# EYE ASSOCIATES OF CAYCE-WEST COLUMBIA

## PATIENT INFORMATION

**PLEASE PRINT & ANSWER ALL SECTIONS COMPLETELY**

Patient Home Cell

Name_____ _____ _____

Address_____
Street City State Zip

Email Address_____

Birth date_____Age____Sex____

Patient SS#_____ Marital Status ☐ Married ☐ Single ☐ Other_____

Referring Doctor_____ How did you hear about us? ☐ MD ☐ Family ☐ Insurance

☐ Web Search / Other _____

Employer_____Occupation _____

## RESPONSIBLE PARTY

Name_____ ☐ Self ☐ Parent ☐ Other_____

Address_____Home Tel_____
Street City State Zip

Bus. Tel_____

## INSURANCE INFORMATION

Vision Insurance: _____

Subscriber: _____

ID Number:_____

SS#: _____ DOB _____ Sex_____

Company Name/Group #_____

Medical Insurance: _____

Subscriber: _____

ID Number:_____

SS#: _____ DOB _____ Sex_____

Company Name/Group #_____

I understand that Eye Associates of Cayce may contact me using the information given for circumstances including, but not limited to, notification and reminder of appointments, notification of the arrival of materials, and notification of payment due. I acknowledge that Eye Associates of Cayce will not share or sell my personal information, and use it only as necessary for practice management.

Patient/Authorized Person's Signature_____Date: _____

# Medical History Questionnaire

Name: _____ Today's Date: ____ / ____ / ____

Address: _____ Phone: _____

Email: _____ Cell: _____

Birth Date: ____ / ____ / ____ Social Security #: ____ / ____ / ____ Last Eye Exam: _____

Name of Medical Doctor: _____ Dr.'s Phone: _____

**Select any of the following that you currently have:** ☐ None ☐ Other _____

| | | | |
|---|---|---|---|
| ☐ Allergies | ☐ COPD | ☐ HIV / AIDS | ☐ Plaquenil Use |
| ☐ Amaurosis Fugax | ☐ Coronary Artery Disease | ☐ Hypercholesterolemia | ☐ Poor Vision |
| ☐ Anemia | ☐ Depression | ☐ Hyperthyroidism | ☐ Prostate Cancer |
| ☐ Anxiety | ☐ Diabetes | ☐ Hypothyroidism | ☐ Radiation Treatment |
| ☐ Asthma | ☐ End Stage Renal Disease | ☐ Insomnia | ☐ Redness |
| ☐ Arthritis | ☐ Eye Pain | ☐ Jaw Pain | ☐ Scalp Tenderness |
| ☐ Atrial Fibrillation | ☐ GERD | ☐ Loss of Vision | ☐ Seizures |
| ☐ Bone Marrow Transplant | ☐ Headache | ☐ Leukemia | ☐ Shortness of Breath |
| ☐ BPH | ☐ Hearing Loss | ☐ Lung Cancer | ☐ Stroke |
| ☐ Breast Cancer | ☐ Hepatitis | ☐ Lymphoma | ☐ Tearing |
| ☐ Colon Cancer | ☐ High Blood Pressure | ☐ Paralysis | ☐ Thyroid Abnormality |

**Past Surgeries:** ☐ None

_____

_____

_____

_____

_____

**Ocular History:** ☐ None ☐ Other _____

| | | |
|---|---|---|
| ☐ Allergic Conjuctivits | ☐ Glaucoma | ☐ Pseudoexfoliation |
| ☐ Blepharitis | ☐ Macular Degeneration | ☐ Retinal Tear: __Right/__Left |
| ☐ Cataract: __ Right/__Left | ☐ Macular ERM: __Right/__Left | ☐ Strabismus |
| ☐ Corneal Dystrophy | ☐ Narrow Angles | ☐ PVD: __Right/__Left |
| ☐ Diabetic Retinopathy | ☐ Ocular Hypertension | ☐ VitreousFloaters:__Right/__Left |
| ☐ Dry Eyes | ☐ Ophthalmic Migraine | |

Do you currently wear glasses? ☐ No ☐ Yes How long? _____

Do you currently wear contacts? ☐ No ☐ Yes How long? _____ What type? _____

**Please turn over to complete**

**Ocular Surgery:** ☐ None ☐ Other _____

- ☐ Blepharoplasty: Right Eye
- ☐ Blepharoplasty: Left Eye
- ☐ Cataract Surgery: Right Eye
- ☐ Cataract Surgery: Left Eye
- ☐ Corneal Transplant: Right Eye
- ☐ Corneal Transplant: Left Eye
- ☐ DSAEK: Right Eye
- ☐ DSAEK: Left Eye
- ☐ Eye Muscle Surgery
- ☐ Intravitreal Injections: Right Eye
- ☐ Intravitreal Injections: Left Eye
- ☐ Lasik: Right Eye
- ☐ Lasik: Left Eye
- ☐ LPI: Right Eye
- ☐ LPI: Left Eye
- ☐ LTP: Right Eye
- ☐ LTP: Left Eye
- ☐ PRK: Right Eye
- ☐ PRK: Left Eye
- ☐ Ptosis Repair: Right Eye
- ☐ Ptosis Repair: Left Eye
- ☐ Punctal Plugs: Right Eye
- ☐ Punctal Plugs: Left Eye
- ☐ Strabismus Surgery
- ☐ Retinal Laser: Right Eye
- ☐ Retinal Laser: Left Eye
- ☐ Trabeculectomy: Right Eye
- ☐ Trabeculectomy: Left Eye
- ☐ Tube Shunt: Right Eye
- ☐ Tube Shunt: Left Eye
- ☐ Yag Capsulotomy: Right Eye
- ☐ Yag Capsulotomy: Left Eye

**Are you currently taking any medications?**: ☐ None ☐ Yes – Please list below

_____

_____

_____

**Are you allergic to any medicines?:** ☐ None ☐ Yes – Please list below

_____

_____

**Social History:** ☐ None

- ☐ Never Smoker
- ☐ Former Smoker
- ☐ Current Smoker
- ☐ Never Drinker
- ☐ Former Drinker
- ☐ Current Drinker

**Driving Status:**

- ☐ Not a Driver
- ☐ Daytime Driver
- ☐ Nighttime Driver

**Are You:**

- ☐ Not Pregnant
- ☐ Pregnant
- ☐ Nursing

**Family History:** ☐ None

- ☐ Blindness
- ☐ Crossed Eyes
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment / Disease
- ☐ Diabetes

**Relationship to You:**

_____

_____

_____

_____

_____

_____

If you answered YES to any of the above conditions, or if you have a condition that is not listed above, please list them below, along with any medications you may be taking for that condition. If you have any other comments, please list them below. Thank you!

_____

_____

_____

_____

_____

_____

Doctor's Signature

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## FINANCIAL POLICY

It is customary to pay for professional services when rendered. Most eye exams can be covered under a patient's routine vision benefits. Patients may be responsible for co-payments for the exam, contact lens fitting and evaluation, and/or material benefits. It is your responsibility to provide us with any and all insurance information up front.

However, if you have a medical problem, we will bill your medical insurance on your behalf, as long as we are in network. Most medical insurance plans, including Medicare, do not cover routine refractions or routine eye exams. Such plans require that we charge separately for that portion of the examination, since it is not a covered service. Most insurance plans do not cover the contact lens fitting and evaluation. You will be responsible for any co-payments, deductibles or non-covered services as determined by your insurance company.

In accordance with our contract and with your insurance provider, we are responsible for collecting, and you are responsible for paying, co-payments, co-insurance, and/or deductibles at the time of service.

A fee of $25 is charged for patients who miss or cancel more than 2 times in a calendar year without a 24 hour notice. Excessive missed appointments may result in a termination of practice-patient relationship.

If you have any questions, please do not hesitate to ask. We are here to help you get the quality care you need.

_____

Patient Name (Please Print)

_____

Signature (Patient, Parent or Guardian) Date

## RETURN / EXCHANGE POLICY

Eye Associates of Cayce does not allow returns on eyeglass lenses or frames. Warranties on eyewear will vary based on options purchased; all warranties will be reviewed with you at time of purchase. Warranties are based on the original date of purchase. Contact lenses purchased here may be returned within 60 days of order, as long as the boxes are unopened and undamaged. A $5/box restocking fee applies. Contacts that are ordered and not picked up within 60 days may be returned, leaving the patient responsible for the restocking fee. Trial contact lenses are available for fitting purposes only, and not to be dispensed for other purposes.

Patient Signature _____

## PRIVACY POLICIES & CONSENT

Eye Associates of Cayce is required to create and store personal health information (PHI) on you, in order to provide you with eye care services. It is often necessary to use and disclose this information in order to treat you, order products, and obtain payment for our services. As outlined in the Notice of Privacy Practices available to you, we will not release your PHI without just cause. An example of just cause might be submitting information to your insurance company, our optical labs, or doctors who are coordinating care. Your PHI will not be released to any individual persons or practices without your written consent. You have the right to request a personal copy of our Notice of Privacy Practices at any time. By signing below, you acknowledge the Notice of Privacy Practices from Eye Associates of Cayce, and consent to the use and disclosure of your personal health information for purposes of treatment, payment, and healthcare operations.

Patient Signature _____

****PLEASE TURN PAGE OVER TO COMPLETE BACK SIDE****

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## AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

Your privacy is important to us. Should you like us to, we will discuss your medical records with the person(s) you designate below. If you would like to designate a family member or other representative with whom Eye Associates of Cayce may discuss your medical records, please indicate below.

□ YES – Eye Associates of Cayce may discuss my medical records with the following individual(s).

| Individual's Name | Relationship to Patient |
|---|---|
| | |
| | |

You may revoke/cancel or modify/change this designation at any time, but it must be given in writing.

By signing below, I agree that I authorize Eye Associates of Cayce to discuss my medical records with the person(s) listed above. I understand that I may revoke/cancel or modify/change this designation at any time, but must do so in writing.

_____
Patient Name (Please Print)

_____
Signature (Patient, Parent or Guardian) Date

## EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone: _____

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# Contact Lens Evaluation Agreement

The charge for evaluating and determining your suitability for contact lens wear is not included in the comprehensive exam fee or refraction fee. This service must be done annually to renew a contact lens prescription. Many insurances do not cover this charge, or may simply discount it. A comprehensive eye exam must be performed prior to the contact lens fitting. If you have not had a comprehensive eye exam within 60 days, you must have a new one. The fee for contact lens fitting and initial follow-up depends on the examination results and the type of lenses that will be prescribed. The fitting fees are as follows:

| Type of Evaluation | New Wearer w/ I&R | Established Wearer | Lens Types |
|---|---|---|---|
| Basic Evaluation | $70.00 | $45.00 | Soft Spheres, excluding Monovision |
| Toric Evaluation | $90.00 | $65.00 | Soft Torics (Astigmatic), RGP lenses |
| Complex Evaluation | $120.00 | $95.00 | Soft Multifocals, Soft Monovision, RGP Multifocals, RGP Monovision |

Trial contact lenses are dispensed for the evaluation purposes only. You must return per instructions for your contact lens prescription to be finalized. It is up to you to strictly adhere to the recommended wearing schedule, lens care procedures, and follow-up appointments. Report any unusual problems including blurred vision, redness, watering of the eye, sensitivity to light, eye discomfort or pain to this office and promptly remove your lenses. We cannot be responsible for unsuccessful wear due to patient noncompliance in following recommended routine.

The following products and services are included in the contact lens fitting and evaluation fee:

- Professional examination of contact lens fit and power
- Contact lens related follow-up care for up to 30 days or first 2 follow-up visits, whichever comes first
- Trial pair of contact lenses (if available)
- Professional insertion and removal training (required for new contact lens wearers)
- Trial size contact lens solution and new contact lens case (if available, for first time wearers only)

The evaluation fee is for professional services and does not include the cost of the lenses. The supply of contact lenses is billed separately. Contact lens prescriptions will only be released after the initial fitting period is successfully completed (which must include the examination, fitting, and follow-up visits), and after all fees are paid. Prescriptions will not be finalized for patients who are unable to successfully complete the insertion and removal training.

REFUND POLICY: Most patients are able to wear contact lenses successfully, but a successful fit and wearing experience cannot be guaranteed. There will be no refund on custom lenses or opened boxes of lenses. Unopened, unexpired boxes may be returned within 60 days of ordering, but are subject to a $5 restocking fee per box. If boxes are not picked up within 60 days of order, they will be automatically returned, and a restocking fee will be charged.

**Please note that fees for professional services, such as examination fees and contact lens evaluation fees, will not be refunded.**

I acknowledge that I have read this agreement, and understand the implications therein. After reading this agreement, by signing below I acknowledge these prices and policies.

_____ _____

Responsible Party Signature Date

_____

Printed Name