Visual expressions

Welcome to Our Office

Section A - Personal Information

☐ **No Change** - If there have been no changes since your last exam, please proceed to **Section B**

Name _____ **Date of Birth** _____ **Sex** ☐M ☐F
LAST FIRST

Address _____ **City** _____ **State** _____ **ZIP** _____

Home Phone _____ **Cell Phone** _____

E-Mail Address _____

Referred By ☐Insurance ☐Yelp ☐Google ☐Walk-In ☐Friends /Family _____

Section B - Insurance Information

Vision Insurance _____ **SSN** _____

Marital Status ☐Single ☐Married ☐Domestic Partner ☐Divorced ☐Other _____

Employment Status ☐Full Time ☐Part Time ☐Self-Employed ☐Unemployed
☐Homemaker ☐Student ☐Retired ☐Other _____

Occupation _____ **Employer** _____

Opt-in to Pre-Appointment System? *Be placed on the schedule one year from today's date, when you are next eligible for exam*
☐Yes ☐No

Section C - Today's Visit is For:

☐ **Comprehensive Eye Exam** General health exam of the inside and outside of the eyes. New prescription for any correction needed to be used with eye glasses.

☐ **Comprehensive Eye Exam & Contact Lens Exam** Be fit into contact lenses or renew/update your existing contact lens prescription. The doctor will evaluate you to provide you a prescription for lenses that are satisfactory in fit and vision. Prescription will be valid for **one year from service date**. There will be a **minimum fee of $85**.

☐ **Medical Office Visit** Our doctors diagnose and treat a variety of ocular abnormalities. If you are experiencing: suddenlyirritated or painful red eye conditions, acute allergies, dry eyes, foreign bodies, trauma, or sudden vision disturbances, it should be investigated urgently. **Often abnormalities must be addressed before routine exams can be performed**. Please present your **medical insurance information and card.**

For Office Use Only

Services

☐ Exam ☐New ☐Existing
☐ Dilation
☐ CL Exam _____
☐ CL Material _____
☐ Office Visit _____
☐ RX Check _____
☐ CL Check _____

Insurance

OptoVue iWellness Scan ☐$45
Conditions
☐ Diabetes ☐ D. Retinopathy ☐ Macular Degeneration
☐ Hypertension ☐ Glaucoma ☐ High Cholesterol ☐ NCL
Autorefraction
☐ OD _____
☐ OS _____

NAME: _____

REVIEW of SYSTEMS (MEDICAL HISTORY): please check if current or past medical conditions apply
Are you currently pregnant and/or nursing? ☐ No ☐ Yes

☐ Cancer (C)	☐ Kidney Disease (GU)	☐ Stroke / CVA (N)	☐ Eczema (I)
☐ Headaches (N)	☐ Thyroid Dysfunction (E)	☐ High Blood Pressure (CV)	☐ Allergies (A/I)
☐ Colitis (GI)	☐ Hearing Loss (ENT)	☐ Osteoporosis (M)	☐ Migraines (N)
☐ Diabetes (E)	☐ Vascular Disease (CV)	☐ High Cholesterol (H)	☐ Lung/Pulmonary Disease (R)
☐ Sinus Problems (ENT)	☐ Arthritis (M)	☐ Multiple Sclerosis (N)	☐ Skin Problems (I)
☐ Seizures (N)	☐ High volume blood loss (H)	☐ Heart Disease (CV)	☐ Lupus (A/I)

OTHER COMMENTS (list any other conditions or symptoms related to general health):

CURRENT MEDICATIONS: list all medication including dosage (include oral contraceptives, aspirin, over the counter medications and home remedies)

ALLERGIES: list any known MEDICATION and OTHER known allergies (ie. latex or food allergies)
☐ NO KNOWN DRUG ALLERGIES

OCULAR HISTORY: please check any that apply to you (current, chronic or history of conditions)

☐ Glaucoma	☐ Red Eyes	☐ Macular Degeneration	☐ Sjogren's Syndrome
☐ Surgery	☐ Amblyopia (lazy eye)	☐ Floaters in Vision	☐ Droopy Eyelid
☐ Itchy Eyes	☐ Cataract	☐ Eye Pain	☐ Retina Tear / Hole
☐ Strabismus (crossed eye)	☐ Double Vision	☐ Injury	☐ Inflammatory Disorder
☐ Glaucoma Suspect	☐ Dry Eyes	☐ Retina Detachment	☐ Excess Tearing / Discharge
☐ Loss of Vision	☐ Patching	☐ Flashes in Vision	

OTHER COMMENTS (list injuries, surgeries or other conditions related to your eye health, including LASIK):

FAMILY HISTORY: medical and ocular history - please indicate relationship to you

☐ Glaucoma _____	☐ Retinal Detachment _____	☐ Macular Degeneration _____
☐ Blindness _____	☐ Retinal Disease _____	☐ Crossed/Drifting Eye _____
☐ Cataract _____	☐ High Blood Pressure _____	☐ Diabetes _____
☐ Cancer _____	☐ Heart Disease _____	☐ Thyroid Disease _____

OTHER (please explain):

SOCIAL HISTORY:
Do you drink moderate to heavy alcohol? ☐ No ☐ Yes: how much? _____

Do you smoke? ☐ No ☐ Yes: what? _____ how much? _____ how long? _____
Hobbies: _____

COMPUTER USAGE:
Average time spent at computer: _____ hrs/day. Computer working distance: _____ inches (measure from eyes to center of screen).
Lighting:
☐ Fluorescent ☐ Incandescent ☐ Halogen

Are you experiencing any of the following symptoms while at your computer? (please check any that apply)

☐ Headaches	☐ Blurred vision	☐ Difficulty refocusing	☐ Neck/shoulder/back pain
☐ Eye strain	☐ Dry/watery eyes	☐ Double vision	

_____ _____ _____
Name Signature (patient or patient's guardian) Date

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At Visual Expressions Optometry, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment.

For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.
If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.
If we change any of the details of this notice, we will notify you of the changes in writing.
You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at (925) 648-9393.
This notice goes into effect as of April 14, 2003.

Acknowledgment

I have received a copy of the Visual Expressions Optometry Notice of Privacy Practices.

Signature _____ Date _____

Print Name _____

If signing as a parent or guardian, please note the name of the patient

_____

Practice Finance Policy

Insurance Coverage

The following financial policy applies to all patients who have insurance coverage. Please carefully read and sign this agreement providing you agree with it. Let our finance staff know if you have any questions.

- We will be happy to bill your insurance company for your care providing you give us all the information we need. Even though you have insurance coverage, remember that paying for your treatment is your personal responsibility. We will verify your insurance benefits by contacting the insurance company. You will need to sign an "Assignment of Rights and Benefits" so we can accept your insurance coverage.
- You will need to pay your portion of the charges as you go. This includes the annual deductible, co-payment, and charges your insurance company refuses to pay. While our office policy does not allow us to extend credit, we can automatically debit your American Express, MasterCard or VISA card for these charges.
  Until we have verified your coverage, you will be responsible for paying for your own care at each visit including the first visit. After we verify your coverage, we will credit the amount you have paid to your portion of the bill. Using your credit card for this purpose will be the easiest for you.
- Once your insurance payment has been received, or sixty days after treatment, whichever occurs first, your account will be balanced. We will either owe you a refund or you will owe us an additional payment.
- Occasionally, an insurance company will send a payment to a patient. If this occurs, bring us the check and the attached stub. The information on the stub is very important. Also, your insurance company may request additional information from you. They will not pay your claim until they receive the information, so please send it immediately.
- If you suspend or terminate your care against the advice of your doctor, all outstanding charges that have not been paid by your insurance company will become immediately due and payable by you personally before you leave or will automatically be charged to your credit card.

By signing below you agree to the terms of this policy.

Patient Name, or Parent/Guardian | Signature | Date

SCHEDULING POLICY

Trying to accommodate every patient's individual needs and work schedules can be difficult. But we do our best. We work very hard to stay on schedule so as to minimize your waiting time in our office.

A scheduled appointment is a commitment of time between the Doctor and the patient. We have reserved that time JUST FOR YOU. When appointments are missed or cancelled, that time is lost.

We ask that when you schedule your treatment, you make every effort to keep that commitment. We understand that personal emergencies do arise, and we always take that into consideration.

But if you cannot keep your scheduled appointment, a 24 hour notice for weekday appointments will allow us to schedule another patient in need of treatment. If your appointment is scheduled for a Saturday, we require 48 hours notice.

It is now our policy that with less than 24 hours notice on a change of commitment (48 hours for a Saturday commitment) , a charge will be considered and could be applied to your account.

If you have any questions regarding this or any of our policies or procedures, as always, we are more than happy to discuss them with you.

Thank you for your understanding and cooperation.

Signature Date

NO REFUND POLICY

There are no refunds in any form under any circumstances.

Eyeglasses are a custom-made medical device for your visual needs, there are **no returns or exchanges for any purchased eyewear** (including eyeglass lenses, frames, and plano sunglasses). All orders of prescription and non-prescription eyeglasses and sunglasses are final. In addition, if the fit of the frames are not satisfactory, the patient is welcome to return to the office so that our Optical professionals can help them so they fit as best as possible.

It is the **patient's responsibility** to notify the office if they are having trouble with their newly received eyewear as soon as possible. If there is a need for a prescription adjustment, such changes are included at **no charge** for a **one-time redo** within **90 days of the doctor's written prescription date.** If there are any discrepancies between the doctor's prescription and the lenses manufactured by the lab, these changes will be provided at no charge. All of our lenses and frames have a 1 year warranty against manufacturing defects for up to one year from the date of purchase. This warranty does not include accidental damage from dropping your eyewear.

Even though the eyeglass frame is under warranty by the manufacturer, the manufacturer does not pay the shipping and handling for the exchange of the defective frames for the new frames. The patient will be responsible for the two-way shipping costs involved **($25.00)**.

Contact Lenses

With regard to orders of non-specialt**y** soft contact lenses, any **unopened & unmarked boxes** may be exchanged, within 6 months if there has been a change to your prescription. The boxes must have valid expiration dates. However, all orders of custom, specialty gas permeable (i.e.,rigid) and hybrid (i.e.,containing both rigid and soft components) contact lenses are final. During the trial period **(90 days)** in determining the proper prescription for such specialty lenses, any exchanges will be granted at **no charge** so long as enough time is given for the lenses to be mailed back to the manufacturer, in order to meet the manufacturer's 90 day exchange policy.

Picking Up Eyeglasses & Contact Lenses

All eyeglasses and contact lenses that have been prescribed, fitted, and ordered by the patient will be kept in the office for a total of **six months** from the order date. If the patient does not pick up his/her eyeglasses or contact lenses within that year, we will subsequently donate them to charity. In order for our **one- time** redo policy to be in effect, the eyewear must be picked up within the 90 days from order date.

Personal Checks are not accepted, however we gladly accept Visa, Mastercard, American Express, and Discover credit cards as well as Apple Pay, Care Credit, Cash and Visual Expressions Gift Cards.

X_____ I have read and understand all aspects of the above policies. It has been made known to me that, if any or all parts of the above policies are not fully understood by me, that further explanation is available and has been provided to me at the time of signing.

X Signature: _____ Print Name:_____ Date:____/_____/____