## Patient Information

**Today's Date** ___/___/____

Name: (Last, First, Middle)________________ Social Security#:________________

Address:________________ City, State, Zip:________________

Birthdate: ___/___/____ Age:______ Sex: M F Marital Status: Single Married Other

Home Phone: (  )________ Work Phone: (  )________ Cell Phone: (  )________ Text okay? Yes No

Employer:________________ Occupation:________________

Student: Yes No Part-Time

Email (for communication/reminders only. We WILL NOT share your email):________________

Person responsible for payment (If different from above):________________ Social Security#:________________

Address:________________ City, State, Zip:________________ Phone: (  )________

Emergency Contact Name:________________ Relation:________ Phone: (  )________

Address:________________ City, State, Zip:________________

**Insurance Information:**

Health Insurance Company:________________ Phone # (  )________ Policy #:________________

Policy Holder (Last, First, Middle):________________

Social Security #:________________ Birthdate: ___/___/____

Address:________________ City, State, Zip:________________

Sex: M F Home Phone: (  )________ Employer:________________

Patient relationship to policyholder: Self Spouse Child

Vision Plan Company:________________ Phone #: (  )________ Policy #:________________

Policy Holder (Last, First, Middle):________________

Address:________________ City, State, Zip:________________

**Office Policies**

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

**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 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, i.e. 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 120 day period or your account will be turned over to our collection agency.

The undersigned specifically agrees to pay all reasonable attorney 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 or Gaurdian Signature:**________________________ Date: ___/___/____
(If under 18)

**Apple Valley Vision**
**Brian F. Rowley   Steven G. Blake**
539 South 100 West
Payson, UT 84651
801-465-0355

Patient Name: ______________________

Today's Date: ______________________

## ACKNOWLEDGEMENT OF RECEIPT OF HIPAA 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. Apple Valley vision must make its notice available in hard copy format to any person who asks for it.

## 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 CANCELLATION and/or 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 included as part of the normal eye health evaluation and vision assessment. These are considered distinct procedural services* 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. Most soft contact lens fees range from $40 to $150.** Fees are customized according to the complexity of the case and the predicted time necessary to care for the individual patient. *Evaluation fees cover the following: fitting, training, sample cleaning solutions, two months of follow up care as well as a pair of initial disposable trial lenses.* Specialty lenses (soft and rigid) 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.

**The Apple Valley Vision Contact Lens Warranty:**

*Apple Valley Vision guarantees all contact lenses purchased at our office. The warranty includes exchange of 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.

**I acknowledge that I have received or have access to Apple Valley Vision's Notice of Privacy Practices and agree to all office financial policies written on this form:**

**Signature** ________________________________________ **Date** ____________________

Rev: 07/09/18

# Medical History Questionnaire

****There are two sides to this form****

Name: ______________________________ Today's Date: ____/____/____

Date of Birth: ______________________________

Name of Medical Doctor: ______________________________

Last Medical Exam: ____/____/____

Last Eye Exam: ____/____/____

## PERSONAL MEDICAL HISTORY

Do you have any allergies to medications? [ ] no [ ] 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: ______________________________

History of past Concussions? If Yes, Describe (quantity, severity, cause, date of last concussion): ______________________________

______________________________

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 (RGP) [ ] Scleral [ ] Soft [ ] Extended Wear [ ] Hybrid [ ] Other: __________

Are they comfortable? [ ] no [ ] yes

Are you happy with your vision/lenses? [ ] no [ ] yes

## FAMILY OCULAR / MEDICAL HISTORY

[ ] unknown/adopted

Please note any family history (living or deceased) of the following conditions: **(Circle All That Apply, Leave Blank if none)**

| Disease/Condition | Immediate Family | | | | Grandparents: Father's Parents | | Grandparents: Mother's Parents | |
|---|---|---|---|---|---|---|---|---|
| Blindness | Father | Mother | Sibling | Child | Father | Mother | Father | Mother |
| Cataract | Father | Mother | Sibling | Child | Father | Mother | Father | Mother |
| Crossed Eyes | Father | Mother | Sibling | Child | Father | Mother | Father | Mother |
| Glaucoma | Father | Mother | Sibling | Child | Father | Mother | Father | Mother |
| Macular Degeneration | Father | Mother | Sibling | Child | Father | Mother | Father | Mother |
| Retinal Detach/Disease | Father | Mother | Sibling | Child | Father | Mother | Father | Mother |
| Arthritis | Father | Mother | Sibling | Child | Father | Mother | Father | Mother |
| Cancer | Father | Mother | Sibling | Child | Father | Mother | Father | Mother |
| Diabetes | Father | Mother | Sibling | Child | Father | Mother | Father | Mother |
| Heart Disease | Father | Mother | Sibling | Child | Father | Mother | Father | Mother |
| High Blood Pressure | Father | Mother | Sibling | Child | Father | Mother | Father | Mother |
| Kidney Disease | Father | Mother | Sibling | Child | Father | Mother | Father | Mother |
| Lupus | Father | Mother | Sibling | Child | Father | Mother | Father | Mother |
| Thyroid Disease | Father | Mother | Sibling | Child | Father | Mother | Father | Mother |
| Other __________ | Father | Mother | Sibling | Child | Father | Mother | Father | Mother |

## 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, not a technician. (Check box)

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 [] HIV [] Syphilis [] Hepatitis

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

____________________

## REVIEW OF SYSTEMS

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

**SYSTEMS**

| **CONSTITUTIONAL** | **NO** | **YES** |
|---|---|---|
| Fever,Weight Loss/Gain | [] | [] |
| **NEUROLOGICAL** | | |
| Headaches | [] | [] |
| Migraines | [] | [] |
| Seizures | [] | [] |
| **EYES** | | |
| Loss of Vision | [] | [] |
| Blurred Vision | [] | [] |
| Distorted Vision/Halos | [] | [] |
| Loss of Side Vision | [] | [] |
| Double Vision | [] | [] |
| Dryness | [] | [] |
| Mucous Discharge | [] | [] |
| Redness | [] | [] |
| Sandy or Gritty Feeling | [] | [] |
| Itching | [] | [] |
| Burning | [] | [] |
| Foreign Body Sensation | [] | [] |
| Excess Tearing/Watering | [] | [] |
| Glare/Light Sensitivity | [] | [] |
| Eye Pain or Soreness | [] | [] |
| Chronic Infection of Eye | [] | [] |
| Sties or Chalazion | [] | [] |
| Flashes or Floaters | [] | [] |
| Tired Eyes | [] | [] |
| **ENDOCRINE** | | |
| Thyroid / Other Glands | [] | [] |
| Diabetes [] Type 1 [] Type 2 | [] | [] |
| **ALLERGIC / IMMUNOLOGIC** | [] | [] |

| **EARS,NOSE,MOUTH,THROAT** | **NO** | **YES** |
|---|---|---|
| Allergies/Hay Fever | [] | [] |
| Sinus Congestion | [] | [] |
| Runny Nose | [] | [] |
| Post-Nasal Drip | [] | [] |
| Chronic Cough | [] | [] |
| Dry-Throat / Mouth | [] | [] |
| **RESPIRATORY** | | |
| Asthma | [] | [] |
| Chronic Bronchitis | [] | [] |
| Emphysema | [] | [] |
| **VASCULAR/CARDIOVASCULAR** | | |
| Heart Pain | [] | [] |
| High Blood Pressure | [] | [] |
| Vascular Disease | [] | [] |
| **GASTROINTESTINAL** | | |
| Diarrhea | [] | [] |
| Constipation | [] | [] |
| **GENITOURINARY** | | |
| Genitals/ Kidney /Bladder | [] | [] |
| **BONES / JOINTS / MUSCLES** | | |
| Rheumatoid Arthritis | [] | [] |
| Muscle Pain | [] | [] |
| Joint Pain | [] | [] |
| **LYMPHATIC / HEMATOLOGIC** | | |
| Anemia | [] | [] |
| Bleeding Problems | [] | [] |
| **PSYCHIATRIC** | | |
| Depression | [] | [] |
| Anxiety | [] | [] |
| Other: ____________ | [] | [] |

**If you answered YES to any of the above or have a condition not listed, please explain:**

____________________

____________________

____________________ ____________________

*Patient's Signature* Date

____________________ ____________________

*Doctor's Signature* Date

Rev: 06/18/2018