Lifetime Eyecare Associates
MEMBER VISION SOURCE

Welcome to our office!

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt #: _____ Date of Birth: _____

City/State: _____ Zip: _____ Cell Phone: _____

Email: _____ Occupation/Employer: _____

Height: _____ Feet _____ Inches Weight: _____ pounds

INSURANCE INFORMATION

Medical Insurance: _____ Plan Type: ☐ PPO ☐ HMO

Vision Insurance: _____ Primary's SS# _____

Name of Primary Insured: _____ Date of Birth: _____

MEDICAL & SOCIAL HISTORY

Reason for today's visit (chief medical complaint): _____

Primary Care Physician (PCP): _____ PCP Phone: _____

Do **YOU** or anyone in your **IMMEDIATE FAMILY** have any history of the following conditions? Mark all that apply.

High Blood Pressure ☐ Self ☐ Family: _____	Glaucoma ☐ Self ☐ Family: _____
Diabetes Type: _____ ☐ Self ☐ Family: _____	Cataract(s) ☐ Self ☐ Family: _____
Heart Disease ☐ Self ☐ Family: _____	Macular Degeneration ☐ Self ☐ Family: _____
Thyroid Disease ☐ Self ☐ Family: _____	Eye Injury/Surgery ☐ Self ☐ Family: _____
High Cholesterol ☐ Self ☐ Family: _____	Currently Pregnant (if applicable) ☐ Yes ☐ No
Depression ☐ Self ☐ Family: _____	Anxiety ☐ Self ☐ Family: _____

Any other conditions not listed above: _____

List **ALL** medications you are currently taking: _____

_____

List any medication **ALLERGIES** you have: _____

Do you currently smoke? ☐ Never ☐ Yes; Packs per Day: _____ ☐ Previous Smoker; Date Stopped: _____

Alcohol Use: ☐ None ☐ 1-2 Drinks daily ☐ Social Use Only ☐ Above Average

OFFICE POLICY

Please read and sign below. Doing so let's us know the patient/guardian has read and understood the office policy terms and conditions, and is authorizing Lifetime Eyecare Associates to provide treatment.

1. All visits to the office are due and payable in full at time of service.
2. Fees paid for services (ex. examination, contact lens evaluation, etc.) are non-refundable.
3. By authorizing to receive treatment, the patient/guardian is aware that Lifetime Eyecare cannot guarantee payment from their insurance company at this time. If it is determined that the patient is not eligible for services for any reason (i.e. lapse of coverage, exceptions in contract, etc.), I understand that I (the patient) is responsible for payment of all services that were not covered by my insurance company.
4. There is a Re-Stocking Fee for all returned frames, lenses, & contacts. Materials must be returned within 30 days from purchase date. Most frames have 1-year Warranty for defects by the Manufacturer only. Warranty void if frame is discontinued. Only one remake of lenses is allowed within 60 Days from Date of Purchase. All other remakes are at full charge.

Patient/Guardian Signature: _____ **Date** _____

Acknowledgment of Notice of Privacy Practices

Lifetime Eyecare Associates
6704 Sterling Ridge Dr., Ste D Woodlands TX 77382
281.465.8300

The law requires that Lifetime Eyecare Associates make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

Please initial only the one that applies:

_____ I was given the opportunity to read, have read or had explained to me Lifetime Eyecare Associates Notice of Privacy Practice prior to any services offered

_____ The Notice of Privacy Practice ***could not*** be read due to the emergent nature of the care and will be acquired when possible

I authorize Lifetime Eyecare Associates to release my personal health information to the following individuals:

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient / Guardian Signature

Date

If you are signing as a personal representative of the patient, please indicate your relationship

Patient Representative Relationship

Lifetime Eyecare Associates

Medical Insurance Waiver

When most people think about getting an eye exam, they think about whether or not the doctor will tell them they need glasses, or maybe about updating their current contact lens or glasses prescription. You may not think of it as medical or health exam. A lot of terms are thrown around, like medical eye exam, comprehensive eye exam, routine vision exam, vision screening, etc., and there ARE differences between different types of eye examinations.

Medical Eye Exam
Glaucoma, Diabetes, Dry Eye Syndrome, Macular Degeneration, Cataracts, Corneal Dystrophy, Retinal Detachments, etc., are all medical issues with the eyes, not things that can be fixed with glasses or contacts. These types of conditions need to be monitored closely by your eye doctor. So when we say we are doing a medical eye exam, those are the kinds of things we're looking for or monitoring**.** A medical eye exam differs from a routine vision exam in that it is an exam where we are evaluating or treating a patient for some sort of medical condition.

Your eye doctor is legally bound to follow healthcare guidelines regarding billing your insurance. A *medical eye exam* should be billed to your *medical insurance*, while a routine vision exam should be billed to either your vision insurance or to you if you are self-pay.

OptoMap Retinal Images to Medical Insurance
If the retinal images are denied by the insurance company, the balance will be forwarded to the patient as payment responsibility. The fee for the OptoMap Retinal Exam is up to **$85.00.** This fee may be further discounted by the insurance company and will be applied when applicable.

Office Visits / Special Testing or Procedures
These types of visits and/or procedures are not a part of a Routine Vision Examination; therefore the claim cannot be submitted to Vision Insurance for payment.

Your doctor will discuss with you what type of exam you are receiving and who it will be billed to.

We will submit the claim on your behalf to your ***Medical Insurance.*** Please be aware that the insurance company may not pay for some or even all services received due to non-coverage or in some cases, deemed unnecessary. In these situations, the patient is responsible for any services rendered that are not paid by your insurance company. Insurance benefits and coverage are an agreement between the patient and the insurance company. Non-payment by the insurance company transfers the responsibility of the claim payment to the patient.

Patient / Guardian Signature	Date

Name of Guardian/Responsible Party (if applicable)

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Attention patients who are interested in and/or receiving a Contact Lens Evaluation.

Please read and sign at the bottom. Doing so let's us know the patient/guardian has read and understood the terms and conditions stated below.

If you are using Vision Insurance:

To avoid insurance filing issues when using Vision Benefits for contact lenses, we require payment for the Contact Lens Evaluation/Corneal Assessment at the time of exam. Doing this leaves the patient with full contact lens benefits towards the materials (boxes), instead of deducting the Contact Lens Evaluation Fee from the Contact Lens Allowance, or the option to use Material Benefits towards frames and/or lenses. The insurance company may discount the fee for the contact lens evaluation. Please do not hesitate to ask if you have any questions.

Many patients ask, "Why do I need to have a yearly contact lens evaluation after having an initial evaluation?"

By Texas State Law, prescriptions are valid for one year after the correct prescription has been determined, unless a shorter term is warranted by the health of the patient's eyes or by potential harm to the health of the patient's eyes. Contact lenses can sometimes cause serious problems for the eyes, so the doctor needs to make sure that a patient's current lenses fit properly over time and are not harming the cornea. The doctor may also need to change the contact lens material from time to time, based on the patient's lifestyle and needs. Sign below to acknowledge that you were provided with a copy of your contact lens prescription at the completion of your contact lens fitting.

Patient / Guardian Signature _____ Date _____

Please take a moment to answer the following questions about your current contact lenses.

. Rate how your contact lenses feel immediately after you first put them in:

Poor [1] [2] [3] [4] [5] [6] [7] [8] [9] [10] Excellent _____

Indicate what time you put your contact lenses in: _____

. Rate how your contact lenses feel just before you take them out:

Poor [1] [2] [3] [4] [5] [6] [7] [8] [9] [10] Excellent _____

Indicate what time you take your lenses out: _____

3. Do you use re-wetting drops? ☐ Yes ☐ No If so, how often? _____

. Are you interested in possibly enhancing or changing your eye color? ☐ Yes ☐ No

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Missed Appointment and Cancellation Policy Agreement

Lifetime Eyecare Associates is committed to providing exceptional care. Due to the national pandemic we have taken many steps to ensure you are safe. For instance, we reserve the lobby for you in an attempt to limit exposure. This cuts back the amount of patients we see on a daily basis.

Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen. **Please call or text us at (281) 465-8300 by 2:00 P.M. on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00 P.M. Friday.** If prior notification is not given, a fee of $39.00 will be charged for the missed/canceled appointment. By signing below, agreement and acknowledgment of our policy is understood and agreed upon.

Client Signature (Client's Parent/Guardian if under 18)	Date