# Patient Information

## Medical and Ocular History

What is the reason for the exam today?

_____

_____

Do you or any of your blood relatives (ie Grandparents, Parents, Brother, or sister) have any of these conditions?

| | Self | Relative | None | | Self | Relative | None | | Yes | No | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Diabetes | [ ] | [ ] | [ ] | Glaucoma | [ ] | [ ] | [ ] | Do you see double? | [ ] | [ ] | |
| Hypertension | [ ] | [ ] | [ ] | Cataracts | [ ] | [ ] | [ ] | Frequent headaches? | [ ] | [ ] | |
| Thyroid | [ ] | [ ] | [ ] | Retinal Disease | [ ] | [ ] | [ ] | Are you pregnant? | [ ] | [ ] | |
| Heart Disease | [ ] | [ ] | [ ] | Macular Degeneration | [ ] | [ ] | [ ] | Eyes been dilated? | [ ] | [ ] | Year?_____ |
| Asthma | [ ] | [ ] | [ ] | Eye Injury | [ ] | [ ] | [ ] | | | | |
| Cancer | [ ] | [ ] | [ ] | Eye Surgery | [ ] | [ ] | [ ] | Primary Care Dr._____ | | | |

Please explain any positive findings: _____

_____

Are you taking any Medications (including eyedrops) prescription or over the counter?If Yes, please list:

_____

_____

Do you have any allergies (medication or other)? If Yes, please explain:_____

_____

Do you drink alcohol? **Y N** If Yes amount:_____ Do you smoke? **Y N**

## Contact Lens History

What brand of contact lenses do you wear? _____ How often do you replace them? _____

Do you regularly sleep in them? _____ How do you clean them? _____

*See “Contact Lens Services” for policies and pricing

**Dilation**: Dilating the eyes is an important way to look at the health of the inside the eyes. Recommended intervals depend on certain ocular and systemic health criteria. The side effects include: blurry vision (especially at near) and light sensitivity for at least 4-6 hours. At Viewpoint we recommend dilation for first time patients, individuals with health conditions like: diabetes, high blood pressure etc, if it has been more than 2 years since the last dilation, or to determine causes of vision changes or loss of vision. If you would like to be dilated, but would need it performed on a separate visit please let the doctor know. Would you like to be dilated today? [ ] Yes [ ] No

How did you hear about us? _____

## Viewpoint Eyecare Policies

- Copays must be collected at the time of service. Prescriptions will be held until the balance is paid in full.
- Eyeglasses will not be processed until balance is paid in full.
- Contact lens orders will not be processed until balance is paid in full.
- Viewpoint Eyecare does not provide personal financing; however, Viewpoint Eyecare does work with Carecredit as a way for patients/customers to pay for products and/or services. Ask an associate for details.
- Adjustments on frames: see Patient own frame (POF) Waiver
- This list is not inclusive

**Exam Services Fee:** When possible, cost of services will be given before the exam begins. We will always strive to be as up front as possible on cost of services and products. Sometimes the complexity of the exam can not be determined until during the exam (i.e. return visits, procedures for treatment).

Routine Vision Exam Pricing (Initial) **$125** Includes: visual acuity assessment, binocular assessment, refraction, ocular health assessment (internal/external) w/ dilation (if necessary)

**Contact Lens Services Fee**: Whenever a contact lens prescription is updated a fee will be assessed. This fee covers the cost of lenses, time spent if follow up visits are necessary, additional testing for CL fit/refit, and the doctor's evaluation for proper fit of contact lenses. If possible a CL prescription will be given the day of the exam if the fit and vision are acceptable to patient and/or doctor. Sometimes a follow up visit is necessary in order to complete the fit of CL. Sometimes, in the case of more difficult fits more time is needed. Due to the extended time, fitting charges may be higher for certain CL like: first time CL wearers, astigmatism, multi-focal, monovision, keratoconus etc. Every fit charge will include, when possible, trials of your prescription to determine overall satisfaction. A refit may be performed within 60 days at no charge (some exclusions apply). You are not required to purchase products from Viewpoint Eyecare.

Contact Lens Services Pricing* (Initial)

| | | |
|---|---|---|
| Spherical (soft): **$50** | Multifocal/Monovision (soft): **$75** | RGP Spherical: **$75** |
| Toric (soft): **$75** | 1st Time Fit (soft/RGP): **+$10** | RGP Toric: **$100** |

*Every time a contact lens prescription is updated a fee will be assessed.
Pricing of contact lens fittings will vary depending on insurance coverage, difficulty of fitting and changes in CL parameters. Some exclusions apply. Specialty Contact: Determined at the time of exam due to complexity

## Guarantee and Warranty policies

We understand there are lots of places to purchase your products. The highest quality standards and products are expected here at Viewpoint Eyecare. If there are any questions about products or services please ask.

- 30 day Satisfaction Guarantee on glasses
- 1 year Warranty on frame and lenses (covering manufacture flaws and defects)

## Financial Assignment Information

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

## Acknowledgement of Notice of Privacy Practices (NPP)

[ ] Yes, I have read or had explained to me by this office the NPP & I wish to continue my care under said terms.
[ ] No, I have not read this office's NPP but I was given the opportunity to read it and declined. I wish to continue my care under said terms.
[ ] The NPP could not be read due to the emergent nature of the care needed.

Signature agreeing to all above terms _____ Date _____