Patient Information **Today's Date____/____/_____**

Name:(Last, First, Middle) ____Social Security#: ______________________

Address ____ City, State, Zip:___________________________________

Sex (MF) ______ Marital Statue: Single Married Other Birth date: _____/____/_____ Age _________

Home # ( )_____________Work# ( )____________ Employer: _________________ Occupation: __________________

Cell phone#( ) _________________________ Student: Yes No Part-Time

Email (for communication only. We WILL NOT share your email):____

Person responsible for payment:(If different than above) ______________________Social Security# _________________

Address ___________________________ City, State, Zip: ______________________________Phone #_______________

In case of an emergency contact: Name ______________________________ Phone number ( ) ______________________

Address: ___________________________________ Payment Choice: Cash ____ Check ____ Credit Card ___Insurance ____

Insurance Information:

Insurance Company: _________________________________ Phone#: _____________Policy #:______________________

Policy Holder: (Last, First, Middle) ____

Social Security#:____________________________ DOB: ___/___/___

Address: ____ City, State, Zip____

Sex: (M/F)_____ Home number: ( ) ______________Employer: ____

Patients' relationship to policyholder: Self Spouse Child

Secondary Company: ________________________ Phone#: ___________________Policy #:___________________________

Policy Holder: (Last, First, Middle) ____________________Social Security#: ____________________ Birthdate: ___/___/___

Address: ____ City, State, Zip____

Office Policy

Payment is required when services are rendered (eye exam, contact lens fits, office visits). A minimum of 50% of the fee for materials must be paid for before they can be ordered and the remaining balance must paid for before they can be released from the office. (Eyeglasses and contact lenses).

Please remember that insurance is considered a method of reimbursing the patient for fee paid to the doctor and is not a substitute for payment. Some companies pay fixed allowance for certain procedures, and others pay a percentage of the charge. It is your responsibly to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

It is the patient's responsibility to know their insurance coverage, and relay that information to the office staff. Please ask if you have any questions about your insurance, we will help you in any way we can. Any fees not covered by insurance within 60 days will be billed to the patient.

I authorize the release of any medical of other information necessary to process this claim. I also request payment of government benefits either to myself of the party who accepts assignment below.

A 1.5% monthly (18% annual) fee will be added to all accounts not current, ie. After 30 days there will be a $5.00 late fee accessed each month if payment is not made. Balance must be paid in full by the end of the 30-day period or your account will be turned over to our collection agency.

The undersigned specifically agrees to pay all reasonable attorneys' fees and court costs in the event legal action is taken to collect on an account. The undersigned further agrees to pay an additional amount representing up to 40% of the principal balance if the account is referred to a collection agency or attorney for collections. This additional amount is in recognition of the cost associated with said collection action processing.

Patient/Guardian Signature: ____ Today _____/____/________

Medical History Questionnaire

Today Date: _______/_____/________

Name: ____ Phone: ____________________

Address: ____ Date of Birth: ____________________

City: ______________________________________

Name of Medical Doctor: ____ Last Medical Exam: ____/_____/______

Medical History

Do you have any allergies to medications: [ ] no [ ] yes If yes, explain:____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies;

List all major injuries, surgeries, and/of hospitalization you have had: ____

List any of the following that you have had: crossed eyes, drooping eyelids, prominent eyes, glaucoma, retinal disease, cataract, eye infections,

or eye injury:____

Are you pregnant and /or nursing? [ ] no [ ] yes

Do you wear glasses? [ ] no [ ] yes If yes, how old is your present pair if lenses? ____________________

Do you wear contact lenses? [ ] no [ ] yes If yes, how old is your present pair if lenses? ____________________

Type of contact lenses? [ ] Rigid [ ] Soft [ ] Extended Wear [ ] Other Are they comfortable? [ ] yes [ ] no

Family History

Please note any family history(parent, grandparent, sibling, children, (living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	RELATIONSHIP TO YOU
Blindness	[ ]	[ ]	
Cataract	[ ]	[ ]	
Crossed Eyes	[ ]	[ ]	
Glaucoma	[ ]	[ ]	
Macular Degeneration	[ ]	[ ]	
Retinal Detachment / Disease	[ ]	[ ]	
Arthritis	[ ]	[ ]	
Cancer	[ ]	[ ]	
Diabetes	[ ]	[ ]	
Heart Disease	[ ]	[ ]	
High Blood Pressure	[ ]	[ ]	
Kidney Disease	[ ]	[ ]	
Lupus	[ ]	[ ]	
Thyroid Disease	[ ]	[ ]	
Other _______________	[ ]	[ ]	

Please turn this form over and complete side two

Social History *This information is kept strictly confidential. However you may discuss this portion directly with doctor if you prefer,*

[ ] yes, I would prefer to discuss my Social History information directly with my doctor.(Check box)

Do you Drive? [ ] no [ ] yes If yes, do you have visual difficulty when driving? [ ] no [ ] yes If yes, please describe:

Do you use tobacco products? [ ] no [ ] yes If yes, type / amount/how long:

Do you drink alcohol? [ ] no [ ] yes If yes, type / amount/how long:

Do you use illegal drugs? [ ] no [ ] yes If yes, type / amount/how long:

Have you ever been exposed to or infected with: [ ]Gonorrhea [ ] Hepatitis [ ] HIV [ ] Syphilis

Review of systems

Do you currently, or have you ever had any problems in the following areas;

SYSTEM	NO	YES		NO	YES
CONSTITUTIONAL			**EARS,NOSE,MOUTH,THROAT**		
Fever,Weight Loss/Gain	[ ]	[ ]	Allergies/Hay Fever	[ ]	[ ]
			Sinus Congestion	[ ]	[ ]
NEUROLOGICAL			Runny Nose	[ ]	[ ]
Headaches	[ ]	[ ]	Post-Nasal Drip	[ ]	[ ]
Migraines	[ ]	[ ]	Chronic Cough	[ ]	[ ]
Seizures	[ ]	[ ]	Dry-Throat / Mouth	[ ]	[ ]
EYES			**RESPIRATORY**		
Loss of Vision	[ ]	[ ]	Asthma	[ ]	[ ]
Blurred Vision	[ ]	[ ]	Chronic Bronchitis	[ ]	[ ]
Distorted Vision/Halos	[ ]	[ ]	Emphysema	[ ]	[ ]
Loss of Side Vision	[ ]	[ ]	**VASCULAR/CARDIOVASCULAR**		
Double Vision	[ ]	[ ]	Diabetes	[ ]	[ ]
Dryness	[ ]	[ ]	Heart Pain	[ ]	[ ]
Mucous Discharge	[ ]	[ ]	High Blood Pressure	[ ]	[ ]
Redness	[ ]	[ ]	Vascular Disease	[ ]	[ ]
Sandy or Gritty Feeling	[ ]	[ ]	**GASTROINTESTINAL**		
Itching	[ ]	[ ]	Diarrhea	[ ]	[ ]
Burning	[ ]	[ ]	Constipation	[ ]	[ ]
Foreign Body Sensation	[ ]	[ ]	**Genitourinary**		
Excess Tearing/Watering	[ ]	[ ]	Genitals/ Kidney /Bladder	[ ]	[ ]
Glare/Light Sensitivity	[ ]	[ ]	**BONES / JOINTS / MUSCLES**		
Eye Pain or Soreness	[ ]	[ ]	Rheumatoid Arthritis	[ ]	[ ]
Chronic Infection of Eye of Lid	[ ]	[ ]	Muscle Pain	[ ]	[ ]
Sties or Chalazion	[ ]	[ ]	Joint Pain	[ ]	[ ]
Flashes/Floaters in Vision	[ ]	[ ]	**LYMPHATIC / HEMATOLOGIC**		
Tired Eyes	[ ]	[ ]	Anemia	[ ]	[ ]
ENDOCRINE	[ ]	[ ]	Bleeding Problems	[ ]	[ ]
Thyroid / Other Glands	[ ]	[ ]	**ALLERGIC / IMMUNOLOGIC**	[ ]	[ ]
			PSYCHIATRIC	[ ]	[ ]

If you answered YES to any of the above of have a condition not listed, please explain & list medications:

Patient's Signature *Date*

Doctor's Signature *Date*

Brian F. Rowley O.D.
539 South 100 West
Payson, UT 84651
801-465-0355

Patient Name: ______________________________

Today's Date: ______________________________

ACKNOWLEDGEMENT OF RECEIPT OF HIPPA PRIVACY LAW

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services, and to conduct healthcare operations involving our office. Our Privacy Policy describes the uses and disclosures in detail.

I acknowledge that I received a copy of Apple Valley Vision's Notice of Privacy Practices:

Signature of Patient, if over 18, or Legal Guardian ___________________________________

REFRACTION FEE

The part of your evaluation that determines your prescription is called a "refraction." If you have routine vision benefits such as VSP, Eye Med, or Medical Eye Services, your refraction is typically included with your exam benefits. Some Medical insurance's, namely Medicare, do not cover the fee for this service. The fee for refraction is $50. My initials and signature below verifies I understand all policies and fees. ________
Initials

SPECTACLE REMAKE POLICY

Each pair of glasses is custom crafted for each patient with their unique prescription. We will start your custom spectacle order immediately. Any cancellations after lenses have been ordered will be billed at 50% of retail. At the doctors' discretion, patients who are not satisfied with the vision in their new glasses will have their prescription adjusted at no cost, within 45 days of the original purchase date. Any patient who fails to adapt to their new progressives will have their prescription remade one time into a lens of their choice at no additional charge. Refunds are not available on progressive lenses, and cash refunds are not possible.

*We require a deposit of 50% on all eyeglass orders. The balance will be due at the time of delivery. ________
Initials

THE CONTACT LENS PROCESS

Contact lens evaluation services are not an included part of an eye health evaluation and vision assessment, and additional fees apply. These fees range between $40 up to $1500 and can only be firmly quoted after a baseline vision status has been determined. Fees are customized according to the complexity of the case and the predicted time necessary to care for the individual patient. Evaluation fees cover: fitting, training, sample cleaning solutions, ***two months of follow up care as well as a pair of initial disposable trial lenses***. Specialty lenses and office visits outside the initial two-month period are not included and will be billed accordingly. Much like glasses, contact lens materials require additional fees. If allowed, insurance benefits will be applied to contact lens overages. Once completed, you will receive a contact lens prescription.

*We warranty unopened boxes of contact lenses if your prescription changes during 1 year after purchase, or if for some reason you are dissatisfied. *All gas permeable contact lenses have a 60-day warranty. ________
Initials

Financial Disclaimers

We will attempt to verify your insurance eligibility for services and or materials before your appointment. Verification of eligibility is done as a courtesy only and is not a guarantee of payment. If I have medical insurance or routine vision benefits, I authorize my plan carrier to directly pay Apple Valley Vision. I also authorize Apple Valley Vision to release any information required for payment. ***If my insurance does not pay, or partially pays, I understand I am responsible for the payment in full or the remaining balance. This includes any collection fees, court costs and attorney fees incurred in collecting the balance.*** There is a $30 fee for returned checks. My signature below verifies I understand and accept this financial agreement with all above disclaimers.

Signature ____ Date____________________