Patient Information Form

Patient's Name:_____ Middle Initial_____ Nickname:
Parent/Guardian's Name (if patient is a minor)
Birthdate:_____ Social Security #_____ Gender: Male / Female
Address:
Primary Phone number:_____ Email Address:
Occupation:_____ Employer:

How did you hear about our office?

Do you currently wear glasses? Yes / No Are you interested in LASIK refractive surgery? Yes / No

Do you currently wear contact lenses?** Yes / No Are you interested in wearing contact lenses?** Yes / No

All contact lens wearers are charged a fitting/evaluation fee. This fee is **Not covered by most insurances. An evaluation/fitting is necessary for a valid contact lens prescription. This fee ranges from $39 to $229.
Initial_____ *

Name of Primary care Physician:_____Date of Last Physical:

Do you have any of the following: Diabetes Yes / No High Blood Pressure? Yes / No High Cholesterol? Yes / No

Are you currently Pregnant or Nursing? Yes / No / NA

Do you currently use tobacco products? Yes / No / NA Do you drink alcohol? Yes / No / NA

Notice of Privacy Practice: The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. In signing below, you are stating that you are aware American Vision Center will not share your medical information without your written consent. A complete copy of the Notice of Privacy Practices is available on request.

Insurance: Your insurance policy is a contract between you and your insurance company. Each plan has it's own set of rules, exclusions, services and materials that are covered. It is your responsibility to be familiar with your specific benefit plan. As a courtesy to you, we will submit a claim to your insurance company. However, you are responsible for any charges not covered by your plan. Medically necessary examinations (eye infection, dry eye, glaucoma, etc) will be billed to your medical provider. Please provide our office with your most recent medical insurance card to ensure proper billing. We are an in-network provider for most major medical plans, but please verify our participation with your insurance carrier prior to exam. If your insurance company does not submit payment within 3 months time, you will then become responsible for payment of goods and services.

Materials Fees: Prescription eyeglasses are custom orders and all purchases are non-refundable and non-returnable. Contact lenses purchased from our office can be returned for credit or exchange IF the boxes are unopened AND unmarked within 30 days of purchase. Our office provides a prescription guarantee policy. If you are not satisfied with your prescription, you have 60 days from the date of purchase to have the doctor re-check the prescription and re-make glasses if necessary.

Financial: Co-payments are due at time of service. A minimum 50% deposit for materials will be collected when ordering and the balance due at the time materials are dispensed. There is a fee of $35 plus any bank charges for returned checks. If a statement needs to be sent, a 2% interest will accrue monthly (24% annually). A billing fee of $5/month will also be added until the account is paid in full. Upon non-payment of your account, you will be responsible for all fees and attorney costs in the collection of unpaid bills.

Dilation: We recommend that your pupils be dilated every 2 years, however certain medical conditions may require annual dilation. Dilating the pupils is necessary for the best evaluation of certain diseases such as cataracts, glaucoma, macular degeneration and other sight threatening conditions. Your pupils will be dilated for 2-4 hours and your vision may be temporarily blurry, especially for near activities. Your eyes will be sensitive to light, possibly making driving and other activities difficult. If necessary, your dilation can be re-scheduled for a more convenient time.

I understand that I am responsible for payment for my services and materials. I accept the terms as explained above:

Signature:_____ Date: