ANNANDALE EYE CLINIC

For Office Use Only			
Ins			
CoPay			
RHA	**S**	**M**	**N**
CL Exam	**Y**	**N**	
OCT	**S**	**M**	**N**

Preferred Contact Method ❑ **phone** ❑ **email** ❑ **mail**

PATIENT INFORMATION

Patient's Occupation or School Grade:	**Patient's Employer or School:**	**Patient's Medical Physician & Clinic:**
Emergency Contact Name:	**Emergency Contact #:**	**Emergency Contact Relationship to Patient:**

What recreational hobbies do you enjoy doing? (Please check all that apply)

❑ Baseball / Softball	❑ Crafts	❑ Hunting	❑ Sewing / Needlework
❑ Basketball	❑ Football	❑ Painting	❑ Snow Skiing
❑ Boating/Fishing	❑ Gardening	❑ Racing/Motor biking	❑ Swimming
❑ Computer/Video Games	❑ Golf	❑ Reading	❑ Tennis/Racquetball
❑ Cooking	❑ Hockey	❑ Running	❑ Woodworking

Are you experiencing any of the following difficulties? (Please check all that apply)

❑ Blurry	❑ Night Time Driving / Glare	❑ Eyestrain / Headaches / Eye Fatigue
❑ Dry Eyes	❑ Sensitive to sunlight	❑ Other_____

Amount of screen time (in hours) per day? _____

ASSIGNMENT AUTHORIZATION / RELEASE OF INFORMATION

I, the undersigned, hereby authorize Litchfield Eye Center, its physicians and/or its agents to apply for benefits on my behalf for services rendered to me. I request payment from my insurance carrier to be made directly to Litchfield Eye Center. I certify that the above information is correct and further authorize the release of any information for any claim to my insurance carrier. I understand the HIPAA compliance regulations and agree to them. I also authorize Litchfield Eye Center, its physicians and agents to disclose any part of or all of the medical records to my insurance carrier. I also understand that it may be necessary to contact my present or past employer in regard to insurance claims.

_____ _____

Signed By **Date**

GUARANTEE OF PAYMENT / NON-COVERED CHARGES

I, the undersigned, understand that I am financially responsible for all charges including those not covered by my health insurance and/or Medicare. I further understand that my health insurance company may not cover all services including, but not limited to: refractions, Optomap/RHA retinal exam, routine eye exams, eye glasses and other ancillary testing, and some of these services are necessary for the completion of the evaluation. Charges for these services may be obtained prior to the examination. **I UNDERSTAND IF MY INSURANCE COMPANY DENIES SERVICES, THEN IT WILL BE MY RESPONSIBILITY TO PAY THESE CHARGES.**

_____ _____

Signed By **Date**

Office Use	Year	Lens	AR	Sun

CONTACT LENS EXAMINATIONS AND FEES

Contact Lens Annual Examination

This examination includes: evaluation of the health of your eyes with contact lenses on, reassess the fit and movement of your contact lenses, updates your prescription as required, and the education to keep you wearing contact lenses successfully. A 30 day period of follow-up care is included. All follow-up visits to finalize your prescription will need to be done during this timeframe or additional fees will be assessed.

❑ $47.50 - $73.50

Contact Lens Refitting Examination

If our doctors have not prescribed contact lenses for you in the past or if a change to modality or type of contact lens is needed this examination is necessary for them to evaluate the health of your eyes with contact lenses on. It also reassess the fit and movement of your contact lenses, update your prescription as required, and educate you on successful contact lens wear. A 30 day period of follow-up care is included. All follow-up visits to finalize your prescription will need to be done during this timeframe or additional fees will be assessed.

❑ $73.50 - $254.00

Initial Contact Lens Examination

This exam will include contact lens training on insertion, removal, and instruction on the care of your contact lenses. It will allow our doctors to evaluate health of your eyes with contact lenses on, assess the fit and movement of your contact lenses, and to educate you on successful contact lens wear. A 30 day period of follow-up care is included. All follow-up visits to finalize your prescription will need to be done during this timeframe or additional fees will be assessed.

❑ $134.50 - 254.00

Do you elect to have a contact lens examination?

❑ Yes ❑ No

A contact lens examination and evaluation is medically necessary and required in order to obtain or renew your contact lens prescription. All contact lens professional service fees are ***non-refundable*** even if not successful and **payment is due at the time of service**.

The contact lens prescription will not be released until full payment is received and only after all prescribed follow-up visits have been completed. Our office requires a valid medical and refractive eye examination to be completed prior to being fit with any contact lenses. This is to assure that there is not any unsuspected or underlying conditions that may prevent successful and healthy contact lens wear.

Unless contact lens coverage is specifically noted in your insurance plan, your insurance will not pay the above fee.

Please note: the above fee does not include the cost of the contact lenses. Contact lenses may only be returned if the original packaging is not opened or written upon within two months of purchase. Contact lenses that are custom ordered are non-refundable.

By signing below, I understand and agree to the above contact lens professional services and associated fees.

_____ _____

Signed By **Date**

OCULAR HISTORY

Date of Last Eye Exam: / /

Last Eye Exam Location:

Eye Diseases or Eye Surgeries (include dates)**:** ❑ None

MEDICAL HISTORY

Pharmacy (Name and Location):

Medications, Over The Counter, Supplements (with Dosage):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____

Allergies with reactions (list all)**:** ❑ None

Medical Problems (check any/all that apply):

- ❑ ADD / ADHD
- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis (type) _____
- ❑ Asthma
- ❑ Autoimmune Disorder (type) _____
- ❑ Bell's Palsy
- ❑ Cancer (type) _____
- ❑ Colitis
- ❑ COPD
- ❑ Crohn's Disease
- ❑ Diabetes (Insulin)
- ❑ Diabetes (Non-Insulin)
- ❑ Depression
- ❑ Epilepsy
- ❑ Fibromyalgia
- ❑ High Cholesterol
- ❑ Heart Disease
- ❑ HIV/AIDS/STD
- ❑ Hormonal Dysfunction
- ❑ Lupus
- ❑ Multiple Sclerosis
- ❑ Muscular Dystrophy
- ❑ Neurofibromatosis
- ❑ Pregnant (weeks) _____
- ❑ Rosacea
- ❑ Sleep Apnea
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Other: _____

Height: _____ feet _____ inches **Weight:** _____ lbs _____ **Tobacco Use:** ❑ Yes ❑ No ❑ Former

Alcohol Use: ❑ None ❑ Social ❑ Moderate ❑ Excessive **Drug Use:** ❑ Yes ❑ No ❑ Former

Medical Surgeries (include Date and Type)**:** ❑ None

FAMILY HISTORY

Conditions (check all that apply, and state the family relationship):

- ❑ Cataracts _____
- ❑ Diabetes _____
- ❑ Glaucoma _____
- ❑ Heart Disease _____
- ❑ High Blood Pressure _____
- ❑ Macular Degeneration _____
- ❑ Retinal Detachment _____
- ❑ Other _____