EVERGREEN EYE CARE

LAST: _____ FIRST: _____ MI:___

ADDRESS: _____

_____

TEL: _____ EMAIL: _____

DOB: _____ AGE: _____ _SEX: _____

HOW DID YOU HEAR ABOUT US?

_____

CURRENT MEDICATIONS (including vitamins/OTC):

DOSAGE/FREQUENCY

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES TO MEDICATIONS?

PRIMARY CARE PHYSICIAN:

_____

MEDICAL HISTORY:

Have you been diagnosed or treated for any of the following?

Please circle which, if applicable	Y	N
DIABETES – T1 / T2		
If yes, last HbA1c and date taken:		
HYPERTENSION		
HIGH CHOLESTEROL		
FIBROMYALGIA		
HEART DISEASE		
VASCULAR DISEASE		
SLEEP APNEA		
ASTHMA		
EMPHYSEMA/COPD		
KIDNEY PROBLEMS		
PROSTATE PROBLEMS		
ARTHRITIS		
CHRONS DISEASE/IBS		
NEUROLOGICAL PROBLEMS		
ANXIETY		
DEPRESSION		
HYPERTHYROIDISM		
HYPOTHYROIDISM		
ANEMIA/BLEEDING DISORDER		
CANCER (Please note type):		
ALLERGIES		
Are you currently pregnant or nursing?		

OTHER:

OCULAR HISTORY:

Have you been diagnosed or treated for any of the following?

Please circle which, if applicable	Y	N
BLINDNESS		
CATARACTS		
CROSSED EYE(S)		
LAZY EYE		
DIABETIC EYE PROBLEMS		
DRY EYE		
FLASHES		
FLOATERS		
FOREIGN BODY		
EYE INFECTION		
ITCHY EYE(S)		
TEARING		
MACULAR DEGENERATION		
POOR VISION		
RETINAL DETACHMENT		
TRAUMA		
EYE SURGERY:		

Procedure/Date:

OTHER:

FAMILY HISORY:

Have any immediate family member been diagnosed or treated for any of the following?

Please circle which, if applicable	Y	N	Mother, Father, Sibling, Grandparent
DIABETES			
HYPERTENSION			
HIGH CHOLESTEROL			
THYROID ISSUES			
CARDIOVASULAR ISSUES			
CANCER			
GLAUCOMA			
RETINAL DETACHMENT			
CATARACTS			
MACULAR DEGENERATION			
BLINDNESS			
OTHER:			

VISUAL NEEDS ASSESMENT:

Occupation: _____

Hours of: Computer use _____ Outdoor Activity _____

Hobbies: _____

Eye or neck strain, headaches: _____

Sports: _____

Hours before reading fatigue? _____

SURGICAL HISTORY: _____

_____

SOCIAL HISTORY:

Do you use cigarettes or alcohol? **Y** / **N** Frequency: _____

The information above is correct to the best of my knowledge. I have reviewed the HIPAA Privacy Policy and understand a copy of the Notice of Privacy Practices is available to me at any time.

Patient Printed Name: _____ Signature: _____

EVERGREEN EYE CARE
EVERGREEN EYE CARE

OPTICAL POLICIES & WAIVER FORM

1. NOTICE: Glasses and contact lenses are medical devices that when dispensing, must be regarded with the same caution you would use for any other prescription. As the patient, you have the right to your prescription immediately after it is finalized, and to have your eyewear dispensed wherever you choose. However, as prescription and dispensing are closely linked, it's best to have your devices dispensed where you have your eyes examined. This is because the creation and dispensing of these medical devices is a complex process that includes numerous measurements and adjustments that must be precise down to the millimeter. There is a lot that can go wrong. Any minor mismeasurement or adjustment with your contacts or eyeglasses can cause blurry and/or double vision, headaches, nausea, fatigue, and other visual dysfunction.

2. WAIVER OF LIABILITY: As much as we would like to help you in these situations, when we do not craft or dispense your eyewear, we are at a loss to determine why you are experiencing issues. This is because we do not have the metrics, measurements, or insight of how your eyewear was processed or what it is made of. It is more difficult to resolve any problems you have when prescribing and supplying are separated. We are happy to service our products and honor any applicable warranty for quality and workmanship from the manufacturer, however, Evergreen Eye Care **will not be** held liable for any product or issues with products that are purchased elsewhere. You will be personally responsible for any expenses associated with loss and/or breakage of frames, repairs, remakes, prescription changes, or office visits associated with amending issues with any products purchased elsewhere.

3. SUPPLYING OUTSIDE PRESCRIPTIONS POLICY: Evergreen Eye Care will happily supply your eyeglasses or contact lenses from an outside provider to the exact prescription as it is written– however, for reasons described within this document, if there are any issues with the final product, you have a few options: You may return to the prescribing provider for a prescription check, or you can have Dr. Felger check the prescription for a $45.00 refraction fee. You will also need to fill out a records request form so we can obtain any necessary records from the prescribing doctor.

4. THE FTC'S OPHTHALMIC PRACTICE RULES/EYEGLASS RULES ELECTION: As stated above, you have the right to your eyeglass prescription as soon as it is finalized, if we have proof of payment on file (either proof of active insurance or personal payment for services). This finalized prescription is available to you in your patient portal immediately after your examination. If you would prefer to have a printed copy of your eyeglass prescription given, this is available to you at any time. By signing below, you consent to have your eyeglass prescription delivered electronically.

   I have read, understand and agree to the above office policies. I also consent to having my eyeglass and/or contact lens prescription(s) delivered electronically.

   Printed Name: _____

   Signature: _____ Date: _____

EVERGREEN EYE CARE

About Your Insurance

There are two types of health insurance that will help pay for your eye care services and optical products. You may have both types and Evergreen Eye Care accepts most insurance plans in both categories: 1) Vision discount plans (such as VSP, EyeMed and others) and 2) Medical insurance (such as Blue Cross/Blue Shield, Medicare and others). **Dr. David Felger is a medical Optometrist** who bills both managed Vision discount plans as well as medical insurance as a professional specialist on a CMS1500 form.

· Vision plans **only** cover routine vision wellness exams, along with eyeglasses and contact lenses. Vision plans do not cover medical eye care (the diagnosis, management, or treatment of eye health problems).

· Medical insurance must be used for medical eye care. This means that if you have had any medical eye conditions (previous or present: cataract surgery, dry eye, retinal or corneal issues for example), medical insurance will be utilized.

· If you have **both** types of insurance plans it may be necessary for us to bill some services to one plan and some services to the other. We will follow a procedure called coordination of benefits to do this properly and to minimize your out-of-pocket expense.

· If some fees are not paid by your insurance, we will bill you for them, such as deductibles, co-pays/coinsurance, or non-covered services as allowed by the insurance contract.

Please provide your insurance cards to our staff member so we can make a copy. We need to have your medical insurance card(s) and/or managed vision discount plan information on file in case we should need it in the future for billing your insurance. If you have any questions about the information provided above, please direct them to a staff member or Dr. Felger.

I have read and accept these policies.

_____ _____

Patient signature (or guardian and relationship, if minor patient) Date