ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY LAW

While 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 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.

OPTOMAP RETINAL IMAGING

As part of *every eye exam,* we take a picture of the back part of your eye, called the retina. This *often replaces dilating drops* and provides an annual, permanent record which gives your doctor comparisons for tracking and diagnosing potential issues.

The copay for this test is $16 per individual

REFRACTION – Glasses prescriptions

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 or may not cover this fee, but MOST do cover it. **The fee for refraction is $55**

SPECTACLE CANCELLATION and/or REMAKE POLICY

Due to the custom nature of each pair of glasses, 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 pickup. Any cancellations after lenses have been ordered, but before pickup, will be billed at 50% of retail. At the doctors' discretion, patients who are not seeing well with their glasses may have their prescription adjusted at no cost, within **45 days** of the original purchase date. There are no refunds or returns on any lenses.

THE CONTACT LENS PROCESS

***Contact lens fitting and evaluation services ARE NOT included as part of a normal ROUTINE EXAM*. These are considered distinct services and additional fees apply.** 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. Contact lens *materials* require additional fees.

-Our contact lens warranty includes exchange of unopened, clean boxes of contact lenses if your prescription changes during 1 year after purchase. All gas permeable contact lenses have a 60-day warranty.

-By Signing below, I am giving consent to receive my contact lens prescription electronically.

Most soft contact lens fees range from $95 to $150, insurance discounts will be applied

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 $40 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. There will be a 3% credit card processing fee added to all purchases made with credit cards, it will appear on your bill under sales tax. 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 and financial policies written on this form:

_____ _____ **Date:** ____/____/_____

Print Patient Name **Patient Signature (or parent/guardian if under 18):**

Patient Information & History

Today's Date: ____/____/_____

(All information is always kept secure and confidential)

PATIENT INFORMATION

Patient's Name: (Last, First, Middle)_____ Social Security#:_____

Birthdate: ____/____/____ Age: _____ Sex: M F (SS for insurance verification)

Address:_____ City, State, Zip:_____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Text okay? Yes No

Email Address:_____

*Text & Email are for appointment reminders and internal communication only.

INSURANCE INFORMATION – skip section if you have verified all of this info at front desk or given us your insurance card(s)

Person responsible for payment **(If different from above):** Name:_____

_____

Medical Insurance Name:_____

Policy Holder Name, Date of Birth (If different than patient):_____

Vision Insurance Name: _____

Policy Holder Name, Date of Birth (If different than patient):_____

Policy Holder SS# (for insurance verification):_____

Address:_____ City, State, Zip:_____ Phone: ( )_____

PERSONAL EYE HISTORY

List any personal history of: crossed eyes, keratoconus, droopy eyelids, glaucoma, retinal disease, cataracts, eye infections, injuries:

_____

List any EYE DROPS you use (artificial tears, prescription, ointments, allergy, etc.): _____

PERSONAL MEDICAL HISTORY

List or provide a copy of ALL MEDICATIONS you currently take (including oral contraceptives, aspirin, over the counter and home remedies):

_____

List MEDICATION ALLERGIES you have, if any: _____

If Female, Are you pregnant or nursing? ☐Yes ☐No

FAMILY OCULAR / MEDICAL HISTORY Please check any ***family*** history (living or deceased) of the following conditions: (Check All That Apply)

☐ Unknown / Adopted

☐ Crossed / Lazy Eye	☐ Retinal Hole, Tear, detachment	☐ Heart Attack / Stroke
☐ Glaucoma	☐ Cancer	☐ High Blood Pressure
☐ Macular Degeneration	☐ Diabetes	☐ Thyroid Disease

REVIEW OF SYSTEMS _____ *Do you currently, or have you ever had any chronic problems in the following areas:*

	NO	YES	IF YES, EXPLAIN:
EYES (flashes/floaters, double vision, dry eye, infection, etc.)	☐	☐	_____
EAR, NOSE, MOUTH, THROAT (Allergies, sinus issues)	☐	☐	_____
RESPIRATORY (Asthma, Chronic Bronchitis, COPD, etc.)	☐	☐	_____
ENDOCRINE (Thyroid, Diabetes)	☐	☐	_____
ALLERGIC/IMMUNE DISORDERS	☐	☐	_____
CARDIOVASCULAR (heart attack, stroke, clots, etc.)	☐	☐	_____
SKIN	☐	☐	_____
BONES, JOINTS, MUSCLES (Arthritis, muscle/joint pain)	☐	☐	_____
NEUROLOGICAL (Headaches, Migraines, Seizures)	☐	☐	_____