

Today's Date: _____

Full Name: _____

(as shown on insurance)

Preferred Name: _____

Date of Birth: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Email: _____

Contact me by: Phone Email

Occupation: _____

Referred by: _____

Primary Doctor(PCP) _____

PCP Location: _____

Date of Last Eye Exam: _____

Previous Eye Doctor: _____

Have your Eyes been Dilated: _____

History of Eye Infections: _____

History of Eye Surgeries: _____

Type of Glasses: None Distance Reading

Progressive Bifocal

Type of Contacts: None Distance Bifocal

Astigmatism Other

Brand of Contacts: _____

Brand of Solution: _____

Please circle the following you are experiencing:

Flashes of Light Foreign Body Sensation

Blurred Vision Drooping Lids

Dryness Headaches

Mucous Migraine

Glare Burning

Tired Eyes Tearing

Loss of Vision Sandy/Gritting Feeling

Eye Pain Infection of Lids

Floaters Crossed/Lazy

Redness Eye Double

Light Sensitivity Vision Itching

Which Eye?: _____

How Long?: _____

Medical History: NONE

Amblyopia Hypertension

Anemia Keratoconus

Arthritis Kidney

Asthma LASIK

Autoimmune Lazy Eye

ADHD Lupus

Lyme Disease Cancer

Cataract Macular Degeneration

Depression Migraine

Diabetes MS

Diabetic Retin. Neurological

Droopy Lid Psychiatric

Gastrointestinal Pregnant/Nursing

Glaucoma Respiratory

Heart Disease Sinus

Heart Murmur Stroke

High Cholesterol Thyroid

HIV Positive Other: _____

Medications: _____

Diabetic A1C: _____ Blood Sugar: _____

Allergies: _____

Family History:

Blindness Hypertension

Glaucoma Heart Disease

Macular Degeneration Lupus

Cataract Kidney Disease

Retinal Stroke

Cancer Thyroid Disease

Diabetes

Social History:

Marital Status: _____

Do you Drive?: _____

Do you Drink Alcohol?: _____

Do you Smoke?: _____

Do you use Recreational Drugs?: _____

Signature: _____

Date: _____

Initials: _____ Reviewed on: _____



PRACTICE POLICIES

Financial Policy

Swan Vision will file claims to your insurance company. We will attempt to verify your insurance coverage before your visit. It is not a guarantee of benefits for services rendered by the doctors at our facility. It is important for you to understand the contract that exists between you and your insurance carrier. We cannot guarantee the accuracy of coverage information received from your insurance company. Payment is due the day services are rendered. You are responsible for all fees generated at the time of your visit and any future visits with the physicians at our facility. You are responsible for all charges your insurance does not cover. If you have questions about your coverage please contact your insurance company.

Private pay patients are required to pay in full on the date of service.

There is a \$25 fee for a returned check in addition to the check amount. Check payments will not be accepted from any patient with two returned checks. Failure to pay after 90 days, the bill will be sent to a collections agency. Once your account has been sent to collections, an additional fee of 30% of the bill total will be accrued to your account for the collection charges.

All missed or canceled appointments with less than 24 hours notice will be subject to a \$75 fee. If our office has not received confirmation of your appointment within one day prior to your appointment we reserve the right to remove you from the schedule and a \$75 no show fee may apply.

Contact lens fits and follow up care is billed separately from your eye exam.

Standard Eye Exams will be billed to insurance companies with two separate codes 92014 and 92015

Medical Insurance vs. Vision Riders

Routine vision exams may or may not be covered by your medical insurance plan. We will attempt to verify coverage for eye exams before your visit. If your insurance company does not provide routine coverage, you will be responsible for the charges upon your insurance denial. Vision Riders (i.e. VSP) will not provide benefits for any medical testing. If a medical condition is present during your exam and the doctor recommends further medical testing, it will be billed through your medical insurance. In the absence of a pre-existing condition we cannot determine if the bill will be sent through your medical or routine insurance until your eye exam is complete.

Assignment of Benefits

I understand I am financially responsible for any and all charges billed during the course of authorized treatment, including those not covered by insurance benefits

I understand that all applicable fees are due on the date that services are provided and agree to pay for the charges in full.

I assign all medical and surgical benefits to Swan Vision, including medical benefits, to which I am entitled.

I authorize my insurance provider to issue check payments to Swan Vision for medical and/or routine services rendered to myself or minors under my insurance.

Authorization to Release Information

I authorize Swan Vision to release any information necessary to insurance providers regarding my treatments, to process insurance claims from my examination, and to allow a photocopy of my signature to be used to process claims.

Acknowledgement of Review of Notice of Private Practices

I have had the opportunity to review Swan Vision's notice of private practices which describes how my medical insurance information will be used, and I understand I am entitled to have a copy provided upon request.

Release of Information

I authorize Swan Vision to release my private healthcare information to the following family/friend if needed. If you DO NOT have a friend/family member you would like to list, please print "none" and sign below.

Family /Friend Name

By signing below, I am stating that I have reviewed and understand Swan Vision practices and policies and agree to all information stated above.

(Patient or Guardian) Printed Name

Signature

Date

Contact Lens Returns

To be eligible for Contact Lens returns boxes must be unopened, undamaged, unmarked and returned within one year of receiving them.

Contact Lens Wear

I agree to have my contact lens prescription emailed to me.

Signature (Patient/Guardian)

Date

Office Use

—

Received and reviewed by: _____ Date: _____



Retinal Photography

We offer state-of-the-art retinal photos to view the inside of the eyes. These photos allow us to assess your eye health for many diseases including: glaucoma, macular degeneration, retinal detachments, ocular tumors, hypertension and diabetic retinopathy.

The advantages of the retinal photo include:

- Quick and painless photo
- Permanent visual record of the retina
- Ability to compare photos from year to year to look for changes
- Ability to email you a copy of your images
- Ability to send images to other providers
- You can see the inside of your eyes!!!

Retinal photos and dilation are the best way for doctors to provide the most thorough and full evaluation of eye health. Dilation of the pupils may or may not be required depending on the findings and eye health risks unique to each patient. **Retinal photos are generally not covered by insurance if there are no medical findings. Screening photos cost \$45.** Medical insurance will cover medical photos and will apply the cost to your deductible.

You can use your HSA to pay for the photos as well.

- _____ Yes, I would like to have retinal photos taken today.
_____ No, I would not like to have retinal photos taken today.
_____ Possibly, I would like more information

Patient/Guardian Signature

Date



Authorization to Release Record

To Previous Eye Doctor: _____

Office Location(address): _____

Phone Number: _____

Fax Number: _____

I hereby authorize you to release records to Swan Vision, LLC. Any information including the diagnosis and records of any treatment or examination rendered.

<input type="checkbox"/>	Last Comprehensive Exam
<input type="checkbox"/>	Visual Field
<input type="checkbox"/>	OCT
<input type="checkbox"/>	Other:

Patient Authorization:

I understand that my records may contain information regarding a diagnosis or treatment. I authorize the use or disclosure of the above specified information to be retrieved for medical purposes only.

My Rights:

I understand that I may revoke this authorization in writing at any time.

Patients Name (Print): _____ Date of Birth: _____

Parent, Guardian or Authorized Representative (Print Name): _____

Signature

Date

Release of PHI: Email Consent

Risk of Using Email

Transmitting patient information by E-mail has a number of risks that Patients should consider before using E-mail. These include, but are not limited to, the following risks:

- **The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") recommends that an E-mail that contains protected health information be encrypted. E-mails sent from Swan Vision Optometry are not encrypted so E-mails may not be secure.** Therefore it is possible that the confidentiality of such communications may be breached by a third party.
- E-mails can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- E-mail senders can easily misaddress an E-mail.
- E-mail is easier to falsify than handwritten or signed documents.
- Backup copies of E-mail may exist even after the sender or the recipient has deleted their copy.
- Employers and online services have a right to inspect E-mail transmitted through their systems.
- E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- Email can be used to introduce viruses into computer systems.
- Practice server could go down and E-mail would not be received until the server is back online.
- E-mail can be used as evidence in court.

Conditions for the use of the E-mail

Practices cannot guarantee but will use reasonable means to maintain security and confidentiality of E-mail information sent and received. Practice and Physician are not liable for improper disclosure of confidential information that is not caused by Practice's or Physician's intentional misconduct. Patients must acknowledge and consent to the following conditions:

- **E-mail is not appropriate for urgent or emergency situations. Practice and Physician cannot guarantee that any particular E-mail will be read and responded to within any particular period of time.**
- E-mail must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via E-mail.
- All E-mails may be printed and filed in the patient's medical record.
- **Office staff may receive and read your messages.**
- Practice will not forward patient identifiable E-mails outside of the Practice without prior consent, except as authorized or required by law.
- The patient should not use E-mail for communication regarding sensitive medical information. Practice is not liable for breaches of confidentiality caused by the patient or any third party.
- It is the patient's responsibility to follow up and/or reschedule an appointment if warranted.
- This consent will remain in effect until terminated in writing by either the patient or the Practice.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of E-mail between the Practice and myself, and consent to the conditions and instructions outlined, as well as any other instructions that the Practice may impose to communicate with patients by E-mail.

I, myself, my heirs, administrators and assigns, fully and forever release and discharge **Swan Vision** and its affiliates, shareholders, officers, directors, physicians, agents, and employees, from and against any and all losses, claims, and liabilities arising out of or connected with the use of such E-mail.

Patient Signature or Personal Representative: _____

Printed Name: _____

Date of Birth: _____

Relationship to Patient: _____

E-mail Address: _____