FIRST AND LAST NAME: _____ DATE OF BIRTH: _____

STREET ADDRESS: _____

CITY, STATE, ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

SOCIAL SECURITY NUMBER: _____ GENDER: M F

EMAIL ADDRESS: _____

NAME OF PARENTS IF MINOR MOTHER: _____ FATHER: _____

PRIMARY CARE PHYSICIAN:

NAME:
CITY / LOCATION:
PRACTICE NAME:
PHONE:

EMERGENCY CONTACTS (NAME AND PHONE NUMBER):

1.
2.

PRIMARY INSURED (PRIMARY PERSON ON POLICY):

FIRST & LAST NAME:
RELATIONSHIP TO PATIENT:

CONDITIONS:	**NONE**	**CIRCLE IF APPLICABLE**
ALLERGY/ IMMUNOLOGY:		rheumatoid arthritis, Sjogren's Syndrome, Herpes Simplex Virus, Lupus, HIV || sinus, sneezing, redness, itching, hives
CARDIOVASCULAR:		high blood pressure, high cholesterol, heart attack, stroke, congestive heart failure, irregular heartbeat, pace maker || chest pain, racing pulse, palpitations
CONSTITUTIONAL:		insomnia || headaches, fever, heat stroke, weight loss, weight gain, fatigue, loss of appetite
ENDOCRINE:		diabetes, Thyroid Eye Disease, Graves Disease, hypothyroid, hyperthyroid || increased thirst, excessive urination, heat/cold intolerance, hormone
GASTROINTESTINAL:		GERD, hernia, ulcers || nausea, upset stomach, diarrhea, constipation
GENITOURINARY:		yellow jaundice, kidney stones, impotence || painful/ frequent urination, blood in urine
HEMATOLOGY:		anemia, sickle-cell || bleeding, blood clots, problems related to blood transfusions
ONCOLOGY:		Cancer - breast, prostate, lung, skin, colon, other
EARS, NOSE, THROAT:		hard of hearing, vertigo, sinus/allergy || ear ache, cough, dry mouth, hoarseness, sore throat
DERMATOLOGIC:		acne, rosacea, melanoma, shingles || pimples, warts, growths, rash
MUSCULOSKELETAL:		rheumatoid arthritis, osteoporosis, fibromyalgia, other type arthritis || joint pain, stiffness, swelling, cramps
NEUROLOGICAL:		Parkinson's, Alzheimer's, seizures, dementia, paralysis, stroke || numbness, memory loss
PSYCHIATRIC:		anxiety, depression, biploar, ADHD
RESPIRATORY:		asthma, COPD, emphysema || congestion, wheezing, short of breath, TB exposure
EYES:		glaucoma, macular degeneration, cataract, keratoconus, detached retina, cornea problems, lazy eye, eye injury/trauma
FEMALES:		Are you pregnant? Are you nursing?

RECEIVED INFLUENZA IMMUNIZATION? Yes / No Year? **RECEIVED PNEUMOCOCCAL VACCINE?** Yes / No Year?

LIST ALL MEDICATIONS:

LIST ALL EYE DROPS/MEDICATIONS:

LIST ALL NON-EYE SURGERIES:

LIST ALL ALLERGIES TO MEDICATIONS:

NONE (CIRCLE IF NONE)

LIST ALL EYE SURGERIES:

TOBACCO USE: None, Occasional, Often **ALCOHOL USE:** None, Occasional, Often **DRUG USE:** None, Occasional, Often

FAMILY **HISTORY, CIRCLE IF APPLICABLE AND WRITE TYPE OF RELATION:**

CONDITION:	RELATION:	CONDITION:	RELATION:	CONDITION:	RELATION:
Macular Degeneration		Lazy Eye		Heart Disease	
Cataract		Arthritis		High Blood Pressure	
Glaucoma		Cancer		Thyroid Disease	
Retinal Detachment		Diabetes		Stroke	

Lenza EYE CENTER

FINANCIAL POLICY AND BILLING PROCESSES

Patient:_____ Date of Birth:_____ Date:_____

- **Payment Due**: I understand that payment is due when service is rendered.
- **Co-pay, Co-insurance and Deductibles:** It is my responsibility to know what my co-pay, co-insurance and deductibles are, and my obligation to pay this at the time of service.
- **Billing Fee:** If I am not able to pay my co-pay, deductible or co-insurance portion at the time of service, my appointment may be rescheduled.
- **Insurance Coverage:** I acknowledge that the insurance cards I have presented are current and accurate.
- **Non-covered Services:** I understand that some services may be considered non-covered services by my insurance plan. I understand that it is my responsibility to know what my insurance does or does not cover and I understand that I am financially responsible for paying all non-covered services.
- **Denied Charges:** I understand that some charges may be denied by my insurance carrier as investigational, experimental or not medically necessary and will not be paid by my insurance carrier. I understand that my physician feels these services are needed whether my insurance carriers deems them payable or not and that I am obligated to pay for these services in full.
- **Refractions:** Refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary in order to write a prescription for glasses or contact lens. Medicare and most medical insurances do not cover the fee for refractions. I understand that I am responsible for this fee and it is payable at the time of service. We can, at your request, file your refraction charge with your insurance plan. If your insurance policy pays this fee. We will then be refunding your payment.
- **Participating Insurance Plans:** If the practice is not a participating provider in my insurance plan, I will be responsible for filing my own claims and I will be responsible for paying in full at the time of service.
- **Returned Checks & Past Due Accounts:** Returned checks will be subject to collection charges, penalties and interest.

  All accounts are considered past due if not paid within 90 days of service. Past due accounts may result in collection turnover and subject to penalties and interest, or the refusal of future appointments until old balances have been paid in full. The practice does not accept post dated checks.
- **Medicaid:** The practice only accepts patients that have only Medicaid coverage if they are referred by another Medical Provider for a medical condition. The practice does not participate with Medicaid for routine vision services. I understand that I am responsible for my copay at the time of service and if I have exceeded my yearly allotted visits that I am responsible for paying for my visit in full at the time of service.
- **Medical Plans that have Vision Benefits:** Please be advised that some medical plans do have routine vision benefits; however, sometimes these vision benefits are with a different carrier than your medical plan. We may be participating providers with your medical plan but not your vision plan. Please contact your carrier to verify your benefits and whether the practice is a provider for both your medical and vision plan.
- **Authorizations:** Some insurance plan require you receive a prior authorization for services by a specialist, please review your policy to see if there is such a requirement and obtain this authorization prior to your visit with our clinic.
- **Contact Lens Fittings:** It is my responsibility to come in for my Contact Lens Follow-Up visits in a timely fashion and to keep my appointments. After 30 days of lapse between visits, I will be charged $30 for the next CL Follow-Up visit. After 90 days of lapse between visits, I will be charged for a new Refraction & new Contact Lens Fitting Exam.

_____ _____

Patient or Guardian Signature Date

_____

Relationship if not signed by patient

Lenza EYE CENTER

WARRANTY, BREAKAGE AND REPLACEMENT POLICIES FOR GLASSES

Patient:_____ Date of Birth:_____ Date:_____

- **Cancellation of Order:**
  - Orders may be cancelled for a refund only if the lab has not yet started processing the lenses. Orders are typically sent to the lab on the same day that the Order is placed with Lenza.
  - We do not give refunds for Orders where the lenses have already been processed by the lab. We will work with the lab, the frame manufacturer, and the Patient's insurance company to correct any issues with an Order.
- **Frame Restyling**:
  - Must be within 60 days of the original order pick-up date.
  - If a Patient finds that they dislike their frame after purchase, the Patient can switch the frame out for another frame of equal or lessor price.
  - Patient will receive a 50% discount on the price of the lenses that will need to be re-made to fit the new frame.
- **Non-Adapt for Progressive Lenses:**
  - Must be within 60 days of the original order pick-up date.
  - Progressive lenses can be switched to a trifocal, bifocal, or single vision with the same lens enhancements at no cost. (A refund will not be given for the difference in cost between the Progressive lenses and the new lenses).
  - Progressive lenses can also be upgraded to a higher quality Progressive lens. The Patient will only be charged the difference in price between the original lenses and the new lenses.
- **Non-Adapt for Other than Progressive Lenses:**
  - Must be within 60 days of the original order pick-up date.
  - All other lenses can be switched to a reader-only lens with the same lens enhancements at no cost. (A refund will not be given for the difference in cost between the original lenses and the new lenses).
  - Lenses can also be upgraded to a higher level lens type. The Patient will only be charged the difference in price between the original lenses and the new lenses.
- **Lens Warranties:**
  - Anti-scratch lens coatings have a 1-year warranty. Lenses will be replaced at no cost.
- **Broken Frames Caused by Patient Mishap:**
  - Must be within 6 months of the original order pick-up date.
  - Patient can receive a 40% discount for a replacement pair of glasses. The discount applies to both the frame and the lenses.
- **Broken Frames Caused by Manufacturer Defect for Discount Frames:**
  - 1-year warranty on frame. Frame will be repaired and/or replaced at no cost. If replacement parts are no longer available, the Patient may choose another frame of equal or lessor price.
  - If new lenses are required, we will replace the lenses up to $200. If the price of the lenses is more than $200, the Patient will pay the difference in the price.
- **Broken Frames Caused by Manufacturer Defect for All Other Frames (Non-Discount Frames):**
  - 1-year warranty on frame. Frame will repaired and/or replaced at no cost. If the frame and/or replacement parts are no longer available, the Patient may choose another frame of equal or lessor price.
  - If new lenses are required, replacement lenses will be provided at no cost.
- **Doctor Prescription Redos:**
  - Must be within 60 days of the original order pick-up date.
  - Lenses can be re-made to fine-tune a prescription at no cost (one time only).
  - If the Patient would like to change the lens prescription after 60 days, or would like more than one Redo, the Patient will receive a 50% discount on the price of the new lenses.

_____ _____

Patient or Guardian Signature Date

_____

Relationship if not signed by patient

Lenza EYE CENTER

AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Due to the **HIPAA Compliance Privacy Laws of the Federal Government**, it is mandatory that we ask you to review and answer the following questions listed below.

Name: _____

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

□ Yes □ No Home Phone: _____ □ Yes □ No Cell Phone: _____

May we contact you at your place of employment? □ Yes □ No
If so, may we leave a message? □ Yes □ No

If yes: Work Phone: _____ Extension: _____

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, and billing)?

□ Yes □ No If yes, please provide:

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____
Is this person your Power of Attorney for medical purposes? □ Yes □ No

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

I hereby authorize Lenza Eye Center to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked**.

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

I have reviewed Lenza Eye Center's Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

_____ _____
Patient or Guardian Signature Date

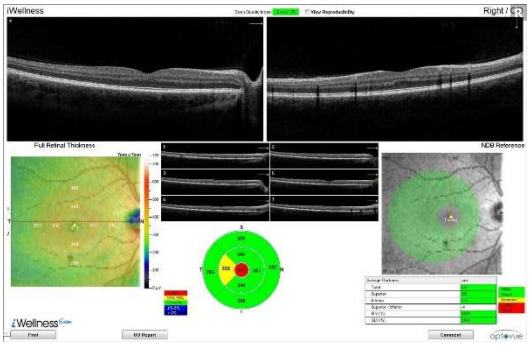
_____
Relationship if not signed by patient

Lenza EYE CENTER
25699 SW Argyle Ave, Unit A, Wilsonville, OR 97070
P: (503) 833-2662 F: (216) 342-1103

Patient Name _____
Last OCT _____
Last Visual Field_____

Preventative Health Screening

OCT wellness screening: This test scans the retina's microscopic layers, allowing your doctor to map and measure the thickness. Measurements help the doctor detect eye diseases such as glaucoma and retina problems much earlier than with an eye exam alone. Unfortunately insurance doesn't cover this screening test, but our charge is only $40. There is no discomfort. We strongly recommend a wellness OCT every 1 to 2 years for the following individuals:

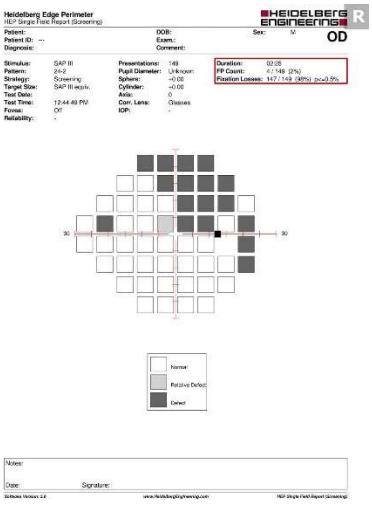


- Anyone over 45 years old
- Anyone who is diabetic
- Anyone with family history of glaucoma or macular degeneration
- People under 45 years old who are very near-sighted or far-sighted

____Yes, I would like to have this screening test performed today

____No, thank you

Visual field screening: This test measures your peripheral vision or "side vision." Using this test, the doctor will be able to assess the presence of blind spots which may lead to early detection of certain eye diseases including glaucoma, strokes, and even tumors. Unfortunately, insurance doesn't cover this screening test, but our charge is only $15. There is no discomfort. We strongly recommend a visual field test every 1 to 2 years for the following individuals:



- Anyone over 45 years old
- Anyone with constant or unusual headaches
- Anyone with family history of glaucoma or macular degeneration
- People under 45 years old who are very near-sighted or far-sighted

____Yes, I would like to have this screening test performed today

____No, thank you