Apple Valley Vision

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." Routine vision benefits such as VSP, Eye Med, or Medical Eye Services, typically include this with your exam benefits. Some medical insurances, namely Medicare, may not cover this fee. The fee for refraction is $50.

SPECTACLE CANCELLATION and/or REMAKE POLICY

Each pair of glasses is custom crafted for each patient. *We require a deposit of 50% on all eyeglass orders before they will be submitted. The remaining balance will be due at the time of delivery. 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 lenses will have their prescription remade one time into a lens of their choice at no additional charge. Refunds are not available after 30 days on all lenses, and cash refunds are not possible. However there is an option for in office credit or a refund to the same card previously used.

THE CONTACT LENS PROCESS

***Contact lens evaluation services are not included as part of a normal ROUTINE EXAM. These are considered distinct procedural services* and additional fees apply. Most soft contact lens fees range from $40 to $150, some up to $1500.** 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 disposable trial lenses, until the prescription is finalized.* 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 toward contact lens purchases.

*Our contact lens 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. **It is the patient's responsibility to know their insurance coverage, and relay that information to the office staff**. Any fees not covered by insurance will be billed to the patient. **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.

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. 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.

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: ____/____/_____

Patient Information

Today's Date: ____/____/_____

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

Name: (Last, First, Middle) ____ Social Security#: ___________________

Birthdate: ____/____/____ Age:______ Sex: M F

Address: ____ City, State, Zip:________________________________

Home Phone: ( ) _____________Cell Phone: ( ) __________ Text okay? Yes No

Employer: ____________________ Occupation:______________ **Email**: ______________________________________

Person responsible for payment **(If different from above):** Name:____________________ Social Security#: ______________

Address: ___________________________________ City, State, Zip:____________________ Phone: ( ) ____________

Emergency Contact Name: _______________________________ Relation: _____________ Phone: ( )____________

Health Insurance:___________________________ Policy #: __________________

Policy Holder (Last, First, Middle): ________________Social Security # ______________________ Birthdate: ____/____/_____

Vision Plan: VSP Eye Med Spectera Other:___________ Policy #:_________________

Policy Holder (Last, First, Middle):________________Social Security # ______________________Birthdate:___/___/______

PERSONAL OCULAR HISTORY

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.): __________________________

____

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'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:*

	NO	YES
CONSTITUTIONAL		
Fever, Weight Gain/Loss	☐	☐
NEUROLOGICAL		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
EYES		
Loss of Vision	☐	☐
Blurred Vision	☐	☐
Distorted Vision/Haloes	☐	☐
Loss of Side Vision	☐	☐
Double Vision	☐	☐
Dryness	☐	☐
Mucous Discharge	☐	☐
Redness	☐	☐
Sandy or Gritty Feeling	☐	☐
Itching	☐	☐
Burning	☐	☐
Foreign Body Sensation	☐	☐
Excess Tearing/Watering	☐	☐
Glare/Light Sensitivity	☐	☐
Eye Pain or Soreness	☐	☐
Chronic Infection of Eye	☐	☐
Sties or Chalazion	☐	☐
Flashes or Floaters	☐	☐
Tired Eyes	☐	☐
ENDOCRINE		
Thyroid/Other Glands	☐	☐
Diabetes ☐Type 1 ☐ Type 2	☐	☐
ALLERGIC/IMMUNOLOGIC	☐	☐
Describe:______________________		
NEUROLOGICAL		
Headaches	☐	☐
Migraines	☐	☐

	NO	YES
EAR / NOSE / MOUTH / THROAT		
Allergic/Hay Fever	☐	☐
Sinus Congestion	☐	☐
Runny Nose	☐	☐
Post-Nasal Drip	☐	☐
Chronic Cough	☐	☐
Dry-Throat / Mouth	☐	☐
Hearing Loss	☐	☐
RESPIRATORY		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
CARDIOVASCULAR		
Heart Pain	☐	☐
High Blood Pressure	☐	☐
Vascular Disease	☐	☐
GASTROINTESTINAL		
Diarrhea	☐	☐
Constipation	☐	☐
GENITOURINARY		
Genitals/Kidney/Bladder	☐	☐
BONES / JOINTS / MUSCLES		
Rheumatoid Arthritis	☐	☐
Muscle Pain	☐	☐
Joint Pain	☐	☐
LYMPHATIC / HEMATOLOGIC		
Anemia	☐	☐
Bleeding Problems	☐	☐
PSYCHIATRIC		
Depression	☐	☐
Anxiety	☐	☐
Other:		
CANCER	☐	☐
Type: ______________________		

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

____

____

Reason for visit: ____

Patient Signature:________________________________ Date:____________________

(or parent if under 18)