Eye Candy Optical Center

Monika Marczak O.D.
Lori Cicchini O.D.

Last Name: _____ First Name: _____ DOB: _____
Month/Date/Year

Address _____ _____ _____ _____
Street Address City State Zip Code

Home Phone_____ Cell Phone_____ Occupation_____

Social Security Number_____ Email_____

Date of Last Vision Exam _____

Patient Insurance Authorization

The Notice of Privacy Practices for this office is presented in written form to all patients before they see the doctor. I authorize my insurance company to directly pay the doctor the benefits otherwise payable to me. I assume financial responsibility for payment of all services rendered if my insurance carrier refuses payment on my and/or on behalf of my dependents. By signing below, I acknowledge the Notice of Privacy Practices.

Signed_____ Date_____
(Self or Parent if a Minor)

Patient Privacy Notice

The privacy notice provided describes how your medical information may be used and disclosed, and how you can access the information. Please review it carefully and sign below. We will keep a copy of this reference. No one else may sign for you. All minors under the age of 18 must have a legal guardian sign for them.

Signature _____ Date_____
(Self or Parent if a Minor)

Please Initial Each:

_____**Financial Policy**

Patients who have medical/vision insurance should know that we submit all services directly to your insurance, but the patient or insurance holder is responsible for any payments/deductibles that are not paid by the insurance. We must emphasize that as a medical/vision care provider, our relationship is with YOU, not your insurance provider. Your cooperation in complying with the terms of this assignment is appreciated.

_____**Optical Orders**

All prescription glasses are custom made to meet the unique visual needs of the patient. While glasses are not returnable, we make every effort to ensure patient comfort. If there are issues with adaption to a prescription, please note that most vision care providers only offer a 30 day window to make any changes. All measurements, adjustments, and professional cleanings are available free of charge. Prescription glasses purchased outside of this office may or may not be serviced, at the discretion of our optical lab manager, if risk of breakage is a concern.

FLIP 

Would you like a Digital Retinal Photo for an additional fee of 20.00? (Circle) YES or NO

Why do I need this test?

Digital Retinal Photography gives us a more comprehensive way of viewing your eyes, and it allows us to perform a more thorough exam. This photo will provide us/you a baseline. This photo adds to our ability to evaluate the health of your eyes, which is especially important if you have headaches, spots or flashes, a family history of glaucoma, diabetes or macular degeneration, high blood pressure, elevated cholesterol, rheumatoid arthritis or melanoma.

Vision vs. Medical Insurance Consent Form

Many of our patients have vision coverage and medical insurance. They are very different in terms of the services they cover and it is important for our patients to understand those differences. Vision coverage (VSP, EyeMed, VBA, etc.) is mainly designed to determine a prescription for glasses and is not equipped to deal with complex medical conditions and/or diagnoses. When a medical condition is present (such as diabetes, cataracts, dry eye, floaters, etc.) it is necessary to file the claim with your major medical coverage (BCBS, Aetna, UPMC, Cigna, etc.) and the co-pays for that insurance will apply in addition to any non-covered services. If you do not have medical insurance but require a medical exam, please realize you will pay a higher fee than the normal well-visit exam.

Insurance carriers set these rules and our office is obligated to follow them. In most cases, it is difficult to determine prior to the examination which type of insurance our office will be billing. In the event that we do not accept your insurance we will provide you with an itemized receipt so that you may file with your carrier for reimbursement. If you have any questions, please let us know.

I understand the guidelines stated above and I authorize Dr. Marczak to bill my insurance accordingly.

Signature _____ Date_____

(Self or Parent if a Minor)

Name of Vision Insurance Provider _____ Name of Policy Holder_____

Name of Medical Insurance Provider _____ Name of Policy Holder _____

How did you hear about our practice?

_____

Are you having any eye or vision problems?

_____

_____

Are you experiencing any of the following? (Circle)

Blurred Vision	Computer Fatigue	Eyestrain	Double Vision
Itching	Burning	Watery Eyes	Dryness
Redness	Flashing Lights	Floating Spots	Glare
Headaches			

Do you wear corrective lenses?

Glasses ☐	Contacts ☐	Both ☐	Neither ☐

Are you interested in (Circle) : Contact Lenses or Lasik

Ocular History:

Lazy Eye	Yes	No
Cataract	Yes	No
Age-Related Macular Degeneration	Yes	No
Glaucoma	Yes	No
Diabetic Retinopathy	Yes	No
Dry Eye	Yes	No
Eye Infection, Inflammation, or Allergy	Yes	No
Floaters and/or Flashes of Light	Yes	No
Iritis or Uveitis	Yes	No
Retinal Detachment or Defect	Yes	No
Eye Surgery or Injury Please List:	Yes	No
Other		

Alcohol Use: YES or NO

Smoking Status: Never smoked/Former smoker/Current Smoker

Please list all medications you are currently taking and the condition being treated.

_____

_____

_____

_____

_____

_____

Are you allergic to any medication(s)? Yes No

List: _____

_____

_____

Review of Systems: (Circle)

	Pregnant/Nursing	Cancer	Other
Ear/Nose/Throat	Hearing Loss	Vertigo	Sinus Problems
Neurological	Multiple Sclerosis	Migraines	Seizures
Psychiatric	Depression	Anxiety	Attention Deficit
Cardiovascular	Hypertension	Stroke	Heart Disease
Respiratory	Asthma	Sleep Apnea	Sarcoid
Gastrointestinal	Crohn's Disease	Colitis	Acid Reflux
Genitourinary	Kidney Disease	Frequent Urination	
Musculoskeletal	Osteoporosis	Ankylosing Spondylitis	Other
Skin	Rosacea	Eczema	Psoriasis
Endocrine	Diabetes: Type I or Type II	Thyroid Issues	Other
Blood/Lymph	Hypocholesterol	Anemia	Other
Allergy Immune:	Allergies	Arthritis	Other

Family History: (Circle)

Cancer	Grandparent/Mother/Father/Sibling
Diabetes	Grandparent/Mother/Father/Sibling
Hypertension	Grandparent/Mother/Father/Sibling
Hyperthyroid	Grandparent/Mother/Father/Sibling
Macular Degeneration	Grandparent/Mother/Father/Sibling
Glaucoma	Grandparent/Mother/Father/Sibling
Other	

Signature_____

FLIP!

THIS PAGE IS FOR CONTACT LENS WEARERS ONLY!

Eye Candy Optical Center Contact Lens Examination Policy

A Contact Lens Service Fee is charged to the patient on an annual basis.
Contact lenses are medical devices which require ongoing evaluation to ensure safe and comfortable wear. This service is in addition to your annual comprehensive examination and includes:

- Evaluation of current, or new lenses, fit on the eye
- Evaluation of corneal, conjunctival and eyelid health as related to contact lens wear
- Mapping of corneal surface and evaluation of changes compared to baseline mapping
- Progress checks related to changes in contact lens prescription or material for 45 days following evaluation and/or fitting of new contact lens.

Our contact lens service fees are as follows:

Annual Evaluation of Contact Lens **$75**

- This service is for established contact lens wearers who do not require a change in contact lens material or a substantial change in contact lens prescription. This is reserved for patients that will not need progress checks prior to finalizing a contact lens prescription.

New Contact Lens Evaluation of Basic Contact Lens Designs **$75**

- This service is for new or established contact lens wearers being fit in a new design or material that is not a multifocal or mono-vision system. This type of fit generally requires an average of one progress check before a final prescription is given. This service includes a training session during which new contact lens wearers learn how to apply and remove their contact lens as well as the proper care and cleaning required.

Evaluation Fitting of Advanced Contact Lens Designs **$85**

- This service is for new or established contact lens wearers being fit in a new design or material such as a multifocal, mono-vision system, or rigid gas permeable that will generally be seen an average of two times for progress checks before the final prescription is given.

Fitting of Medically Necessary Contact Lens **Varies by Design**

I have read the above and understand the following:

- The global follow up period for progress checks and finalizing a contact lens prescription is <u>45 days</u>. **After 45 days a $30 contact lens progress check may apply.**
- After 90 days, or once a contact lens has been agreed upon by both the patient and the doctor and has been finalized, a $75 fee may apply for refitting into an alternate lens.
- After one no-show for a scheduled progress check a fee of $30 for subsequent checks may apply. (In this case a no-show is considered a scheduled appointment that was not cancelled or rescheduled by speaking with someone within 24 hours of the appointment time.)
- Exceptions to this policy are at the discretion of our office.

Patient / Parent/ Guardian: _____ Date: _____