



Patient Information

Today's Date: ___/___/___

(all information is kept secure and confidential at all times)

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: _____

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 be 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 may be a \$5.00 late fee added 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 Signature (or parent/guardian if under 18): _____ Date: ___/___/___



Apple Valley Vision
Brian F. Rowley Steven G. Blake
 539 South 100 West | Payson, UT 84651

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.**

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.**

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, clean 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.

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:

Patient's Name: _____

Patient Signature (or parent/guardian if under 18): _____

Date: ____/____/____



Medical History Questionnaire

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

Name: _____ Today's Date: _____

Birthdate: ___/___/___

Name of Medical Doctor: _____ Date of Last Medical Exam: _____

Date of Last Eye Exam: _____ Where? _____

PERSONAL OCULAR HISTORY

What is your reason for visiting us? _____

List any of the following that you have or have a history of: crossed eyes, drooping eyelids, glaucoma, retinal disease, cataracts, eye infections, or eye injuries: _____

List any eyedrops you use (including artificial tears, prescription eye drops, ointments, allergy drops, etc.): _____

Do you drive? No Yes → If Yes, do you have visual difficulty when driving? _____

Do you wear glasses? Yes No

Do you wear contact lenses? Yes No

-What type? Soft RGP (hard) Scleral Hybrid Other: _____

-Are they comfortable? Yes No I wish comfort was better

-Are you happy with vision? Yes No I wish my vision was improved

PERSONAL MEDICAL HISTORY

List all MAJOR INJURIES, SURGERIES, AND/OR HOSPITALIZATION you have had: _____

List MEDICATION ALLERGIES you have: _____

List any MEDICATIONS you currently take (including oral contraceptives, aspirin, over the counter and home remedies): _____

History of PAST CONCUSSIONS? If Yes, Describe (quantity, severity, cause, date of last concussion): _____

Are you pregnant or nursing? Yes No

FAMILY OCULAR / MEDICAL HISTORY

Please note any family history (living or deceased) of the following conditions: **(Circle All That Apply)**

[] unknown/adopted

Disease/Condition	Immediate Family				Grandparents			
	Father	Mother	Sibling	Child	Father's Parents		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

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the 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 / vape? No Yes If Yes, type / amount/how long: _____
- Do you drink alcohol? No Yes If Yes, type / amount/how long: _____
- Do you use illicit/illegal drugs? No Yes If Yes, type / amount/how long: _____
- Do you use marijuana? 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:*

CONSTITUTIONAL	NO	YES	EAR / NOSE / MOUTH / THROAT	NO	YES
Fever, Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>	Allergic/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL			Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
EYES			Dry-Throat / Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY		
Distorted Vision/Haloes	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	CARDIOVASCULAR		
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL		
Burning	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY		
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	BONES / JOINTS / MUSCLES		
Chronic Infection of Eye	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Flashes or Floaters	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC / HEMATOLOGIC		
ENDOCRINE			Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC		
ALLERGIC/IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Describe: _____			Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL			Other: _____		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	CANCER	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____		

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

Patient Signature: _____
(or parent if under 18)

Date: _____