



"Preserving the gift of sight"

Welcome to our office!

Patient's Name _____ Birth Date _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

SS# _____ Emergency Contact & Phone Number _____

Email address _____ Occupation _____

Whom may we thank for referring you to our practice? _____

Date of Last Eye Exam _____ Name of Previous Eye Doctor _____

Personal Medical Information: Do you currently, or have you had any problems in the following areas:

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Ears, Nose, Mouth, Throat
Cardiovascular/Vascular (heart)
Respiratory (lungs)
Gastrointestinal (stomach, intestines, liver)
Genitourinary (kidneys, urinary/reproductive tract)
Musculoskeletal (arthritis, muscles, bones)
Surgeries (what type & when)
Integumentary (skin, breasts)
Neurological (headaches, numbness)
Psychiatric (mental, depression, anxiety)
Endocrine (diabetes, thyroid)
Lymphatic/Hematologic (blood, lymph node)
Allergic/Immunologic (allergies, immune disorders)

Are you in good health? Yes No

Do you have any allergic reactions to medications or other substances? Yes No

If yes, please list _____

Name of primary care physician and phone number _____

Do you smoke? Yes No How much? _____

Do you drink alcohol? Yes No How much? _____

Do you use other substances? Yes No

Do you take medications? Yes No Please list _____

Have you or your blood relatives had any of the following conditions?

Table with 4 columns: Condition, YOURSELF, FAMILY, YOURSELF, FAMILY. Rows include High Blood Pressure, Glaucoma, Crossed Eyes, Lazy Eyes, Eye Surgery, Retinal Detachment, Macular Degeneration, Diabetes, Arthritis, Thyroid disease, Stroke, Blindness, Heart Disease, Cancer.

Other condition(s) not listed above: _____

Do you experience any of the following:

- Do you experience any of the following:
Blurred Vision
Floating Spots
Itchy/Scratchy
Wear Glasses
Loss of Vision
Dryness
Eye Injuries
Wear Contacts
Headaches
Redness
Eye Surgeries
Interested in Contacts
Flashes of light
Burning
Eye Infections

If you are having any other eye problems at this time, please explain _____

Are you interested in laser vision correction? Yes No

Financial Policy

This statement is to inform you of our financial policy. We are committed to providing you and your family with the highest quality vision care using only the latest technology available today. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

As a condition of treatment by this office, fees must be paid at the time the service is performed. All charges you incur are your responsibility regardless of your insurance coverage. **We must emphasize that as your vision care provider, our relationship is with you, our patient, not with your insurance company.** As a courtesy to you, we will help you process all your insurance claims. We accept no responsibility in collecting overdue insurance claims or negotiating settlement on disputed claims. All insurance information must be presented before any services are rendered. **Claims cannot be re-processed to insurance after date of service.**

Payment of your portion of the charges is due on the date of service, unless other specific arrangements have been made. Contact lens purchases require payment in full before orders can be placed, glasses require a minimum 50% deposit before orders can be placed. **All order cancellations and returns are subject to a 50% fee. Any order with a balance due after 90 days from the date glasses are ready for pickup, will be considered canceled.** Insurance copays towards glasses, specifically for progressive lenses, are non-refundable. Our office accepts cash, personal checks, MasterCard, Visa, American Express and Discover. Returned checks are subject to a \$35.00 fee.

By signing below, I understand and agree to the terms described herein and agree to accept responsibility for the payment of services. I agree to pay all costs incurred by my failure to remit for services rendered, including fees charged by a collection agency. I grant my permission to you, or your assigns, to telephone me at home or other phone numbers listed to discuss financial matters related to this form. Furthermore, I authorize the release of any medical or other information necessary to process this claim and authorize the vision benefits otherwise payable to me to be paid directly to MacAlpine Eye Care.

Return Policy

All **non-prescription sunglass** sales are final.

All **contact lens** sales are final.

Prescription eyewear has a thirty day return policy. Items can be returned for store credit only.

All returns are subject to a fifty percent (50%) restocking fee.

Outside Prescriptions

MacAlpine Eye Care can not be responsible for any errors made in a prescription provided by another doctor. We will verify that the lenses provided to you will match the prescription provided by your doctor and we will ensure proper fitting of the frame. If lenses need to be replaced for any prescription correction, it will be at your sole expense.

HIPAA PRIVACY ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY NOTICE

_____ (Initial here), I have been shown the Notice of Privacy Policy (the "Policy") of this provider and have been offered a copy of such policy to keep for my records.

OR

_____ (Initial here) I hereby refuse to acknowledge receipt of the policy. I understand that even though I may refuse to sign this acknowledgement, Provider may still provide treatment to me.

Refused to Sign Notice of Privacy Policy

Reason: _____

Employee Signature

Date

I have read the above conditions of treatment and agree in content:

Signature of Patient or Legal Guardian _____ Date _____