The Vision Shop Optometry

Registration Form

Patient Information

Last Name: ______________________ First Name: ______________________ MI: __________

Date of Birth: ____________ Age: _____ Gender: ☐ M ☐ F Parent/guardian ______________________

Address: ____

City: ______________________ State: __________ Zip Code: ______________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Email: ______________________ Occupation: ______________________

Emergency Contact Name: ______________________ Phone: ______________

Relationship: ______________________ How did you hear about us?: ______________________

Insurance Information

Name of Insurance Plan: ______________________ Name of Primary Subscriber: ______________________

Subscriber's DOB: ____________ Subscriber's SSN: ______________ Insurance ID: ______________

Group No: ______________ Policy No: ______________ Employer: ______________

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Medical History

Any allergies to medications? ☐ Y ☐ N If Yes, explain: ______________________ Are you pregnant? ☐ Y ☐ N

List all systemic medications and major eye injuries, infections, or surgeries: ______________________

____

Last medical exam: ____/____/____ Name of physician ______________________

Ocular/Eye History

Last eye exam? ___/____/____ Name of previous eye doctor and center ______________________

Glasses? ☐ Y ☐ N, Age of glasses? ________ , Contact lens? ☐ Y ☐ N, Age of contacts? _______, Sleep in contact? ☐ Y ☐ N

Name of contacts? ______________________ Type? ☐ Rigid ☐ Soft ☐ Disposable ☐ Extended Wear

Review of Systems

Do you currently or have you ever had any of problems in the following areas:

- ☐ Skin Conditions
- ☐ Headaches
- ☐ Migraines
- ☐ Seizures
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic Bronchitis
- ☐ Sleep Apnea
- ☐ Allergies
- ☐ Dry Throat/Mouth
- ☐ Deaf
- ☐ Hearing Aids
- ☐ Diabetes
- ☐ Heart Diseases
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Rheumatoid Arthritis
- ☐ Muscle Pain
- ☐ Joint Pain
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Thyroid
- ☐ Psychiatric
- ☐ Loss of Vision
- ☐ Blurred Vision- Near
- ☐ Blurred Vision– Far
- ☐ Distorted Vision
- ☐ Halos
- ☐ Loss of Side Vision
- ☐ Double Vision
- ☐ Tired Eyes
- ☐ Dry Eyes
- ☐ Mucous Discharge
- ☐ Red Eyes
- ☐ Itchy Eyes
- ☐ Burning Eyes
- ☐ Something in your eye
- ☐ Excess Tearing
- ☐ Glare/Light Sensitivity
- ☐ Floaters

Family History

Does your family currently or have had any of problems in the following areas:

- ☐ Blindness
- ☐ Crossed Eye
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Retinal Detachments
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Cancer
- ☐ Heart Diseases
- ☐ Lupus
- ☐ Arthritis
- ☐ High Cholesterol
- ☐ Thyroid Diseases

Privacy Policy

_________ Initials

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

I acknowledge that I have been offered and/or received a copy of the Privacy Policy.

Insurance/Financial Acknowledgments

_________ Initials

Insurance: I authorize the doctors of The Vision Shop Optometry, to release any information, including diagnosis, and the records of any treatment or examinations rendered to my dependent or myself during the period of such medical and/or vision services to third party payers and/or to other health practitioners. I authorize payment for my vision benefits directly to The Vision Shop Optometry. Authorization obtain at the time of service does not guarantee payment. I agree that if my employer, insurance carrier, or plan sponsor denies payment of all or any portion of my claim, I will be financially responsible for all outstanding charges, including any fees for collection services if needed. Any cancellation or changes to my orders will be at the discretion of my insurance and I will be responsible for any cancellation fees charged by my insurance and/or insurance labs.

_________ Initials

Private Pay: I agree to be personally responsible for payment of all services rendered on my behalf or my dependents, including any fees for collection services if needed.

Dilation Exam

_________ Initials

Our office routinely dilates patients to achieve the most comprehensive evaluation of the health of your eyes. Whether pupil dilation is necessary for your eye exam depends on the reason for your eye exam, your overall health and your risk of eye diseases.

Dilating the pupils may cause temporary blurring of your vision. We advise you to exercise caution in operating any equipment of machinery, including driving, until the effects have worn off.

Please check one of the following:

______ I would like my eyes dilated today if the doctor believes it to be necessary.
______ I do not want my eyes dilated.

Refunds and Exchanges

_________ Initials

Eyewear refunds are available as long as the frames are not damaged with no visible sign of defects within 30 days. If the eyewear is deemed damaged, no refund will be issued. All refunds will be either a return charge or a check. **No cash refund will be given**. There are no returns for marked or open boxes of contacts.

A restocking fee of 20% of the total cost of the eyewear will be charged for all returns after 30 days. Per patient's requests, The Vision Shop Optometry will one time refit and re-style into any new frame of equal or lesser value of the original eyewear. Deposits and down payments will be good for 90 days. After 90 days, the deposits will be non-refundable and all orders will be canceled. Frames will be held for up to 1 year upon full payment.

There are no refunds for services. However, The Vision Shop Optometry will work diligently to resolve all issues.

Contact Lens Fees

_________ Initials

Contact lens evaluation services are not an included part of an eye health evaluation and vision assessment; therefore, additional fees will apply. Fees are customized according to the complexity of the case and the predicted time necessary to care for the individual patient. Fees for contacts lens evaluation services range approximately between $50 and $175. The fee will cover the **initial evaluation, a trial pair,** and **all contact lens related follow-up visits** for a period of **3 months**. As with glasses, contact lens boxes are an additional fee.

My signature below verifies I understand all policies stated above and that I will comply to the terms of each policy.

____ Patient's/Guardian's signature

_____/______/_____ Date

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about your, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

USES OR DISCLOSURES OF YOUR MEDICAL INFORMATION
Your protected health information may be used and disclosed by your optometrist, our office staff and others outside of our office that are involved your care and treatment for the purpose of providing health care services to you, to pay your health care bill, to support the operations of the optometrist's practice, and any other use required by law.

For Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

For Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your information be disclosed to the health plan to obtain approval for services rendered.

For Health Care Operations: We may use or disclose, as needed, your protected health care information in order to support the business activities of your optometrist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for the other business activities. In addition, we may also call your by name in the waiting when your optometrist is ready to see you. We may use or disclosed your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclosed your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroner, Funeral Directors and Organ Donation; Research; Criminal Activity; Military Activity and National Secretary; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or Opportunity to object unless required by law.

You may revoke this authorization at any time in writing, except to the extent that you Optometrist or the Optometrist's practice has taken an action in reliance on the use or disclosure indications in the authorization.

Your Rights: following is a statement of your rights with respect to your protected health information.
You have the right to inspect and copy our protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes' information compiled in reasonable anticipation of , or use in, a civil criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means that you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state specific restrictions requested and to whom you want the restriction to apply. Your Optometrist is not required to agree to the restrictions that you may request.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of our protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaint: you may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.