Patient NAME: ______________________________ **Date**: ____________________

PRIVACY POLICY

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.
I acknowledge that I have been offered and/or received a copy of the Privacy Policy from Abundo Eye Care.

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SIGNATURE OF PATIENT, IF OVER 18 OR PARENT OF PATIENT DATE

REFRACTION FEE

The part of your evaluation that determines your prescription is called a "refraction". A refraction is also done under certain circumstances for diagnostic purposes. If you have routine vision benefits such as VSP, EyeMed or other vision insurance, your refraction is typically included with your exam benefits. Medical insurances that do not include routine vision benefits, such as Medicare, do not cover a refraction. ***The fee for a refraction is $30.00.*** My initials and signature below verifies I understand the refraction fee. _______
Initials

CONTACT LENS FEES

Contact lens evaluation services are not an included part of an eye health evaluation and vision assessment, 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 fitting, training, sample cleaning solutions, two months of follow up and a pair of initial disposable trials. Specialty lenses and office visits outside the initial two month period are not included and additional fees may apply.
Fees for contact lens evaluation services range between $40 and $170 and can only be firmly quoted after a baseline vision status is determined. As with glasses, contact lens materials are an additional fee. If allowed, insurance benefits may be applied to contact lens overages. My initials and signature below verifies I understand the contact lens fees. __________
Initials

FINANCIAL DISCLAIMERS

We will attempt to verify your plan 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.*** Please check with your plan if you have any questions regarding your eligibility.

Liability
If I have medical insurance or routine vision benefits, I authorize my plan carrier to directly pay Abundo Eye Care. I also authorize Abundo Eye Care to release any information required for payment to be made. ***If my plan carrier 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 $25 fee for returned checks.
My signature below verifies that I understand this agreement and the above financial disclaimers.

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SIGNATURE OF PATIENT IF OVER 18 OR PARENT OF PATIENT DATE

MEDICARE AUTHORIZATION (MEDICARE PATIENTS ONLY)

I request that payment of authorized Medicare benefits be made on my behalf to Roland Abundo, OD (Abundo Eye Care) for any services furnished me by him. I authorize any holder of medical information about me released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item #9 of the HCFA-1500 Form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. ***Medicare pays at 80%. The patient or supplemental insurance is responsible for 20%. Medicare will only pay for services that it determines to be "reasonable and medically necessary". Medicare does not cover glasses or contacts except after cataract surgery (one time only).*** "Post-op" glasses include a standard frame (up to $85) and a pair of standard lenses (plastic single vision, bifocals and trifocals). ***Non-covered services for Post-op glasses include tints, coatings, transitions, specialty materials, progressive lenses, oversize charges and edge treatments.***

I've read and understand the information above. I agree to pay for any services and materials I order that are not covered by Medicare.

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SIGNATURE OF PATIENT IF OVER 18 OR PARENT OF PATIENT DATE

Patient Information

Last Name:_________________________
First Name:_________________________
Title: Mr. Mrs. Ms. Dr.
Address: ___________________________
Address:___________________________
City:_______________________________
State:__________**Zip**_________________
Home Phone: (____)_________________
Daytime Phone: (____)_______________
Cell Phone: (____)___________________
Fax: (____)_________________________
Email:____________________________

Sex: M F
Birth Date: __________________
Patient SSN#:_______________________
_Single __ Married__ Widowed _Divorced
Employee Status:
__Full-time__Part-time__None__ Student
Employer:__________________________
Occupation:________________________
Referral Source: Friend Family PCP Phonebook Insurance Promo Other

Referred by:_________________________

Vision Insurance Information:
Insurance Name:___________________
ID: ______________________________
Relationship to Pt: Self Parent Spouse
Subscriber Name: __________________
Subscriber DOB: ___________________

Medical Insurance Information:
Insurance Name:___________________
ID:_______________________________
Relationship to Pt: Self Parent Spouse
Subscriber Name: __________________
Subscriber DOB: ___________________

Eye symptoms you have (circle): dry eyes, red eyes, burning or stinging sensation, sandy/gritty feeling, foreign body sensation, watery eyes, light sensitivity, itchy eyes, eyelash loss, discharge, crusting around your lashes, floaters, flashing lights, double vision, contact lens discomfort, eyestrain, eye pain, eye soreness. Other (explain)_______________________________________

List any **EYE** problems or diseases you have:____
List any **MEDICAL** problems or disease you have:____
List any medical or eye surgeries you have had:____
List any family history of medical problems including relation (i.e. diabetes – mother)___________________________________
____
List any family history of eye problems including relation (i.e. cataracts – father)______________________________________
List your medications (systemic or eye):____
List any medications you are allergic to: ____
Do you smoke: ☐No ☐Yes and how much_____________ Do you drink alcohol: ☐N ☐Y and how much_____________
Would you like to know if you are a candidate for LASER VISION CORRECTION? ☐No ☐Yes

What would you change about your current contacts?____
Name your contact lens brand you wear___________________________ Name your contact lens solution__________________________
How often do you change your contacts___________________________ How often are they supposed to be replaced________________
Do you sleep with contacts overnight: ☐No ☐Yes. How many nights do you sleep with them? __________________________
Have you had any damage to your eyes while wearing contacts? ☐No ☐Yes. Please explain:____________________________

Review of Systems - Please list any symptoms you have with the following systems.

Allergy______________________	Hematologic (blood)______________________	Cranial / Facial______________________
Cardiovascular (heart)______________	Endocrine (diabetes)______________________	Gastrointestinal (stomache)__________________
Genitourinary (prostate)______________	Immunologic ______________________	Skin Musculoskeletal______________________
Neurologic______________________	Psychiatric______________________	Respiratory (lungs)______________________

Eyewear and Contact Lens Orders

Abundo Eye Care uses the most advanced supply chain system for the ordering of eyewear and glasses available. This system enables us to begin processing your order before you even leave the office. While this expedites the order and decreases the number of days until you receive your order, it limits our ability to change or cancel your order once it is placed. Prescription lenses are “custom made” and we begin incurring charges as soon as the order enters the system. Changes or cancellations to an order can be made depending on the status of the job. Any charges incurred at the time of the change or cancellation will be billed at 50% of retail. There is a $3.00 restocking fee per item on all contact lenses.
All frames purchased at our office carry a one-year warranty against normal wear and tear, but not abuse. Lenses that have been treated with a scratch coating or a level “B” anti-reflective coating carry a one-year warranty with a one-time replacement. “ TD2” scratch coating and Level “C” antireflective coatings carry a two-year warranty with a one-time replacement. ***If you choose to use your own frame in your eyewear order, we will give you a professional opinion of its condition. However, we accept no responsibility for loss, breakage or warranty for materials supplied by you.***

My signature below verifies I understand and agree to the above Eyewear policy.

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Signature of Patient if over 18 or parent of patient Date