

New Patient Information

Patient Name: _____

Have you ever had any of the following eye problems? If yes, is it current (within the last month)?

Condition	No	Yes	Current?	Condition	No	Yes	Current?
Glaucoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Eye Turn/Crossed Eye	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Macular Degeneration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Double Vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cataracts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Lazy Eye/Amblyopia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Retinal Tear/Detachment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Glare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eye Injury	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Flashes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dryness/Burning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Floater	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic Redness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Eye Surgery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Itching/Allergies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Complete Blindness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chronic Watering	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Prosthetic Eye	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you answered yes to any of the above, please let us know which eye is affected and any other details you feel might be helpful for us to know: _____

Please list all eye drops or ointments currently used: _____

For Glasses Wearers: How old are your glasses? _____ What do you wear them for? Distance Near Everything

What do you like about your glasses? _____ What do you not like about your glasses? _____

Did you bring your prescription sunglasses? Yes No Did you bring your prescription computer glasses? Yes No

Did you bring your prescription safety eyewear? Yes No Are you interested in new glasses today? Yes No

For Contact Lens Wearers: Are you wearing them now? Yes No Are you happy with your current contacts? Yes No

How is the comfort of your contacts? _____ How is your vision with your contacts? _____

Average wear time/day? _____ (Hours) How often do you wear them? _____

How often do you replace them? _____ How often do you sleep in your lenses? _____

How old is your present pair? _____ Brand? _____ What solution do you use? _____

Routine eye exams do not include professional services for contact lens evaluations. Any fees are the responsibility of the patient.

We are not able to use your materials benefits to pay for this service with most insurances.

Have you ever had any of the following medical problems? If yes, is it current (within the last month)?

Condition	No	Yes	Current?	Condition	No	Yes	Current?
Seasonal/Environmental Allergy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Rosacea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medication Allergy (List Below)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Multiple Sclerosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High Cholesterol/Triglycerides	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	ADD/ADHD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hyperthyroid (Overactive)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Autism	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hypothyroid (Underactive)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Dementia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes (Insulin Dependent, 1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes (Non-Insulin Dependent (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	COPD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Herpes Simplex (Oral/Genital)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Migraine Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Herpes Zoster (Pox/Shingles)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HIV/Aids	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Sjogren's Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lyme Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Autoimmune Disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other medical conditions or details you feel might be helpful for us to know: _____

Please list all medications/birth control/vitamins/supplements currently used: _____

Family History: Do you have any blood relatives with any the following:

Ocular Condition	No	Yes	Relation	Medical Condition	No	Yes	Relation
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Glaucoma	<input type="radio"/>	<input type="radio"/>		High Blood Pressure	<input type="radio"/>	<input type="radio"/>	
Eye Turn/Crossed Eye	<input type="radio"/>	<input type="radio"/>		Diabetes	<input type="radio"/>	<input type="radio"/>	
Macular Degeneration	<input type="radio"/>	<input type="radio"/>		Thyroid	<input type="radio"/>	<input type="radio"/>	
Ocular Cancer	<input type="radio"/>	<input type="radio"/>		Autoimmune Disorder	<input type="radio"/>	<input type="radio"/>	
Retinal Tear/Detachment	<input type="radio"/>	<input type="radio"/>		Cancer	<input type="radio"/>	<input type="radio"/>	

Review of Symptoms: Have you had any of the following? If yes, is it current (within the last month)?

Symptom	No	Yes	Current?	Symptom	No	Yes	Current?
Allergy				Hematologic/Lymphatic			
Itching	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Bruise Easy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sneezing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Slow Clotting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hives	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Swollen Nodes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cardiovascular				Integumentary (Skin)			
Chest Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Rash	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Racing heartbeat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Sores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Constitutional				Musculoskeletal			
Unplanned Weight Loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Stiffness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unplanned Weight Gain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Cramps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loss of Appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Back pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fatigue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Neurological			
Endocrine				Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Frequent Urination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Memory Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Excessive Thirst	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Muscle weakness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gastrointestinal				Vertigo	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stomach Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Psychiatric			
Stomach Upset	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Anxious	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jaundice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Depressed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Genitourinary				Paranoid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble Urinating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Respiratory			
Burning on Urination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Trouble Breathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ear/Nose/Throat				Shortness of Breath	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sinus pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Wheezing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cough	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	If you have symptoms not listed above please list here: _____ _____ _____			
Dry Mouth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Hearing Loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Trouble Swallowing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				

For Women: Are You Pregnant? Yes No If Yes, How Many Months? _____ Are you breast feeding? Yes No

Social History:

Do you use tobacco? Yes No Type used: Cigarettes/Cigars Chewing tobacco For how long ? _____

Did you ever use tobacco? Yes No If you've quit, how long ago? _____

Do you drink? Yes No Type used: Beer Wine Liquor For how long? _____

Do you use any recreational drugs? Yes No What type(s): _____ For how long? _____

Smoking is a known risk factor in the development of macular degeneration, cataracts, dry eye and many other ocular conditions. It is our recommendation that you take action to cease smoking to limit your risk of eye disease.

The Centers for Medicare and Medicaid Services (CMS) requests **ALL PATIENTS** provide the following information about race, ethnicity and preferred language. These classifications were determined by CMS. If you have questions please ask the staff.

Ethnicity: Not Hispanic or Latino Hispanic/Latino **Preferred Language:** English Spanish Other

Race: American Indian/Alaskan Native Asian Black/African American Hawaiian/Other Pacific Islander
 Caucasian
 Other _____

By signing below you attest the information provided on this form is accurate and true.

Patient Signature (Guardian if under 18): _____

Date: _____

Guardian Name (if under 18, Please Print): _____

Financial Responsibility Statement/Acknowledgement of Office Policies

Financial Policy

Payment is expected at the time service is rendered and before orders are placed. A returned check will incur a fee of \$25. Any unpaid balances exceeding 30 days post notice of balance owed may be turned over to a collections agency, which will result in an additional fee equal to 35% of the balance owed plus an administrative fee of \$45. A cancellation fee of \$125 may be assessed for any appointment missed without at least 24 hours prior notice. By signing you agree to be held liable for all expenses, costs and reasonable court, attorney and collection agency fees for any delinquent balance.

Prescription Recheck Policy

The doctor will recheck your glasses prescription one time at no cost within 60 days of the date on which the prescription in question was determined. Should the prescription change be determined by the doctor to be caused for medical reasons the visit will be billed as a medical exam and your medical copays if applicable will apply. This policy does not apply for planned rechecks as determined by the doctor for issues such as expected adaptation or amblyopia. For glasses not purchased through our office, a lens verification fee to confirm the correct fabrication of your glasses will apply prior to being scheduled with the doctor. This fee applies even if your glasses are found to be within tolerance. After 60 days, a fee will be incurred for any recheck as multiple factors can affect your prescription that are beyond the doctor's control. Rechecks will not be performed after 6 months from original exam date and a new exam will be necessary as too many factors can change within a short period of time that affect your prescription.

Eyewear and Low Vision Device Policies

This office will remake prescription glasses purchased from our office once within 60 days of pickup at no charge to the patient in cases of prescription change. Progressive lens non-adapts will be remade into lined bifocals or trifocals at no additional charge. Any remakes required beyond the initial remake will be charged 50% of our usual and customary fees.

Glasses purchased from our office are covered by our No Hassle Warranty for up to one year from date of order placement. All warranty repairs and warranty replacement will be covered for a \$50 copay per incident. This warranty does not cover lost or stolen eyewear.

If you wish to be reframed, you may do so once for a \$50 administrative fee for frames of equal or lesser value within 60 days of the original order date. You may select a frame with a higher value and pay the difference in frame cost and the administrative fee. Reframing will count towards your first time warranty replacement option.

A \$50 administrative fee will be charged for same day cancellations of eyewear orders submitted to the processing lab. As eyewear is a custom made medical product, no refunds are available. Eyewear orders not picked up after 90 days of initial notice are considered abandoned and will be dismantled and disposed.

Low vision devices and magnifier sales are final, no returns, exchanges or refunds.

Contact Lens Policies

Contact lens services are a separate service from your eye exam. Should you wish to obtain a prescription for contact lenses, either a separate fitting or an evaluation of your current contact lens parameters is required to ensure the health of your eye. Fitting fees are nonrefundable. Contact lenses come in two forms, custom made and mass produced. Mass produced lenses may be returned for store credit if the boxes are unopened and in saleable condition (i.e. no markings). A restocking fee of 35% of usual customary charges for custom orders cancelled same day. Custom made contact lenses have special policies specific to each lens design and will be reviewed at the time of fitting.

To our patients with vision/medical benefits:

Medical insurance and vision plans are very different in their terms of service and their coverage. We are unable to determine which, if any, can be billed until after the examination is completed and the diagnosis for your primary complaint has been determined. It is your responsibility to know your coverage and co-pay amounts. Please be aware, unless your insurance plan has specific benefits for contact lens fittings, you will be expected to pay that amount along with your co-pay and any other non-covered services. Any out of pocket expenses collected from you at the time of service are estimates only, your insurance will determine your final out of pocket costs.

We will do our best to inform you of non-coverage prior to performing a service or ordering materials. In the event that your insurance company determines that you are not eligible at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you are confirming your understanding that you are financially responsible for any and all charges incurred by you and not paid by your third-party plan. Be aware that any pre-authorizations received by our office are not a guarantee of payment from your insurance company. After we receive your plan's response, all remaining balances will be due within 30 days. If we do not receive a

response from your insurance company within 90 days we will bill you for the balance due in full. Due to the timely filing restrictions imposed by many insurance companies, failure to supply us with the correct insurance information may result in payment in full being owed by you.

By signing below, you attest that this information was provided to you and that you understand your financial obligations.

Patient Signature (or Guardian, if under 18): _____ **Date:** _____

Guardian Name, if under 18 (Please Print): _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Visionary Eye Center make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- I have read, or have had explained to me, Visionary Eye Center’s Notice of Privacy Practices prior to any services offered at Visionary Eye Center and agree to continue my care with Visionary Eye Center under said terms.

- I declined to read Visionary Eye Center’s Notice of Privacy Practices, but wish to continue my care with Visionary Eye Center under the terms of Visionary Eye Center’s Privacy Policies.

- I have read, or have had explained to me, Visionary Eye Center’s Notice of Privacy Practices prior to any services offered at Visionary Eye Center and do not wish to continue my care with Visionary Eye Center under said terms.

Patient Name (Printed)

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient Signature

Date

If you are signing as a personal representative of the patient, please indicate your relationship

Representative

Relationship to Patient

Date

List below any individuals you authorize to have access to your information and/or pick up material orders (i.e spouse, child, power of attorney).

1) _____ Relation: _____

2) _____ Relation: _____

3) _____ Relation: _____

Electronic Prescription Release Consent:

To remain compliant with 2024 Federal Trade Commission regulations, we are required to document proof that a copy of any glasses or contact lens prescription, once completed, has been provided. In efforts to limit the additional cost to the consumer these needless additional regulations create and to decrease the paperwork burden on our staff we have chosen to comply by uploading your prescriptions to your private electronic record portal through our electronic medical records system. This portal is available to you 24 hours a day. Access to this portal will be emailed to you if an email is provided. Should you not wish to provide an email, you may provide us a unique username and password and then navigate on your own to: <https://www.crystalpm.com/PatientPortal.jsp?crystalpmid=4042> to access your prescriptions. A link to the portal will also be available on our website at www.visionaryeyecenter.com

By signing this document, you are consenting to accept delivery of any glasses and contact lens prescriptions through the portal. You understand this does not prevent you from also obtaining a paper copy should you desire one at the time of your appointment. Should you not wish to sign this document please let us know so we can document your refusal for the FTC.

Patient Name (Printed)

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient Signature

Date

If you are signing as a personal representative of the patient, please indicate your relationship

Representative Relationship to Patient

Date