Welcome to Vision Plus of Ballard!

Please make all corrections below

First Name:_____ Last Name:_____

Date of Birth:_____ Name of Parent/Guardian:_____

Address Line 1:_____ Home Phone:_____

Address Line 2:_____ Cell Phone:_____

City:_____State:_____Zip:_____ Email:_____

If no changes are necessary, please checkmark this box ☐

Check off all that apply:

Self	Family	
☐	☐	Macular Degeneration
☐	☐	Glaucoma
☐	☐	Cataracts
☐	☐	Blindness
☐	☐	Retinal Degeneration
☐	☐	Crossed/Lazy Eyes
☐	☐	Color Blindness
☐	☐	High Blood Pressure
☐	☐	Diabetes
☐	☐	Heart Problems
☐	☐	Cholesterol
☐	☐	Arthritis
☐	☐	Thyroid Condition
☐	☐	HIV/Hepatitis
☐	☐	Asthma/Allergies
☐	☐	Neuromuscular
☐	☐	Autoimmune:_____
☐	☐	Other:_____
☐		Pregnant or Nursing

What brought you in:

- ☐ Blurry Distance Vision
- ☐ Blurry Near Vision
- ☐ Poor Night Vision
- ☐ Eye Strain
- ☐ Glare/Reflections
- ☐ Sandy/Dry Eyes
- ☐ Watering
- ☐ Discharge
- ☐ Pain in the Eye
- ☐ Burning Eyes
- ☐ Red Eyes
- ☐ Itchy Eyes
- ☐ Discomfort in Sunlight
- ☐ Floaters or Spots in Vision
- ☐ Flashes of Light
- ☐ Double Vision
- ☐ Headaches
- ☐ Eye Injury: _____
- ☐ History of Wearing an Eye Patch
- ☐ History of Eye Surgery
- ☐ Annual/Regular Exam
- ☐ Other: _____

Are you interested in:

- ☐ New Spectacles
- **Contact Lenses:**
  - ☐ Regular/Current
  - ☐ Daily Disposable
  - ☐ Multi-focal
- ☐ Anti-Reflective Lens
- ☐ Sunglasses
- ☐ Safety Glasses
- ☐ Lasik
- ☐ Dry Eye Therapy

How you were referred to us:

- ☐ Family Doctor
- ☐ Insurance Company
- ☐ Yelp
- ☐ Facebook
- ☐ Other: _____

Social history:

- ☐ Tobacco Use
- ☐ Alcohol Use
- ☐ Drug Use

Last Eye Exam:_____

Medications:_____

_____

Occupation:_____

Employer:_____

Family Doctor:_____

Allergies:_____

Acknowledgment of Receipt of this Notice

This Practice is concerned about the privacy of our patients' health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your healthcare services will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

I acknowledge that I have received the Notice of Privacy Practices for Vision Plus.

Signature of patient/authorized representative:_____ Date:_____

Optomap Retinal Scan

In a routine eye exam, it is important to check the health of your retina (back of the eye) as well as assess changed to your prescription. Retinal health is traditionally checked through dilation. This shows a small part of the retina at one time, and allows the doctor to assess macula and optic nerve health, identify various other eye conditions that may need additional treatment (AMD, Glaucoma, Retinal tears/holes, high blood pressure, high cholesterol, etc) and evaluate other diseases like Diabetes, Hypertension, Stroke risk, and more. Early detection is essential for successful treatment. Note: Dilation will affect near vision for 4-6 hours.

An Optomap Retinal Scan can be done instead of traditional dilation. It will take pictures of the back of your eye, and can show the whole retina at once (270 degrees). It is quick, painless, and does not require dilation drops. Once pictures are taken, it will become a part of your electronic medical record. Note: This service is generally not covered by insurance.

Initial Below	**Please Initial Next to One Choice**
_____	I will pay the $39 fee for the Optomap Retinal Scan.
	-OR-
_____	I elect to have my eyes dilated.

Contact Lens Exam

Contact lens exams are an elective additional exam provided during your routine eye exam. If you're interested in wearing contacts, this exam is required in order for us to provide you with a contact lens prescription. If you choose to have this exam, your contact lens prescription will be valid for 2 years in the state of Washington. There is usually an additional charge for this service.

Current Contact Lens Wearers: A new prescription is needed every 2 years in the state of Washington, and with each eye exam, a fee will be charged for this service. Contact lens exam fees range from $60.00 - $100.00 depending on the type of correction needed for your eye. If you choose not to have a contact lens exam during your routine eye exam, we are able to perform a separate contact lens exam up to 6-months after your routine eye exam.

During your exam, you will be provided a set of trial contact lenses. We will require feedback from you regarding these trial lenses before finalizing the prescription. If the trials provided during your exam are not comfortable or do not provide visual clarity, please call us and we will provide you with a different trial pair. If more than 3 trials have been provided, we may need to schedule you for a doctor recheck to verify your prescription at no additional fee. During the exam, you will need to insert and remove your contact lenses from both eyes. If additional training is needed, we will provide this training at no additional cost. Note: All training and prescription adjustments with trial contact lenses must be completed within 2 months of your original contact lens exam date. After that time, we may require a new exam to be done.

Initial Below	**Please Initial Next to One Choice**
_____	Yes, I would like an updated contact lens prescription with my exam
	-OR-
_____	No, I do not need a contact lens prescription at this time

All Service Fees are due on the date of service.

Medical/Vision Insurance Policy

Vision benefit plans such as VSP and Eyemed are not medical insurance. They pay for an annual eye wellness exam and a prescription and glasses and/or contact lenses. They usually provide patients with a hardware benefit and allowances.

They do NOT cover medical eye problems.

Medical insurance covers anything that happens to your body, including your eyes. i.e.: diabetic eye exams, eye allergies, scratched cornea, dry eyes, infections, and chronic eye diseases such as macular degeneration, cataracts, and glaucoma.

Authorization/Responsibility Agreement

I understand that my portion of the balance due is to be paid at the time services are rendered. The undersigned will be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees in addition to the account balance due. There will be a service charge on all returned checks. I understand that screening tests may not be covered by my insurance and that I will be responsible to pay in full for these tests. Professional services are not refundable and all product sales are final. Any returns that are approved may be subject to a restocking fee. I authorize payment from my insurance to be paid directly to Vision Plus of Ballard. I understand that billing any out of network insurance will be my responsibility. ***I understand that if my insurance requires a referral to be seen at Vision Plus of Ballard, it is my responsibility to get the referral before service are rendered***. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. I authorize the use of this form on all insurance submissions and the release of all information to my insurance companies. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I permit a copy of this authorization to be used in place of the original.

Authorization to Release Medical Information

I authorize the release of medical information regarding myself/my dependent and my current condition to my referring, consulting, or treating physician.

Acknowledgment to Release Medical Information

According to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you may request a copy of your medical record in writing.

We will not disclose your records to others unless given your written consent or legal authorities authorize or compel us to do so.

Our full Notice of Privacy Practices describes how your health information may be used or disclosed and is available upon request.

I acknowledge that I have had a chance to review and agree to the terms and conditions of the Notice of Privacy Practices and, upon request, I may have a copy.

Co-Payments: By law, we must collect your carrier designated co-pay at the time of service. Please be prepared to pay your co-pay at each visit.

Self-Pay: Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

Account Balances: You are responsible for timely payment of your account. We reserve the right to reschedule or deny any future appointments on delinquent accounts.

PLEASE BE ADVISED IF YOU HAVE THE FOLLOWING INSURANCE COMPANIES

- TRICARE
- KAISER PERMANENTE
- PREMERA
- REGENCE
- MEDICARE

If patients **HAVE NOT** paid into their deductible for the year, there is a chance that today's visit will be applied to your deductible. You have the option of utilizing our Private Pay option for $109 for your comprehensive eye exam.

Refund/Return Policies

No refund can be made on clinical procedures or services, including comprehensive eye examination, refraction, contact lens fitting, and medical office visits.

Refunds for optical products, which include frames, lenses, and unopened boxes of contact lenses can only be made within 30 days of receiving the product, provided that the product is returned to the store without damage at the time the refund is issued. Opened boxes of contact lenses are non-refundable. After the 30 days period, only 50% of the original payment made by the patient (private-pay or with vision medical insurance) can be issued back to the patient as store credit with the return of the product. 90 days after a product is dispensed, no refund, nor exchange, nor return can be made on any goods purchased.

CONSENT FOR TREATMENT: I/We hereby authorize the practice to administer diagnostic and medical procedures as may be necessary for proper health care.

SIGNATURE:_____ DATE:_____

PRINT NAME:_____

Patient Responsibility

As a courtesy, our Patient Service Specialist will verify insurance coverage for all our patients. We will also bill your insurance company on your behalf and only collect the out-of-pocket amount deemed your responsibility by your insurance plan. This will include payment for any co-payments and for any deductible/coinsurance or non-covered services determined by your policy with your insurance company.

After your insurance is billed and have paid, they will transfer any remaining balance back to you as the patient. By signing this, you are accepting responsibility for any balance not paid for by your insurance. _____
Initial Here

If you feel that there are discrepancies with what insurance has covered, please contact your insurance company and refer to your specific plan benefits. We will do our best to work with you and your insurance company to make sure coverage and billing are accurate.

The verification we receive from your insurance plan is not a guarantee of benefits. We recommend that you also verify your vision benefits with your insurance company prior to your appointment and let us know if there are any inconsistencies with your coverage quoted.

_____ _____

Patient Signature **Date**

All service fees are due on the date of service