

WELCOME

OFFICE POLICIES

OUR PART:

Our policy is that we are on your side! We do everything we can to help you receive any benefits you are eligible for.

YOUR PART:

You have to tell us if you have a vision plan and/or major medical, and we'll take it from there. With hundreds of insurance plans and variables, **there is no way for us to find it.**

You are responsible for the services rendered in the event that your insurance doesn't pay. The *dispute is between you and the insurance company*, and we are here to assist you.

METHODS OF PAYMENT

1. NO INSURANCE?

No problem. We save some money from time and fees when filing an insurance claim, and we pass it on to you with our **non-insurance discount**. Cash, all major credit cards, and Care Credit

2. VISION PLANS

We are providers for most. We'll educate you as to how to maximize your benefits with each individual plan.

3. MAJOR MEDICAL INSURANCE, MEDICARE

Refractions (checking vision) & the contact lens portion of the exam are **not** covered by medical plans. But the majority of your exam is often covered as follows:

We are in network with most medical insurances. We keep this information on file because we perform a lot of medical eyecare, and **often a large portion of your exam** has a medical reason billable to your carrier, reducing your out of pocket cost for your exam. (Headaches, Dry eye, Allergic Eye conditions, Glaucoma, Eye Teaming conditions). We also use this for visits with infections, removing objects from eyes etc.....

*****If you have a high or unmet deductible, and prefer to use our non-insurance processing discount, just let us know, otherwise we'll file it normally and we will invoice for any balances after insurance.**

We're always here to answer questions regarding your situation. Thanks!

*PLEASE SIGN HERE – PRIVACY PRACTICES

I acknowledge that I have read or have had the opportunity to read the Notice of Privacy Practices. (Available at the front desk)

Patient Name: _____ DATE: _____

Signature of Patient or Guardian: _____

WELCOME

Thanks you for choosing our office for your eyecare needs. We're glad to help if you have questions.

All Patient Information is kept Confidential

Name	Date
Address:	City/State Zip
Daytime Phone	Cell/Alternate Phone
Email	Birthdate
Patient's Social Security #	Employer
Primary Physician/Pediatrician	
Spouse's Name	Children

Insurance Information

If you are using insurance, we need to copy your medical and vision cards. We treat both medical eye problems as well as vision care. Thank you.

Primary Member's Name:	Primary Member's Employer:
Primary's social security #	Primary Member's Birthdate:

Health History

Please indicate if you or your family (blood relatives only) have any of the following:

Condition	Patient	Family	Condition	Patient	Family
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Turned Eye	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Blindness	<input type="checkbox"/>	<input type="checkbox"/>

Other health conditions:

Please indicate if any of the following conditions apply to you:

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Drug allergies | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Sinus trouble | |

Please list all medications your are allergic to:

None

Medications you are currently taking:

None

Your Eye Health and Vision is important to us.

Approximate Date of Last Eye Exam? 6 mths 1 year 2 years 3 or more years

Do you currently wear glasses? Yes No If yes, when do you wear your glasses?

- All the time Reading/Near work Distance tasks only work
 Work Safety Computer wear Other, please explain

Are you planning on getting new glasses today? Yes No Unsure

Have you ever worn contact lenses? Yes No

Are you renewing your contact lens prescription today? Yes No Unsure

Do you work on a computer more than 4 hours per day? Yes No

Are you interested in Laser Vision Correction? Yes No

How did you become aware of our practice?

- friend recommendation co-worker recommendation referred by other professional
 insurance provider other: _____

Payment Information

I authorize you to bill my insurance for any applicable services or products, and I understand that payments for non-insured services are due the same day services are rendered.

Signature _____



Monte Harrel O.D.

Tiffany Harrel O.D.

Lynsey Bigheart O.D.

Shannon Morgans O.D.

Please check any that apply to help us
know how to provide the best care for your child.

- Slow reader
- Points with finger while reading
- Poor reading comprehension
- Poor handwriting skills
- Homework takes longer than it should
- Short attention span, restless, unable to stay on task
- Avoids close work
- Loses place, omits or confuses small words while reading
- Rubs eyes, squints or blinks excessively
- Smart in everything but school
- Has an Individual Education Plan (IEP)
- Resource Room for _____
- Tutor for _____
- Substitutes words while reading or copying
- Difficulty remembering what was read
- Headache after doing close work
- Confuses right with left directions repeatedly
- Feels unusually tired after finishing a visual task
- Fatigue, frustration, stress
- Unusual posture/head tilt while reading or writing
- Double vision
- Speech/Language Therapy
- Has repeated _____ grade
- Other: _____