Lenza
EYE CENTER

Patient Information Form

(Please print legibly and complete all information.)

Today's Date: ____/____/____

Patient's Name: _____ **DOB:** ____/____/____ **Age:** ____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Pronouns: ◯ They/Them ◯ She/Her ◯ He/Him ◯ Ze/Zie ◯ Non-binary ◯ Name only ◯ None ◯ Any/other_____

Communication *(Please indicate your primary source by checking the appropriate box)*

◯ **Home Phone:** (_____) _____-_____ ◯ **Cell Phone:** (_____) _____-_____

◯ **Email:** _____ **Language Spoken:** _____

SSN: ____-____-____ **Birth Gender:** ◯ Male ◯ Female (Need for medical reasons)

Race: ◯ American Indian ◯ African-American ◯ Asian ◯ White ◯ Native Hawaiian ◯ Other: _____ **Ethnicity:** ◯ Hispanic or Latino ◯ Not Hispanic or Latino

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Employer: _____ **Occupation:** _____ **Work Phone:** (_____) _____-_____

Family Physician: _____ **Physician Phone:** (_____) _____-_____

Emergency Contact Information:

Name: _____ **Phone:** (_____) _____-_____ **Relation**: _____

Referral Information

How did you hear about us? ◯ Social Media ◯ Existing Patient ◯ Patient Referral ◯ Employee Referral ◯ Referring Provider

Referring Provider Information

Name: _____ **Office Phone:** (_____) _____-_____

Specialty: _____

I authorize Lenza Eye Center to manage my care, including scheduling appointments and handling insurance claims. I accept responsibility for any fees and allow my information to be used for Medicare and related claims. This authorization permits document duplication for these purposes.

Patient Signature: _____

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Patient History Questionnaire

(Please print legibly and complete all information.)

Today's Date: ____/____/____

Patient's Name: _____ **DOB:** ___/___/____ **Age:** _____

Condition locations	**Medical History**: Have you ever had any of the following? (*Circle all that apply*)
Eyes	glaucoma, macular degeneration, cataract, keratoconus, detached retina, cornea problems, strabismus, amblyopia, eye injury
Cardiovascular	high blood pressure, high cholesterol, heart attack, stroke, congestive heart failure, irregular heartbeat, pacemaker, chest pain, racing pulse, palpitations
Allergy/Immunology	rheumatoid arthritis, Sjogren's syndrome, herpes simplex virus, lupus, HIV, sinus, sneezing, redness, itching, hives
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, has had COVID, Long COVID
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, Autism, PTSD, OCD
Respiratory	asthma, COPD, emphysema, congestion, wheezing, shortness of breath, TB exposure
OTHER	PLEASE LIST:

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Continuation of Patient History Questionnaire

Eye History

Do you have a history of: (Check all that apply)

◯ Cataract ◯ Glaucoma ◯ Macular Degeneration ◯ Dry Eyes ◯ Keratoconus ◯ Cornea Problems ◯ Lid Issues ◯ Eye Surgery(s)_____

Allergies: ◯ No known allergies ◯ List Allergies (general and medications):

_____

Yearly vaccines: (circle applicable) Influenza YES/NO Pneumococcal YES/NO

Current Medications List of medications (tablets and drops) and dosages:

_____

_____

_____

_____

Tobacco Use	None / Occasional / Often
Marijuana Use	None / Occasional / Often
Alcohol Use	None / Occasional / Often
Other drug use	None / Occasional / Often
Pregnant / Nursing (if Applicable)	YES/NO YES/NO

Family Health History

Do any family members have: (Check all that apply)

◯ Cataract ◯ Glaucoma ◯ Macular Degeneration ◯ Dry Eyes ◯ Eye Surgery ◯ Keratoconus ◯ Lazy eye ◯ Diabetes ◯ Cancer ◯ Stroke ◯ Heart disease ◯ High blood pressure ◯ Thyroid disease ◯ Arthritis ◯ Psychiatric condition

Relationship of family member with condition:

I hereby confirm that the above information is accurate to the best of my knowledge.

Patient Signature: _____

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Refraction Fee

(Please read carefully and sign acknowledgment on the page.)

Your eye examination consists of two distinct parts, each billed separately:

1. **Medical Eye Examination:** This covers the doctor's evaluation of your eye health. This service can be billed to your insurance company and to Medicare.
2. **Refraction Test:** This test determines the best corrective lenses for each of your eyes. While it's crucial for vision clarity, it's classified as a non-medical procedure. Medicare and most insurance plans **DO NOT COVER** the cost of this service, which is currently **$60.00**.

We kindly ask for the refraction test payment to be made at the time of your visit. *By signing below, you're acknowledging that you've received and understood this notice. Payment deferral for the refraction test isn't an option.*

Patient Name (printed): _____

Patient Signature: _____

Date: _____

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Patient Appointment No-Show Fee Agreement

(Please read carefully and sign acknowledgment on the page.)

This document outlines the terms for patient appointments and a **$30.00** no-show fee.

No-Show Fee: Patients agree to pay **$30.00** for each appointment no-show or cancellation within 24 hours.

Payment: Fees are due promptly after your missed appointment.

Exceptions: Emergencies may waive/adjust fees at Clinic discretion.

Cancellation: Patients should give 24-hour notice to avoid fees.

Term: Effective upon signing, until terminated in writing.

By signing below, you acknowledge that you've received and understood this agreement.

Patient Name (printed): _____

Patient Signature: _____

Date: _____

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Notice of Privacy Practices (HIPAA)

(Please read carefully and sign acknowledgment on the page.)

OUR COMMITMENT TO YOUR PRIVACY

Lenza Eye Center is dedicated to maintaining the privacy of your protected health information (PHI). We are required by law to maintain the confidentiality of your medical information.

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED

We will use your medical information for treatment, payment, and healthcare operations.

-**Treatment:** Your PHI may be used and disclosed to those who are actively and/or directly involved in your care.

-Payment: Your PHI will be used to obtain payment for your medical services.

-Healthcare Operations: Your PHI will be used to evaluate the services and quality of care provided to you.

YOUR RIGHTS

You have the right to:

-Request a restriction on the disclosure of your PHI.

-Obtain a paper copy of this notice.

-Inspect and obtain a copy of your PHI.

COMPLAINTS

You have the right to file a complaint if you believe your privacy rights have been violated.

CHANGES TO THIS NOTICE

We have the right to change this notice at any time.

By signing below, you're acknowledging that you've received and understood this notice.

Patient Name: _____ Date: _____

Patient Signature: _____

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Patient Rights and Responsibilities

(Please read carefully and sign acknowledgment on the page)

At Lenza Eye Center, we are committed to providing exceptional eye care services. We believe in fostering understanding and cooperation between patients and health care providers, ensuring positive outcomes and enhancing patient satisfaction. While patients have specific rights in our clinic, these rights come with accompanying responsibilities.

PATIENT RIGHTS

Access to Care: At our clinic, patients are assured access to essential eye care services and treatments that are medically appropriate. Ethical discussions involving the patient's care will always include the patient, their family, or designated representatives.
Respectful Care: Every patient is treated with respect and dignity, free from any form of discrimination based on race, color, religion, sex, national origin, disability, sexual orientation, or payment method.
Information on Treatment: Patients are entitled to clear and comprehensive information about their eye condition, potential treatments, and expected outcomes. Assistance like interpreters or visual aids is available for those with communication barriers.
Refusal of Care: Patients have the right to refuse specific treatments or services within legal bounds and will be informed of any potential risks tied to their decision.
Privacy & Confidentiality: Upholding patient privacy is a top priority. All interactions, examinations, and treatments are managed with utmost discretion. Lenza Eye Center strictly adheres to HIPAA regulations, safeguarding the confidentiality of all health records.
Financial Notification: Transparency is key. Patients can always inquire about the financial aspects of their treatments.

PATIENT RESPONSIBILITIES

Communication: Patients are encouraged to be open and accurate in sharing information about their eye health, vision issues, and any other relevant medical history.
Respecting Others: Mutual respect ensures a harmonious environment. Patients are expected to be considerate of other patients, clinic staff, and the facility.

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Patient Rights and Responsibilities Continued

Participation: It's essential for patients to comply with prescribed treatments, attend follow-up appointments, and collaborate with our eye care professionals.

Financial Obligations: Patients are expected to provide accurate billing details and address any financial commitments related to their care.

PHYSICIAN INVESTMENT

Please be informed that your physician might have a financial interest or ownership in Lenza Eye Center.

PATIENT COMPLAINT AND GRIEVANCE

Lenza Eye Center values feedback. If you have any concerns or suggestions, please don't hesitate to let us know.

All patients have the right to voice concerns or complaints about the care they receive. Unresolved issues can be directed to the Clinic Administrator.

Contact

Lenza Eye Center
25699 SW Argyle Ave Suite A
Wilsonville, OR 97070
Edgar D. Reyna, Chief Operating Officer
Phone: 210-294-6164
Email: edgar@lenzaadmin.com

Formal complaints will receive a response within 14 days.

Patient Name: _____ Date: _____

Patient Signature: _____

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Financial Policies and Billing Processes

(Please read carefully and sign acknowledgment on the page.)

- **Payment:** Due upon service.
- **Insurance:** Cards must be current. Know your co-pay, deductible, and co-insurance; pay at the time of service.
- **Billing:** Failure to pay results in possible rescheduling.
- **Non-Covered Services:** You are responsible for knowing insurance coverage of services and handling non-covered services fees.
- **Denied Charges:** You are responsible for fees denied by insurance.
- **Refractions:** Essential test for determining the need for corrective eyeglasses or contact lenses. Insurance might not cover this; you are responsible for the matching fee.
- **Participating Insurances:** If we are not in-network, you manage filing insurance claims and full payment of services at the time of service.
- **Returned Checks & Past Due Accounts:** Subject to penalties. Accounts past due after 90 days may result in collection actions and other penalties.
- **Medicaid:** Specific referred medical conditions only. Co-pay due at service.
- **Vision Benefits:** Check with your provider; we might not be in-network for vision.
- **Authorizations/Referrals:** Secure necessary referrals before visits.
- **Contact Lens Evaluations:** $30 fee after a 30-day gap; new evaluation fee after 90 days.
- **No-Show fee:** $30 (if notified less than 24 hrs); surgery $50 (if notified less than 48 hrs).
- **Prior Authorization Fee:** $25.
- **Refraction Rechecks:** $60 refraction fee within 150 days of exam or must complete another exam.

Patient Name: _____ Date: _____

Patient Signature: _____

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AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

(Please read carefully and sign acknowledgment on the page.)

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 Yes, 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: _____

Is this person your Power of Attorney for medical purposes? □ Yes □ No

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 Name: _____ Date: _____

Patient or Guardian Signature: _____

Relationship if not signed by patient: _____

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Glasses and Contact Lens Policies

(Please read carefully and sign acknowledgment on the page.)

GLASSES ORDER CANCELLATION

Refunds are possible only if processing hasn't begun.

FRAME RESTYLING

Within 60 days of pick-up, frames can be swapped for equal or lesser value. New lenses come at a 50% discount.

LENS EXCHANGES

Lenses can be exchanged within 60 days. Progressive lenses can be exchanged for trifocal, bifocal, or single vision at no extra charge. Other lenses can be changed to single vision for free. Upgrades are charged the difference.

LENS WARRANTIES

Terms are based on lens type, detailed at purchase.

FRAME WARRANTY

One-year manufacturer's defect warranty on frames. If irreparable, choose an equivalent/cheaper frame. Replacement lenses are free, if necessary. Sale frames and user-inflicted damages are excluded.

PRESCRIPTION CHANGES

A single free lens remake is allowed within 90 days of purchase. Post-90 days or for additional remakes, lenses come at a 50% discount. A $60 fee applies for new prescription refractions.

CONTACT LENS RETURNS

Unopened, undamaged boxes of soft contact lenses are returnable within 90 days (office) or 1 year (home delivery). Gas permeable lenses are exchangeable within 120 days but aren't refundable.

Patient Name: _____ Date: _____

Patient Signature: _____

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Preventive Health Screening

(Please read carefully and sign acknowledgment on the page.)

All screening recommended to be done every 1-2 years

Insurance doesn't cover these screening tests. <u>All screenings are pain-free</u>.

1. OCT Wellness Screening - $40

Description: Scans the retina's layers to detect early signs of diseases like glaucoma and macular degeneration.

Recommended For: Individuals over 45, those with a family history of glaucoma or macular degeneration. Also for individuals under 45 who are highly near-sighted or highly far-sighted.

◯**Yes, I'd like the screening today.** ◯**No, thank you. Last Screening: _____**

2. Visual Field Screening - $25

Description: Assesses peripheral vision or "side vision" to detect early signs of diseases like glaucoma, macular degeneration, potential strokes, and tumors.

Recommended For: Individuals over 45, those experiencing constant or unusual headaches, those with a family history of glaucoma or macular degeneration.

Also for individuals under 45 who are highly near-sighted or highly far-sighted.

◯**Yes, I'd like the screening today.** ◯**No, thank you. Last Screening: _____**

3. Dry Eye Screening - $25

Description: Assesses tear film, oil glands, and corneal surface for better treatment planning.

Recommended For: Those experiencing light sensitivity, sharp pain, or foreign body sensation, individuals with symptoms like burning eyes, red eyes, or eye fatigue, those with excessive tearing or mucous. Also having trouble reading or focusing on screens and/or eyes feeling tired or fatigued after reading for a short time.

◯**Yes, I'd like the screening today.** ◯**No, thank you. Last Screening: _____**

Patient Name: _____ Date: _____

Patient Signature: _____