FIRST & LAST NAME: ______________________ DATE OF BIRTH: ______________

PREFERRED NAME: ____________ PRONOUNS: ____________

STREET ADDRESS: ______________________

CITY, STATE, ZIP: ______________________

HOME PHONE: ____________ CELL PHONE: ____________

EMAIL ADDRESS: ______________________

SOCIAL SECURITY #: ____________ BIRTH SEX: MALE FEMALE

PRIMARY CARE PHYSICIAN:

NAME:
LOCATION:
PRACTICE:
PHONE:

NAME OF PARENTS IF MINOR: ______________________

EMERGENCY CONTACTS (NAME & PHONE NUMBER):
1.
2.

PRIMARY INSURED (PRIMARY PERSON ON POLICY):
FIRST AND LAST NAME:
RELATIONSHIP TO PATIENT:

CONDITIONS	**NONE**	**MEDICAL HISTORY: CIRCLE IF APPLICABLE**
EYES		glaucoma, macular degeneration, cataract, keratoconus, detached retina, cornea problems, strabismus, amblyopia, eye injury
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, pacemaker || chest pain, racing pulse, palpitations
CONSTITUTIONAL		insomnia, headaches || fever, heat stroke, weight loss/gain, fatigue, loss of appetite
ENDOCRINE		diabetes, thyroid eye disease, Graves' disease, hypothyroid, hyperthyroid || increased thirst, excessive urination, heat/cold intolerance
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, blood clots || bleeding, problems related to blood transfusions
ONCOLOGY		cancer: breast, prostate, lung, skin, colon, other
EARS, NOSE, THROAT		hard of hearing, vertigo, sinus allergies || earache, cough, dry mouth, hoarseness, sore throat
DERMATOLOGY		acne, rosacea, melanoma, shingles || pimples, warts, growths, rash
MUSCULOSKELETAL		osteoporosis, fibromyalgia, other type arthritis || joint pain, stiffness, swelling, cramps
NEUROLOGICAL		Parkinson's, Alzheimer's, seizures, dementia, paralysis || numbness, memory loss
PSYCHIATRIC		anxiety, depression, bipolar disorder, ADHD
RESPIRATORY		asthma, COPD, emphysema || congestion, wheezing, shortness of breath, TB exposure
OTHER		PLEASE LIST:

FEMALES:	Are you pregnant?	Yes / No
	Are you nursing?	Yes / No

VACCINES:	Influenza:	Yes / No
	Pneumococcal:	Yes / No

TOBACCO USE:	None / Occasional / Often
ALCOHOL USE:	None / Occasional / Often
DRUG USE:	None / Occasional / Often

LIST ALL MEDICATIONS:

LIST ALL EYE DROPS/MEDICATIONS:

LIST ALL NON-EYE SURGERIES:

LIST ALL ALLERGIES TO MEDICATIONS:

LIST ALL EYE SURGERIES:

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 POLICIES 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, co-insurance, or deductible 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 deem 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 lenses. 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 refund 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, penalties, 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 and Referrals:** Some insurance plans require you to obtain a prior authorization or referral for services by a specialist. Please review your policy to see if there is such a requirement and obtain this authorization or referral prior to your visit with our clinic.
- **Contact Lens Evaluations:** 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 contact lens follow-up visit. After 90 days of lapse between visits, I will be charged for a new refraction and new contact lens evaluation.

____ _________________________

Patient or Guardian Signature Date

____

Relationship if not signed by patient

Lenza EYE CENTER

GLASSES AND CONTACT LENS POLICIES

Patient:____________________________________ Date of Birth:________________ Date:_________________

- **Cancellation of Glasses Order:**
  - Orders may be cancelled for a refund only if the lab has not yet started processing the lenses.
- **Frame Restyling**:
  - Restyling must be within 60 days of the original order pick-up date.
  - If patients find that they dislike their frame after purchase, patients can switch the frame out for another frame of equal or lesser value.
  - Patients will receive a 50% discount on the price of the lenses that will need to be made to fit the new frame.
- **Non-Adapt to Glasses Lens Styles:**
  - Lenses must be returned within 60 days of the original order pick-up date.
  - Progressive lenses can be switched to a trifocal, bifocal, or single vision lens 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.
  - All other lenses can be switched to a single vision 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 be upgraded to a higher level lens type. Patients will only be charged the difference in price between the original lenses and the new lenses.
- **Glasses Lens Warranties:**
  - Lens warranties are determined by the lens options chosen and will be explained at the time of purchase.
- **Broken Frames Caused by a Manufacturer's Defect:**
  - Current frames have a one year warranty. The frame will be repaired and/or replaced at no cost. If replacement parts are no longer available, patients may choose another frame of equal or lesser value.
  - If new lenses are required, replacement lenses will be provided at no cost.
  - Discount and sale frames are not covered under warranty.
  - Damage from patient mishap is not covered under warranty.
- **Doctor Glasses Prescription Changes:**
  - Patients must return for a prescription check within 90 days of the original prescription date.
  - Lenses can be re-made at no cost one time only.
  - If patients would like to change the lens prescription after 90 days or would like more than one remake, they will receive a 50% discount on the price of the new lenses.
- **Contact Lens Returns and Exchanges:**
  - Soft contact lens boxes must be in originally purchased condition. Boxes that are open or have any damage or writing will not be eligible for return.
  - Soft contact lenses shipped to our office and picked up by the patient are eligible for return within 90 days of the notification date.
  - Soft contact lenses shipped to the patient's home are eligible for return within 1 year of the ship date.
  - Gas permeable contact lenses are under warranty and eligible for exchange within 120 days of notification date. Gas permeable contact lenses cannot be returned for a refund.

____ ___________________________

Patient or Guardian Signature Date

____

Relationship if not signed by patient

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.

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 who 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 it is 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

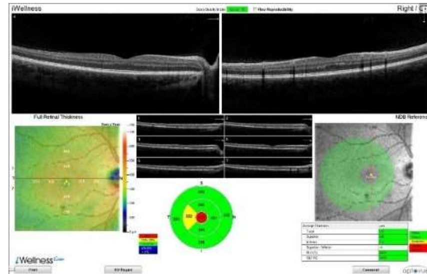
____

Relationship if not signed by patient

Lenza EYE CENTER

Preventative Health Screening

OCT Wellness Screening: This test scans the retina's microscopic layers, allowing your doctor to map the area and measure the thickness. Measurements help the doctor detect eye diseases such as glaucoma and macular degeneration 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:



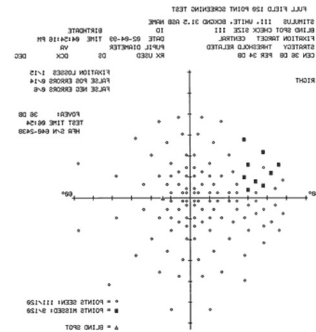
- Anyone over 45 years old
- Anyone with family history of glaucoma or macular degeneration
- People under 45 years old who are very near-sighted or far-sighted

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

____No, thank you.

Last Screening: ___________________

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 $25.** There is no discomfort. We strongly recommend a visual field test every 1 to 2 years for the following individuals:



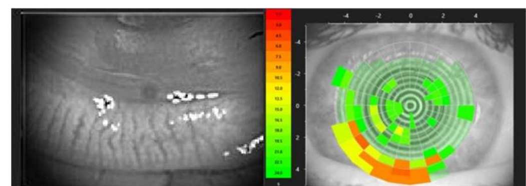
- Anyone over 45 years old
- Anyone with constant or unusual headaches
- Anyone with family history of glaucoma or macular degeneration
- People under 45 years old who are very near-sighted or far-sighted

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

____No, thank you.

Last Screening: ____________________

Dry Eye Screening: This is a combination of tests that evaluates your tear film, meibomian oil glands, and corneal surface. This test allows the doctor to better assess the cause of your symptoms to provide a proper treatment plan. An impaired tear film can induce blurred vision and affect the precision of your glasses prescriptions. **Unfortunately, insurance doesn't cover this screening test, but our charge is only $25.** There is no discomfort. We strongly recommend a dry eye testing every 1 to 2 years if you have any of the following symptoms:



- Light sensitivity, sharp pain, foreign body sensation
- Burning or scratchy sensation, red eyes, eye fatigue
- Excessive tearing, mucous

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

____No, thank you.

Last Screening: ____________________