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:_____

Medical History: NONE

Amblyopia	Hypertension
Anemia	Keratoconus
Arthritis	Kidney
Asthma	LASIK
Autoimmune	Lazy Eye
ADHD	Lupus
Lyme Disease	Cancer
Cataract	MacularDegeneration
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:_____

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?: _____

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:_____

Reviewed on: _____ Initials:_____

COVID-19 Pretest Questionnaire

1. Have you been fully Vaccinated for COVID-19? Yes___ No___
2. Have you tested positive for COVID-19 within the last 2 weeks? Yes___ No___
3. Have you been in close contact with anyone (or anyone that lives with you), that has tested positive for COVID-19 within the last 14 days? Yes___ No___
4. Have **YOU** experienced any symptoms of COVID-19? (Which include: fever, cough, sore throat, respiratory illness or difficulty breathing) Yes___ No___
5. Has **anyone** that you have been in contact with or cared for experienced any symptoms of COVID-19? Yes___ No___
6. Do you currently have any signs or symptoms of a respiratory infection? Such as fever, cough and shortness of breath, body aches or sore throat. Yes___ No___
7. Have you had any symptoms of respiratory illness, cough or nasal congestion, in the past 14 days? Yes___ No___

Signature:_____ Date:_____

If you have answered **YES** to **ANY** of the questions 2 to 7, we must reschedule your appointment for the safety and health of our employees and patients

Swan Vision
Optometry

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.

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 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

Swan Vision
Optometry

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.

☐	Last Comprehensive Exam
☐	Visual Field
☐	OCT
☐	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

38 Town Line Rd, Rocky Hill, CT 06067 Phone: (860) 785-8176 Fax:(860) 785-8376