# Welcome! Thank you for choosing our practice for your eye care. We strive to provide personal and caring medial service in an atmosphere of respect and privacy. If you have any questions or concerns, please do not hesitate to ask for help at any time. To help serve you better, please answer the following questions.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PATIENT REGISTRATION RECORD | | | | | | | | | | | | | |
| Patient Legal Name (Last, First, Middle) | | | | Preferred First Name | | | | Date of Birth | | | Legal Gender   * Male * Female | | * Single * Married * Domestic Partner |
| Mailing Address | | | | | | City | | | | | | Zip Code | |
| Home Phone | | Work Phone | | | | | Cell Phone | | | | | | |
| Social Security # of patient: | | Email for reminders: | | | | | | | | | | | |
| Occupation? | | | Student? | | | | | | | | | | |
| Name of primary insurance carrier (spouse, domestic partner or parent) | | | | | Primary’s Social Security # | | | | | Primary’s Date of Birth | | | |
| Name of person to notify in an emergency | | | | | Relationship | | | | | Phone | | | |
| How did you find our office? | * Friend / Co-worker * My doctor * Insurance provider * Other: | | | | What internet site helped make your decision? | | | | * Yelp.com * Google / Google+ * Iris Eye Center website * Other: | | | | |

|  |  |
| --- | --- |
| INSURANCE INFORMATION | |
| Name of Major Medical Insurance ( | Name of Insured |
| Medical card ID# | Group # (if any) |
| Vision Plan Name for Glasses/Contacts (VSP, Eyemed) | |

PLEASE READ & SIGN. Routine eye exams, refraction (glasses prescription), contact fitting or contact lenses, may not be covered by insurance; In these cases the patient is responsible for payment. A referral is not a guarantee of payment. It is your responsibility to know your coverage. I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits paid and not paid by insurance.

Signed Date

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| PLEASE ANSWER ALL SECTIONS |  |  |  |  |
| When was your last eye exam? |  | Name of your past / current eye doctor? | | |
| Name of your personal physician? |  | What city? Phone number? | | |
| Please list your medications: (including vitamins, creams, inhalers, sprays & injections) | | | | |
| Any allergies to medications? (please list) |  | The name and location of your pharmacy : | | |
| What brand of eye drops do you use? | Number of alcoholic drinks per day: | | Number of cigarettes per day:  Are you a fomer smoker? Y N | |
| Would you like to see without glasses?   * Yes! I want to try contact lenses. * Yes! I want more information on LASIK. * Yes! I want more information on cataract surgery. * OTHER: | | Do you experience any of the following:   * Dry eyes? * Computer-related eyestrain? * Halos while driving at night? * Sensitivity to sunlight? * OTHER: | | Do you enjoy any of these activities?   * Camping / Hiking / Travel * Sailing / Fishing / Snow / Golf Do you wear eye makeup? Yes / No   If yes, how do you remove it? |
| Any of these run in your family?   * High blood pressure * Diabetes * High cholesterol |  | * Glaucoma * Macular Degeneration * Retinal Disorder | □  □ L  □ | Cataracts azy Eye OTHER: |
| Do you have, experience or take? Y N   * □ Alcoholic abuse * □ Accutane medication * □ Acne Rosacea * □ Asthma * □ Asthma medication * □ Blood disorder (Anemia / Leukemia) * □ Blurred vision * □ Bronchitis / Emphysema * □ Bumps on eyelid margin(s) * □ Burning sensation in eye(s) * □ Cancer * □ Computer Eye Strain * □ Chronic obstructive pulmonary disease * □ Color blindness * □ Depression * □ Diabetes * □ Diabetes when pregnant * □ Discharge from eye(s) * □ Difficulty breathing * □ Digestive problems * □ Double vision * □ Drug abuse * □ Dry eye(s) * □ Erectile dysfunction medication |  | Y N   * □ Eye injury * □ Eye surgery * □ Feeling of something in eye(s) * □ Fatigue * □ Fever * □ Flashes of light * □ Floaters in your vision * □ Fluctuating vision * □ Glaucoma * □ Glaucoma medication * □ Gritty/sandy feeling in eye(s) * □ Hay fever symptoms * □ Headaches * □ Heart problems * □ Hepatitis * □ High blood pressure * □ HIV * □ Hormonal Dysfunction * □ Itchy eye(s) or eyelid (s) * □ Itchy nose * □ Joint pain * □ Kidney problems * □ Lazy eye or eyelid * □ Light sensitivity * □ Liver problems | Y  □  □  □  □  □  □  □  □  □  □  □  □  □  □  □  □  □  □  □  □  □  □  □  □  □ | N   * Lupus * Menopause * Migraines * Muscle pain * Multiple Sclerosis * Numbness * Osteoarthritis * Pets (dogs or cats) * Recent weight loss / gain * Red eye(s) * Retinal tear / detachment * Rheumatoid arthritis * Sarcoidosis * Schizophrenia * Sexually transmitted disease * Sinus Infection * Sleep apnea * Sjogren's disease * Skin problems * Stroke / Vascular Disease * Swollen eye(s) or eyelid(s) * Thyroid problems * Upper Respiratory Infection * Watering / Watery Eye(s) * Watering / Watery Nose |

# Thank you for choosing our practice for your eye care. To ensure the privacy, respect and courtesy to our patients, we enforce the following acknowledgements and policies. Please do not hesitate if you have any questions.

|  |  |
| --- | --- |
| Please Initial that you have read and agree to the following: | |
|  | I have received the NOTICE OF PRIVACY PRACTICES information from Iris Eye Center (available for download on our website & in person at the office). |
|  | Payment of co-pays, deductibles or any balances not covered by insurance is due at the time of service. If you are being seen today, payment is due TODAY. |
|  | We value your time. We try our very best to stay on schedule, although emergencies sometimes arise. If we are seriously delayed, we will try to notify you beforehand. |
|  | If you are unable to make your appointment for any reason, please feel free to reschedule as soon as possible. There is a $40 no-show / same day cancellation fee. |
|  | DILATED PUPIL EXAM: Our comprehensive exam includes dilation to detect eye disease as needed. Dilation with eye drops will last approximately 1-4 hours. You will experience sensitivity to light and blurry near vision. If you did not bring dark glasses, we will provide you with a disposable pair. |
|  | GLASSES: Glasses are custom-made for you and only you. There is no return or exchange on glasses (includes the lenses and frame). All our lenses and frames carry a 30 day to 1 year warranty against manufacturer's defect. Damage due to dropping your glasses, etc. is not covered. Payment in full is required before glasses can be ordered. |
|  | CONTACT LENSES: Because contacts are a medical device, we follow a strict return / exchange policy. Please review The Contact Lens Agreement for detailed information. |
|  | MODEL RELEASE. During your visit, you may be asked to pose for a photo. Posing for a photo to be used on social media or our website constitutes consent to use your image. No personal information such as your name, etc will be used with your image. |

~ We reserve the right to refuse service for any reason. ~

|  |
| --- |
| ALL CO-PAYS, DEDUCTIBLES AND PAYMENTS ARE DUE AT THE TIME OF SERVICE. |
| NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT:  I understand that under the Health Insurance Portability & Accountability Act of 1966 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:   * Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly; * Obtain payment from third-party payers (such as my insurance company); * Conduct normal healthcare operations such as quality assessments and physician certifications   I have received, read and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my heath information. I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time to address above to obtain a current copy of the Notice of Privacy Practices.  I understand that I may request in writing that you restrict how my information is used to disclose or carry out my treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. |
| **Patients Name (please print)** |
| **Patient's Signature** |

**SPECTACLE PURCHASE POLICY: PLEASE READ CAREFULLY**

When you purchase spectacles from Iris Optometric Center, the order is sent out by computer immediately in order to expedite processing.

Spectacles are custom-ordered and made to fit a specific prescription and cannot be adapted to anyone else once the are made. Therefore, please be very sure of your choice of frame, lenses and lens additions when you order them. Because these spectacles are made to your personal specifications, we require a full, non-refundable payment at the time of ordering.

**FOR EXAMS PROVIDED BY IRIS:**

We have a 30-day, one time re-do policy. If the doctor changes your prescription during this time frame, or if you cannot adapt to a progressive lens and need to change it to a bifocal or single vision lens, we will do this at no charge to you once in the 30 days following of the receipt of your original purchase. Any additional re-do’s following or any re-do’s after 30 days will be full price.

**FOR OUTSIDE PESCRIPTIONS:**

If the Rx you provided is incorrect, there will be a 50% charge of original price to re-do the exam and correct the prescription, since the lab does charge for re-do’s. Any additional re-do will be full price.

**STATEMENTS:**

Statement are sent out once we receive payment from your insurance company or as necessary. If you have insurance, we will bill your insurance as a courtesy to you. If we have not received payment from your insurance carrier within 45 days of the date of service, we will re-bill your carrier one time only. If we again receive no response from your insurance carrier, you will be responsible for payment in full.

Any balance over due at 90 days is immediately payable or a payment schedule must have been negotiated with the office manager. Failure to clear an account balance within 90 days or failure to adhere to a payment schedule will result in consideration for immediate referral to a collections agency. Any amount shown as “due from the patient” on your statement has been processed and identified as your responsibility by your insurance carrier, or your carrier has failed to respond in a reasonable period of time.

Thank you for choosing Iris Optometric Center for your optical needs.

|  |  |
| --- | --- |
| *I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE FINANCIAL POLICY FOR PAYMENT OF FEES AND THAT THE PATIENT IS ULTIMATELY RESPONSIBLE FOR ALL FEES.* | |
| **Patient’s / Parent’s Signature** | **Date** |

|  |  |
| --- | --- |
| C O N T A C T L E N S ES A R E A W E S O M E , L E T ’ S K E E P I T T H A T W A Y | |
| Thank you for choosing us to prescribe your contacts! We know you have many choices when buying your contacts. After rebates, we are 99% of the time less expensive than the internet . . . plus we will always exchange and guarantee your contacts should a problem arise.  More importantly, we appreciate you supporting our local business where your money is spent directly on our employee wages, benefits and Oakland public works.  Please initial each item:  Remember, no tap water can touch the contact lens or contact lens case! Tap water contains bacteria and can increase your risk for contamination or infection. Rinse with contact lens solution instead.  Studies show that the healthiest wearing schedule is 40 hours a week in contact lenses. You should be kind to your eyes and wear both contact lenses and glasses.  The contact lens exam is $150-$250 (depending on Rx) and covers up to 3 appointments for follow-ups. Specialty lenses may require more appointments, additional visits are $35.00 per visit.  All contact lenses are 100% exchangeable with a 15% restocking fee up to 1 month as long as the package remains unopened and are not expired. Please open trial contact lenses first if available.  \_\_\_ We will exchange lenses or replace defective lenses under the lens manufacture’s warranty within a period of 15 days after the initial fitting visit-You must return for your follow-up visits as directed within this period of you may be charged another fee for a refit.  Many of our contact lenses are priced the same and usually less than the internet after rebates. Thank you in advance for supporting local business.  As mandated by California law, contact lens prescriptions have to be renewed every 1 year.  I consent to a friendly pop quiz about this agreement from the doctor.  You must be able to perform the following before you can order contacts:  Safe insertion and safe removal of your contact lenses. (Staff initial )  Hygienic handling of the contact lenses including hand washing before insertion. (Staff initial )  Can’t do these things? No problem. We are here to help! We will provide you with training at the time of your appointment! *We hope you will enjoy your contact lenses!* | |
| *I have read and understand The Contact Lens Agreement above. I am financially responsible for all fitting service and material fees.* | |
| Signature: |  |
| Print Name: | Date: |