Welcome to Highland Eye Boutique!

Legal Name: First _____ M.I. _____ Last _____

Sex: M ____ F ____ Marital Status _____ Date of Birth: _____/_____/_____

Social Security #: _____ - _____ - _____ (At least last 4 for insurance verification)

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Daytime Phone: _____ Cell Phone:_____

Employer: _____ Occupation: _____

Email Address: _____ Best way to reach you: Telephone Text Email

How did you hear about Highland Eye Boutique? _____

You need only complete policy holder information below if insurance holder is <u>NOT</u> the above patient

Policy Holder Name: First _____ Last _____

Date of Birth: _____/_____/_____ Policy Holder's Social Security #: _____ - _____ - _____

Policy Holder Employer _____

Policy Holder Relationship to Patient: _____

Address: _____

<u>Consent for Treatment of a Minor</u>

I, _____, the parent/guardian of the above stated minor patient, give consent to authorize any treatment deemed necessary by Dr. Kristie Bennett.

_____ _____

Signature of Patient/Guardian

<u>HIPAA Information</u>

I have read (and received if requested) a copy of Highland Eye Boutique's Notice of Privacy Practices.

_____ _____

Signature of Patient/Guardian Date

For Our Patients with Insurance

The filing of insurance claims is a courtesy that we are happy to extend to our patients, in order to help you receive your maximum benefits. Your insurance is a contract between you, your employer, and the insurance company; we are contractually obligated to accept the insurance provider's terms and co-pays for your services.

I, the undersigned, authorize all benefits that would otherwise be paid to me to be assigned to Highland Eye Boutique. I understand that I am personally responsible for all non-covered services. I authorize the release of medical information to my insurance carriers as deemed necessary for financial purposes.

_____ _____
Signature of Patient/Guardian Date

Vision Insurance versus Medical Insurance

There are two types of insurance that may help pay for your eye care services and optical products. The first of these is vision insurance, such as VSP or EyeMed. The second is medical insurance, such as Medicare, Blue Cross & Blue Shield, and others.

** Vision plans only cover routine vision wellness exams, along with materials such as glasses or contact lenses.
Vision plans do not cover medical eye care, such as injuries or infections.
Medical insurance must be used for medical eye problems. This can include yearly diabetic eye exams. **

If you have both types of insurance plans, it may be necessary for us to bill some services to one plan and some services to the other. We will follow coordination of benefits procedures in order to minimize your out-of-pocket expenses.

I have read and accept these policies. I consent to having my insurance billed as the staff at Highland Eye Boutique deems necessary based on my conditions and diagnoses.

_____ _____
Signature of Patient/Guardian Date

Payment Policies

- Accounts 90 days old are subject to collection fees.
- There will be a $25.00 service charge on all returned checks.
- All co-pays and material costs not covered by your insurance are due at the time of service.

I understand and agree to the payment policies as detailed above.

_____ _____
Signature of Patient/Guardian Date

Refraction/ Eyeglasses Prescription

Refraction is a test to determine a person's best corrected vision. One possible result of this test is that you are given an eyeglass prescription. However, this test is also done to determine whether there is a problem with your vision. If it appears that a change in glasses can improve your vision, an eyeglass prescription will be written. In some cases, a change in lens power will not improve your vision and there will not be a prescription for eyeglass, however there is still a charge for the refraction.

I understand that the refraction must be done every year at my annual comprehensive exam, whether there is a change in my vision or not. I also understand that the $40 refraction fee may not be covered by my insurance, and payment is due at the time of my exam.

_____ _____
Signature of Patient/Guardian Date

Medical History Form

Patient Name: _____ Primary Care Physician: _____

List any medications you currently take (Rx and over-the-counter): _____

_____

List all eye drops you currently use: _____

Are you allergic to any medications? **YES** **NO** If so, please list: _____

Please list *all* previous surgeries or major injuries: _____

Are you currently: Pregnant? _____ Nursing? _____ Using tobacco products? _____ Drink alcohol? _____

When was your last eye exam? _____

Have you noticed any changes in your distance or reading vision since your last exam? _____

If you wear contact lenses, how many hours per day? _____

How often do you put in a new pair? _____ What solution do you use? _____

Family Medical History **(**Please indicate relationship)

☐ Blindness _____	☐ Retinal Problems _____
☐ Cataracts _____	☐ Lazy Eye _____
☐ Corneal Problems _____	☐ Dyslexia _____
☐ Macular Degeneration _____	☐ Diabetes _____
☐ Glaucoma _____	☐ Heart Disease _____

Personal Medical History Do you currently have or have you recently had any of the following?

Constitution:	□ Fever □ Weight loss □ Weight gain	Gastrointestinal:	□ Heartburn □ Diarrhea
Skin:	□ Acne □ Rash □ Skin Cancer	Cardiovascular:	□ Cholesterol □ High blood pressure □ Heart Disease
Eyes:	□ Diabetic Retinopathy □ Glaucoma □ Macular Degeneration	Genitourinary:	□ Kidney Stones □ Prostate
Neurological:	□ Headache □ Multiple sclerosis	Musculoskeletal:	□ Arthritis □ Joint Pain
Endocrine:	□ Diabetes □ Thyroid	Lymphatic and Hematologic:	□ Bleeding problems □ Swollen lymph nodes
Ears, Nose, Mouth:	□ Allergies □ Hearing loss □ Sinus congestion □ Cough	Immunologic:	□ HIV/AIDS □ Cancer
Respiratory:	□ Asthma □ Bronchitis/emphysema	Psychiatric:	□ ADD/ADHD □ Anxiety □Depression

Contact Lens Evaluations

Contact lens patients require additional testing which is not included in a routine eye exam. **Even if you already wear contact lenses, an evaluation is necessary every year in order to renew your prescription.** This is to ensure that your contact lenses are still properly fitting, and providing you with the highest quality of vision, health, and comfort.

There is an additional fee for this service (over and above the fee for a routine eye exam), which varies depending on a number of factors, including the complexity of the prescription and the need for follow up visits. This service can only be provided in conjunction with your annual exam, and cannot be done separately.

Most insurance companies, including vision plans, do not cover contact lens evaluations. Payment of the contact lens exam is due at the time of service. Contact lens prescriptions expire yearly, and renewals are not allowed after **1 year** without an examination, per Georgia state law.

Please initial one selection

_____ Yes, I want a contact lens evaluation _____ No, I do not want a contact lens evaluation.

Pupil Dilation

During your examination, it is often necessary to dilate your pupils. This allows for a more thorough examination of the health of the inside of your eye. The difference is similar to looking into a room with the door wide open versus through a door only partially open.

We recommend dilation to all new patients. **Annual** dilation is recommended for all patients over the age of 60, all patients who have high-risk conditions (such as diabetes or cataracts), and patients with high prescriptions (above -6.00). Otherwise, dilation is recommended every two years. To dilate the pupils, eye drops must be administered. Once your pupils are dilated, you may experience blurred vision, especially in your near vision range, and your eyes will be more sensitive to the light. These symptoms may last about 3-5 hours. If you do not have sunglasses with you today, we will provide you with a disposable pair before you leave.

Please initial one selection

____ Yes, I understand the side effects and health benefits of dilation, and I consent to having my pupils dilated by the doctor.

_____ No, I understand the benefits of dilation, and the risks associated with declining this procedure, and I do not consent to having my pupils dilated by the doctor.

Retinal Screening Photos

Dr. Bennett recommends a retinal screening photo with your **dilated** eye examination. These photos of the back of your eye provide a visual record of the inside of the eye. This can be helpful in detecting subtle changes over time due to diseases like glaucoma, macular degeneration, and diabetes. Dr. Bennett feels this is an important part of a comprehensive examination for all ages and should be done at least every other year. This fee for this procedure is $39, and will not be covered by your insurance. After the pictures are taken, Dr. Bennett will show you the images and explain all findings.

Please initial one selection

_____ YES, I want this procedure _____ NO, I do not want this procedure

Print name:_____ Date of birth: _____ Date of exam: _____