McAlear Eye Care

NEW PT

EXIS PT

Patient's Name_____ Date of Birth_____
Mail Address: _____City_____State_____Zip_____
Telephone: Home _____ Cell _____ □ OK to send text messages
Email: _____ Occupation_____
Emergency Contact & Phone Number_____
Race: ☐ African American ☐ American Indian/Alaskan Native ☐ Asian ☐ Caucasian ☐ Hispanic
☐ Multiracial_____ ☐ Other_____
Preferred Language: ☐ English ☐ Spanish ☐ Other _____
Date of Last Eye Exam_____ Name of Previous Eye Doctor_____
Have you been to any other eye doctor in the past year? ☐ **Yes** ☐ **No** If yes, who and why _____
_____
Name of primary care physician and phone number: _____
Preferred Pharmacy: _____ Phone: _____
Whom may we thank for referring you to our practice? _____

Do you currently: ☐ **Wear Glasses** ☐ **Wear Contacts** ☐ **Both**

Please note: A contact lens examination is more in depth than a typical routine eye exam. A comprehensive contact lens exam includes a thorough evaluation of your vision, the internal health of your eyes; your cornea where the lens sits, the underside of your lids as well as additional testing that requires more of the doctor's time and expertise. The fee for this service is either $50 or $75 depending on your RX and is collected every year as we have to check your eye health annually.

Please list any concerns you have that you would like to discuss with the doctor:
Please note: We encourage you to raise any eye health concerns with the doctor, however, please understand that these issues are likely outside the scope of a routine eye exam, and your visit may need to be billed to your medical insurance. In this case, medical insurance copays and deductibles apply.

Concern/Discussion Ex. Headaches	Date of Onset Ex. June 2015	Frequency (if applicable) Ex. 4 x per week	Severity Ex. Moderate
1.			
2.			
3.			
4.			

THE FOLLOWING INFORMATION IS REQUIRED BY THE FEDERAL GOVERNMENT'S MEANINGFUL USE PROGRAM, PLEASE FILL OUT COMPLETELY AND AS ACCURATE AS POSSIBLE.

Please list: Height: _____ **Ft.** _____ **In.** **Weight:** _____

For Women: Are you, or could you be pregnant? ☐ **Yes** ☐ **No** ☐ **Maybe/Planning** ☐ **Nursing**

Do you have any allergic reactions to medications or other substances? ☐ **Yes** ☐ **No**
If yes, please list_____

Do you take medications? ☐ **Yes** ☐ **No** If yes, please list_____
_____

Do you smoke? ☐ **Yes Currently** ☐ **Never Smoked** ☐ **Former Smoker - how long since quitting**_____
Do you drink alcohol? ☐ **No** ☐ **Occasionally/Socially** ☐ **Regularly**
Do you use other street drugs? ☐ **Yes** ☐ **No** If yes, please list_____

Do you or have you experienced any of the following?

☐ Blurred Vision	☐ Loss of Vision	☐ Headaches	☐ Flashes of light
☐ Floating Spots	☐ Dryness	☐ Redness	☐ Burning
☐ Itchy/Scratchy	☐ Eye Injuries	☐ Eye Surgeries	☐ Eye Infections

Personal Medical Information: Do you currently, or have you had any problems in the following areas:

- ☐ Ears, Nose, Mouth, Throat
- ☐ Cardiovascular/Vascular (heart)
- ☐ Respiratory (lungs)
- ☐ Gastrointestinal (stomach, intestines, liver)
- ☐ Genitourinary (kidneys, urinary/reproductive tract)
- ☐ Musculoskeletal (arthritis, muscles, bones)
- ☐ Integumentary (skin)
- ☐ Neurological (headaches, numbness)
- ☐ Psychiatric (mental, depression, anxiety)
- ☐ Endocrine (diabetes, thyroid)
- ☐ Lymphatic/Hematologic (blood, lymph node)
- ☐ Allergic/Immunologic (allergies, immune disorders)

If any of the above are checked, please explain: _____

_____

Please list any surgeries (what type & when) _____

Have you or your blood relatives had any of the following conditions?

	YOURSELF	FAMILY		YOURSELF	FAMILY
High Blood Pressure	☐Yes ☐No	☐Yes ☐No	Diabetes	☐Yes ☐No	☐Yes ☐No
Glaucoma	☐Yes ☐No	☐Yes ☐No	Arthritis	☐Yes ☐No	☐Yes ☐No
Crossed Eyes	☐Yes ☐No	☐Yes ☐No	Thyroid disease	☐Yes ☐No	☐Yes ☐No
Lazy Eyes	☐Yes ☐No	☐Yes ☐No	Stroke	☐Yes ☐No	☐Yes ☐No
Eye Surgery	☐Yes ☐No	☐Yes ☐No	Blindness	☐Yes ☐No	☐Yes ☐No
Retinal Detachment	☐Yes ☐No	☐Yes ☐No	Heart Disease	☐Yes ☐No	☐Yes ☐No
Macular Degeneration	☐Yes ☐No	☐Yes ☐No	Cancer	☐Yes ☐No	☐Yes ☐No

Other condition(s) not listed above: _____

If you are having any other eye problems at this time, please explain _____

_____

Vision Care Plan Acknowledgement

Our role is to be your advocate and to help you to maximize your benefits. We want to make sure you receive everything you are entitled to and we want you to be happy and satisfied.

We also want to make sure you are aware of the following:

1) With few exceptions, vision care plans provide routine exams only, not medical eye care.
2) Copayments are set by your insurance plan.
3) Your vision plan uses their lab to manufacture your eyewear.
4) It can take at least 2 weeks (sometimes longer) for them to send us your eyewear.
5) We have **no control** over when your eyewear will be ready.
6) Your insurance company **does not provide refunds**, and any warranty is according to their terms.
7) Eyewear orders are submitted to your insurance company immediately once the order is finalized. **Changes cannot be made after submission**.

If you are unhappy with the eyewear your insurance company provides we will be your advocate and assist you, **BUT** your insurance company makes the final decision about how any concerns will be resolved.

As a reminder: all copays and fees are due at time of service. By signing below you acknowledge all statements on both sides of this form and agree to pay upon the conclusion of your visit.

Signature of Patient or Legal Guardian:_____ Date_____

Relationship to patient (if other than patient):_____

(For Office Use Only)

ANTICIPATED INS: Routine CL Medical CEE Medical PF REF Only CL: IN OUT

OPTOMAP: Elective Screening Medical DILATION DLY WAIVER

INSURANCE: Davis EyeMed VSP Medicaid/Other: _____ Medicare

BCBS/HP HMO or PPO Med Ins: _____ None/OOP

Office Policies

Insurance:
We are pleased to accept many vision and medical insurance plans. It is your responsibility to know what insurance plan(s) provide your coverage and provide us with all the necessary information **before** services are rendered. **Claims cannot be re-processed to insurance after the date of service.** Copayments and any non-covered charges are due on the date of service. Most vision plans provide coverage for a **routine** eye exam, which specifically excludes the evaluation and management of any medical condition(s)**. If your visit includes the evaluation and/or management of any medical condition(s), we will bill your medical insurance for your visit**, which may result in a higher out of pocket cost due to the copays and deductibles your policy specifies.

As a courtesy to you, we will gladly submit claims directly to your insurance company. While we will make our best effort to verify your insurance coverage before providing services to you, this is by no means a guarantee that your insurance will actually pay your claim. **In the event that your insurance company does not pay your claim, whether due to an unmet deductible, a requirement for Primary Care Physician (PCP) referral, or any other reason, you agree to personally and promptly pay any balance owed.** We accept no responsibility in collecting overdue insurance claims or negotiating settlement on disputed claims.

Eyewear:
All eyewear purchases require a minimum 50% non-refundable deposit before orders will be placed; this deposit will not be refunded if the order is cancelled. Any order with a balance due after 90 days from the date glasses are ready for pickup will be considered canceled. **Eyewear purchases are non-refundable.** Manufacturers' warranties cover lenses and frames for one (1) year after dispensing against defects in materials and workmanship; minor cosmetic flaws due to normal wear and tear and breakage due to abuse are explicitly excluded. Lenses with scratches significantly interfering with vision may be replaced one time only during the first year of use at our sole discretion; scratching due to abuse is explicitly excluded.

Patients who are unable to adapt to Progressive Addition Lenses (PALs) after a reasonable effort will be afforded the opportunity to have their lenses replaced with a lined bifocal or single vision lens at their option and our expense, provided their concerns are brought to our attention within thirty (30) days of dispensing. No refunds will be made in this situation.

Patients who are unsatisfied with an eyewear prescription provided by this office will be seen for a courtesy Rx check, provided they bring their concerns to our attention within thirty (30) days of dispensing. If the prescription requires modification, we will replace the lenses at our expense.

Different terms and conditions may apply to eyewear provided through vision insurance plans, as dictated by the insurance company. Please ask for details about your specific insurance, if applicable.

Outside prescriptions:
We are happy to fill outside prescriptions**. If the prescription is dated more than 6 months prior to the order date, any Rx changes will be at the patient's expense.** If the prescription is six months old or less, we will honor a Dr.'s change of Rx one time only, if the new Rx is presented to us within thirty (30) days of dispensing of the eyewear in question. After 30 days or one remake any changes will be at the patient's expense.

Contact Lenses:
Contact lens purchases require payment in full before orders can be placed. Contact lenses cannot be returned for refund, but can be exchanged in the event of prescription change, provided the original boxes are unopened and not defaced in any way.

Medical Records:
Request for Medical Records can take up to 24 hours to be processed and is required in writing. All requests for records must be in writing and be on file in order to process any requests. Our office has a policy for copying medical records of 25-cents per page, not to exceed $20 per record.

Appointments:
We value our patient's time as well as Dr. McAlear's time**. If you cancel your appointment or no show within 24 hours a $25.00 fee will be assessed to your account.** If you no show or cancel your appointment within 24 hours **twice in a row** you will not be permitted to choose any prime appointment slots such as Saturdays or evenings after 5:00 PM. These slots are in high demand and we would hate to turn patients away who truly need these particular times.

Our office accepts cash, checks, MasterCard, Visa, American Express and Discover**. Returned checks are subject to a $35.00 fee.**

By signing below, I understand and agree to the terms described herein and agree to accept responsibility for the payment of services. I agree to pay all costs incurred by my failure to remit for services rendered, including fees charged by a collection agency. I grant my permission to you, or your assigns, to telephone me at home or other phone numbers listed to discuss financial matters related to this form. Furthermore, I authorize the release of any medical or other information necessary to process this claim and authorize the vision benefits otherwise payable to me to be paid directly to McAlear Eye Care.

HIPAA PRIVACY ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY NOTICE

_____ **(Initial here)**, I have been shown the Notice of Privacy Policy of this provider and have been offered a copy of such policy to keep for my records.

IF YOU ARE OVER THE AGE OF 18, WE CAN NOT DISCLOSE ANY MEDICAL INFORMATION TO YOUR FAMILY MEMBERS WITHOUT YOUR CONSENT. IF YOU WOULD LIKE US TO BE ABLE TO TALK TO A FAMILY MEMBER OR CAREGIVER (i.e Parent, spouse or adult child) PLEASE LIST THEM HERE. WE WILL NOT DISCUSS YOUR CONDIDTIONS OR HISTORY WITH ANY FAMILY MEMBERS NOT LISTED HERE.

NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT
1. **2.** **3.** **4.**		

I have read the above conditions of treatment and agree in content:

Print Patients Name:_____ Date_____

Signature of Patient or Legal Guardian:_____

Relationship to patient (if other than patient):_____