



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	Mother	Sibling	Child	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:*

CONSTITUTIONAL	NO	YES	EAR / NOSE / MOUTH / THROAT	NO	YES
Fever, Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>	Allergic/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
NEUROLOGICAL			Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
EYES			Dry-Throat / Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY		
Distorted Vision/Haloes	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	CARDIOVASCULAR		
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL		
Burning	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY		
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	BONES / JOINTS / MUSCLES		
Chronic Infection of Eye	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Flashes or Floaters	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC / HEMATOLOGIC		
ENDOCRINE			Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC		
ALLERGIC/IMMUNOLOGIC	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Describe: _____			Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
			Other:		
			CANCER	<input type="checkbox"/>	<input type="checkbox"/>
			Type: _____		

If you have a condition not listed, please explain if necessary:

Reason for visit: _____

Patient Signature: _____

Date: _____

(or parent if under 18)