____

_____

MEDICATION DRUG ALLERGIES

_____

_____

PHARMACY

NAME: _____

CITY: _____

PHONE #: _____

PRIMARY CARE PHYSICIAN

NAME: _____

CITY: _____

PHONE #: _____

Are you currently pregnant or nursing? Y / N

Do you currently use the following? Circle all that apply.

CIGARETTES	SMOKELESS TOBACCO
ALCOHOL	RECREATIONAL DRUGS

INSURANCE ASSIGNMENT, CONSENT, RELEASE AND REQUEST OF MEDICAL RECORDS, DISCLOSURE OF INFORMATION, AND NOTICE OF PRIVACY

ASSIGNMENT OF INSURANCE BENEFITS

Patients with insurance (vision or medical) please read and sign below. I hereby assign all benefits to which I am entitled thru private medical insurance and any other vision plans to New Albany Vision Clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize New Albany Vision Clinic to release all information necessary to secure payment.

Signature_____ **Date:**_____

CONSENT FOR TREATMENT

The undersigned hereby consents to treatment, including examination and procedures that are deemed necessary, including dilation, for appropriate diagnosis, by New Albany Vision Clinic.

Signature_____ **Date:**_____

NOTICE OF RECEIPT OF HIPAA PRIVACY PRACTICES

I hereby certify that I have reviewed a copy of the HIPAA Privacy Practices for New Albany Vision Clinic. (Please tell us if you would like a copy for your personal records).

Signature_____ **Date:**_____

AUTHORIZATION TO REQUEST AND RELEASE MEDICAL RECORDS AND INFORMATION

This authorizes you to release to New Albany Vision Clinic, located at 484 W Bankhead Street, New Albany, MS 38652, their agents or representatives, full and complete medical records, evaluations, consultations or information (hereinafter collectively referred to as "medical records") you may have in custody concerning the undersigned patient. The undersigned represents and warrants that he/she has full authority to request said records and to agree to all the conditions recited herein.

This also authorizes New Albany Vision Clinic to release said "medical records" described above to any physician's office in which you have been referred or is involved in any treatment or care of the undersigned.

The undersigned expressly releases and forever discharges and agrees to identify and hold harmless New Albany Vision Clinic, its directors, officers, agents, employees, successors and assigns from any and all claims, damages, actions, causes of action or suits of any kind or nature whatsoever arising of, or from, the release or receipt of any medical records pursuant to this authorization.

Signature_____ **Date:**_____

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

NOTE: **In order for New Albany Vision Clinic to disclose your Private Health Information, the person listed must be able to provide the patient's date of birth and identify themselves by name and date of birth. If no persons are listed no information will be given to anyone except patient or parent of minor child.**

Name	Relationship to You	Date of Birth

I understand that it is my responsibility to update this list in order to keep accurate those authorized persons to discuss and use the patient's healthcare information.

Patient or Legal Representative Signature:_____ **Date:**_____

DESIGNATION OF ANOTHER PERSON TO CONSENT FOR MEDICAL CARE

I (parent or legal guardian) _____, cannot accompany my child, _____, to New Albany Vision Clinic.

Therefore, I give permission to the non-parent caregiver of legal age accompanying above said child to appointment, to verbally consent to medical treatment (including any type of procedure, dilation or other medical testing) to assist in the examination of said above named child without having to contact me. This form will remain in effect until revoked by parent or legal guardian by filling out a revocation form, available upon request.

_____ _____

(Signature of parent or legal guardian) (Date)

_____ _____

(Signature of witness) (Date)

NEW ALBANY VISION CLINIC
484 W BANKHEAD ST
NEW ALBANY, MS 38652
662-534-0101

PATIENT NAME:_____

CONTACT LENSES: PROFESSIONAL FEE POLICY

- Our routine eye exam includes a complete ocular health evaluation and measurement for glasses prescription. Our charge for a routine exam ranges from $103-$118. The fitting and prescribing of contact lenses is not a part of a routine exam. **This is an additional service for which there is a separate fee and is due whether you order contact lens or not and is non-refundable. Our fitting fee ranges from $35-$105.**
- **What is a contact lens fitting?**
  The size, material, curvature, and power of the contact lens must be specified to the characteristics of your eye. To do this, your doctor must take additional measurements and do additional evaluations beyond what is required for the prescription of eyeglasses. The curvature of the front of the eye is measured and the eye is evaluated for suitability to wear contact lenses. Following this, your doctor will often recommend a pair of trial lenses. The vision and fit of the lenses are then evaluated and, if necessary, adjustments are made. This entire process is called the **contact lens fitting.** A proper contact lens fitting is the only way to establish your correct contact lens prescription, even if you have already worn contact lenses previously.
- In most cases, a one-week follow-up visit is required before your final contact lens prescription can be released. If you are trying bifocal, RGP, or astigmatism lenses, the fitting process typically involves more visits with the doctor. These follow-up visits are included at no additional charge if you make and keep your scheduled appointments.
- **Our doctors will work with you to finalize the fitting process for up to 60 days after your initial exam. If you fail to return for your follow-up visit within 60 days, then you will be charged $35-$105 for visit(s) needed to finalize your prescription. If you fail to return for your follow-up visit within SIX MONTHS, you may be required to have a new eye exam before a contact lens prescription can be released.**
- Only routine contact-lens follow-ups are included in your original exam fee. You will be charged for all other visits unrelated to the original fit of the contacts, such as infections or trauma. You may be charged if you decide to change brands of contact lenses if this involves a new lens evaluation.
- It is the law that contact lens prescriptions are valid for **ONE** year. We cannot dispense lenses to you, trial or otherwise, after your prescription has expired. You should have annual exams to monitor the health of your eyes.
- Contacts are not a substitute for glasses. All contact lens wearers should have back-up glasses! Proper eye protection should still be worn when necessary.

By my signature, I acknowledge that I have read and understand the terms of this contract lens fee policy. I know that if I do not return for recommended follow-up visits, I will not have a final contact lens prescription and may be charged an additional refitting fee.

X_____ **Date**_____

Signature of Patient or Legal Guardian