Lenza EYE CENTER

PATIENT INFORMATION

Legal Name:_____ **D.O.B.:**_____ **Today's Date:**_____

Preferred Name:_____ **Birth Gender:** ☐M ☐F **Pronouns:**_____

Preferred Language:_____ **Social Security Number:**_____

Street Address:_____ **Home Phone:**_____

City, State, Zip:_____ **Cell Phone:**_____

Email Address:_____

Race:
☐ American Indian/Alaska Native
☐ Native Hawaiian/Pacific Islander
☐ African American
☐ Asian
☐ White
☐ Other:_____

Ethnicity:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

Marital Status:
☐ Single
☐ Married
☐ Divorced
☐ Widowed

Emergency Contact:_____ **Phone:**_____

Relationship:_____

Employer:_____ **Phone:**_____

Occupation:_____

Primary Care Doctor:_____ **Phone:**_____

Location/Address:_____

Referring Doctor:_____ **Phone:**_____

Location/Address:_____

How did you hear about us?
☐ Social Media ☐ TV Commercial ☐ Internet Search
☐ Insurance Company ☐ Patient Referral ☐ Provider Referral
☐ Other:_____

Lenza EYE CENTER

PATIENT MEDICAL HISTORY

Legal Name:_____ **D.O.B.:**_____ **Today's Date:**_____

Please check if you have any of the following conditions:

Eyes
☐ amblyopia
☐ cataract
☐ corneal condition
☐ detached retina
☐ dry eyes
☐ eyelid condition
☐ glaucoma
☐ keratoconus
☐ macular degeneration
☐ strabismus

Cardiovascular
☐ congestive heart failure
☐ heart attack
☐ high blood pressure
☐ high cholesterol
☐ irregular heartbeat
☐ stroke

Constitutional
☐ fatigue
☐ headaches
☐ insomnia
☐ weight loss/gain

Endocrine
☐ diabetes type I
☐ diabetes type II
☐ Graves' disease
☐ hyperthyroidism
☐ hypothyroidism
☐ thyroid eye disease

Gastrointestinal
☐ acid reflux
☐ GERD
☐ hernia
☐ ulcers

Genitourinary
☐ impotence
☐ jaundice
☐ kidney stones

Hematology
☐ anemia
☐ blood clots
☐ sickle cell disease

Immunological
☐ herpes simplex virus
☐ HIV
☐ lupus
☐ rheumatoid arthritis
☐ Sjögren's syndrome

Oncology
☐ breast cancer
☐ colon cancer
☐ prostate cancer
☐ skin cancer
☐ lung cancer

Musculoskeletal
☐ fibromyalgia
☐ osteoporosis

Ear, Nose, Throat
☐ hard of hearing
☐ sinus allergies
☐ vertigo

Dermatology
☐ acne
☐ rosacea
☐ shingles

Neurological
☐ Alzheimer's disease
☐ dementia
☐ paralysis
☐ Parkinson's disease
☐ seizures

Psychiatric
☐ ADHD
☐ anxiety
☐ bipolar disorder
☐ depression
☐ PTSD

Respiratory
☐ asthma
☐ COPD
☐ emphysema

Other (Please List)
_____
_____
_____

Lenza EYE CENTER

PATIENT MEDICAL HISTORY

Legal Name:_____ **D.O.B.:**_____ **Today's Date:**_____

List all current medications:

_____

List all allergies to medications or check none:

☐ no known drug allergies

List all eye treatments and eye drops:

List all eye injuries:

List all eye surgeries:

List all non-eye surgeries:

Are you pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Have you received the following vaccines?

Influenza: ☐ Yes ☐ No

Pneumococcal: ☐ Yes ☐ No

Please indicate your use of the following:

Smoking/Tobacco: ☐ None ☐ Occasional ☐ Often

Alcohol: ☐ None ☐ Occasional ☐ Often

Other Drugs: ☐ None ☐ Occasional ☐ Often

Please check all family eye conditions:

	Mom	Dad	Sibling
Amblyopia	☐	☐	☐
Cataract	☐	☐	☐
Corneal Disease	☐	☐	☐
Glaucoma	☐	☐	☐
Keratoconus	☐	☐	☐
Macular Degeneration	☐	☐	☐
Strabismus	☐	☐	☐

Please check all family health conditions:

	Mom	Dad	Sibling
Arthritis	☐	☐	☐
Cancer	☐	☐	☐
Diabetes	☐	☐	☐
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
Stroke	☐	☐	☐
Thyroid Disease	☐	☐	☐

Lenza EYE CENTER

FINANCIAL POLICIES AND BILLING PROCESSES

Legal Name:_____ **D.O.B.:**_____ **Today's Date:**_____

Payment: Payment is due upon service. Failure to do so may result in rescheduling.

Insurance: Insurance cards must be current and presented at time of service. It is the patient's responsibility to know the copay, deductible, and coinsurance fees.

Non-Covered Services: It is the patient's responsibility to know what insurance does and does not cover. The patient is responsible for all non-covered services.

Denied Charges: The patient is responsible for any charges denied by the insurance company.

Participating Insurances: If we are not a participating provider for a patient's insurance plan, the patient is responsible for paying in full at time of service and filing his/her own insurance claim.

Refractions: Refraction is the process of determining if there is a need for corrective eyeglasses. It is an essential part of the eye exam in order to write a prescription for glasses or contacts and also to evaluate medical eye conditions. Most MEDICAL insurances do NOT cover this service, and it is the patient's responsibility to pay. The fee is $60. This service IS included in a vision exam.

Returned Checks and Past Due Accounts: Returned checks will be subject to collection charges, penalties, and interest. Accounts past due after 90 days may result in collection charges, penalties, interest, or the refusal of future appointments.

Medical Insurance and Vision Plans: Some medical plans have routine vision benefits through a different carrier. We may be a participating provider with the medical insurance but not the vision plan.

Exam Authorizations and Referrals: It is the patient's responsibility to obtain any necessary prior authorizations or referrals needed for his/her exam and services prior to the appointment.

Prior Authorization Fee: There is a $25 fee for each prior authorization for medications.

No Show Fee: There is a $30 fee for cancelling an appointment less than 24 hours from the appointment time. There is a $50 fee for cancelling surgery less than 48 hours from the surgery time.

Prescription Rechecks: There is a $60 fee for complex refraction rechecks. There is a $60 fee for any refraction rechecks after 60 days. A new exam may be required for a new prescription past that time.

Contact Lens Rechecks: There is a $30 fee for contact lens follow-ups after 30 days. A new exam and evaluation may be required for a new prescription past that time.

Patient/Guardian Signature:_____ **Date:**_____

Relationship if Not Signed by Patient:_____

Lenza EYE CENTER

PATIENT RIGHTS AND RESPONSIBILITIES

Legal Name:_____ **D.O.B.:**_____ **Today's Date:**_____

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, his/her family, and/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 conditions, 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 the utmost discretion. Lenza Eye Center strictly adheres to HIPAA regulations, safeguarding the confidentiality of all health records.

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. Disrespectful behavior will not be tolerated.
- **Participation:** It is essential for patients to comply with prescribed treatments, attend follow-up appointments, and collaborate with our eye care professionals.
- **Financial Obligation:** 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 may have a financial interest or ownership in Lenza Eye Center.

Patient Complaints and Grievances

Lenza Eye Center values feedback. If you have any concerns or suggestions, please do not 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.

Patient/Guardian Signature:_____ **Date:**_____

Relationship if Not Signed by Patient:_____

Lenza EYE CENTER

GLASSES AND CONTACT LENS POLICIES

Legal Name:_____ **D.O.B.:**_____ **Today's 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 date.
- There is a $100 restocking fee.
- The patient is responsible for the difference in cost of the new frame in addition to the restocking fee.
- A $20 warranty fee will be applied to make new lenses.

Non-Adapt to Glasses Lens Styles

- Lenses must be returned within 60 days of the original order date.
- Progressive lenses can be exchanged for trifocal, bifocal, or single vision lenses at no cost.
- All other lenses can be switched to a single vision lens at no cost.
- A refund will not be given for the difference in cost between the original and new lenses.
- Lenses can be upgraded to a higher level lens type. Patients will only be charged the difference.

Lens Option Changes

- A $20 warranty fee will be applied to make new lenses if the patient chooses to change any lens options.

Glasses Lens Warranty

- A $20 warranty fee will be applied to make new lenses if original lenses become scratched or damaged.

Broken Frames Caused by a Manufacturer's Defect

- Current frames have a one year warranty for manufacturer's defects.
- Discount and sale frames are not covered under warranty.
- Damage from patient mishap is not covered under warranty.

Doctor Glasses Prescription Changes

- Lenses can be remade with a new prescription at no cost one time only within 60 days of purchase.
- If there is a prescription change after 60 days, a $20 warranty fee will be applied.
- If the patient would like more than one remake, a 50% discount will be given on the new lenses.

Contact Lens Returns and Exchanges

- Soft contact lenses shipped to our office and picked up by the patient are eligible for return within 90 days of the order date.
- Soft contact lenses shipped to the patient's home are eligible for return within one year of the ship date.
- Gas permeable contact lenses are eligible for exchange within 120 days of the order date.
- Gas permeable contact lenses cannot be returned for a refund.

Patient/Guardian Signature:_____ **Date:**_____

Relationship if Not Signed by Patient:_____

Lenza EYE CENTER

AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Legal Name:_____ **D.O.B.:**_____ **Today's Date:**_____

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.

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 Work Phone:_____

If so, may we leave a message?

☐ Yes ☐ No

Do you have a particular person or family member who you authorize to receive and discuss information regarding your personal health information (general information and billing)?

☐ Yes ☐ No Name:_____ Best Phone:_____

Relationship:_____ Alternate Phone:_____

Is there a person who is your Power of Attorney for medical purposes?

☐ Yes ☐ No Name:_____ Best Phone:_____

Relationship:_____ Alternate Phone:_____

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/Guardian Signature:_____ **Date:**_____

Relationship if Not Signed by Patient:_____

Lenza EYE CENTER

NOTICE OF PRIVACY PRACTICES (HIPAA)

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

- **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

- **Restrict:** You have the right to request a restriction on the disclosure of your PHI.
- **Copy:** You have the right to obtain a paper copy of this notice.
- **Inspect:** You have the right to 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 without notice at any time.