# DESERT VIEW EYE CARE

## *PATIENT INFORMATION*

First Name_____ Last Name _____MI_____ Sex_____

SS#_____Birthdate_____Marital Status_____

**Mailing Address** _____**City**_____ **State**_____ **Zip**_____

Telephone: Home_____Cell_____Work_____

Email Address:_____Text Confirmation: Yes ❑ No❑

How do you prefer to be contacted _____ How did you hear about our office? _____

Employer_____Occupation_____

Hobbies_____

## *PARENT OR GUARDIAN INFORMATION (If minor)*

Name_____Birthdate_____SS#_____

Address_____
(Street/Mailing address if different) (City) (State) (Zip)

Telephone: Home_____ Cell_____ Work_____

Employer_____Relationship to Patient_____

## *INSURANCE INFORMATION*

Name of Policy Holder _____Birth Date _____SS#_____

Address_____City_____State_____Zip_____

Telephone: Home_____Cell_____Work_____

Primary Insurance_____ Policy ID#_____

Employer_____ Relationship to Patient _____

***INSURANCE AUTHORIZATION AND ASSIGNMENT*** I AUTHORIZE TREATMENT OF THE PERSON NAMED ABOVE AND AGREE TO PAY ALL FEES & CHARGES FOR SUCH TREATMENT. I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO DESERT VIEW EYE CARE. I AUTHORIZE DESERT VIEW EYE CARE TO RELEASE ANY INFORMATION REQUIRED FOR MY INSURANCE.

SIGNATURE_____ PRINT NAME_____

DATE _____

# DESERT VIEW EYE CARE FINANCIAL POLICY

***FULL PAYMENT IS DUE AT TIME OF SERVICE*** **– IF INSURANCE IS BILLED CO-PAYMENT AND/OR DEDUCTIBLE IS DUE AT TIME OF SERVICE.** ****GLASSES AND CONTACT LENSES MUST BE PAID IN FULL BEFORE THEY ARE ORDERED.****

## CONTACT LENS EVALUATION

A contact lens evaluation and fitting can cost between $85.00 and $105.00 or more, depending on the type of evaluation performed.

## OPTOMAP RETINAL SCREENING

Optomap Retinal Screening is not covered by insurance. The out of pocket copay is $39.00 for Adults and $29.00 for Children.

## REGARDING INSURANCE & UCR (Usual & Customary Rates)

You are responsible for payments regardless of your insurance company's arbitrary determination of "Usual And Customary Rates". Your insurance policy is a contract between ***YOU and your insurance company.*** Any disagreement you have concerning the amount your insurance pays should be directed to your insurance company. If insurance does not cover all charges, you may be balance billed.

## DIVORCE

In case of divorce, Desert View Eye Care is not party to the divorce settlement. The person signing **this** agreement is responsible for any and all payments for services. Any disagreement between two parties of a divorce must be dealt with between those parties and ***DOES NOT*** involve Desert View Eye Care.

## PAST DUE ACCOUNT

If Desert View Eye Care refers your account to a collection agency, you will be charged reimbursement fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs and expenses, including reasonable attorney's fees Desert View Eye Care incurs in such collection efforts.

## RETURNED CHECKS

There is a fee ***(currently $25.00)*** for any checks returned by the bank.

## CANCELLED ORDERS/REFUNDS

When you order glasses or contacts, the order goes out electronically that **same day**. If you choose to cancel after that, there will be a cancelation fee per the lab. Anything with a prescription is custom made for you therefore, ***NO REFUNDS.***

## INTEREST CHARGE

If insurance is billed then co-payment and /or deductible is due at the time of service unless prior approval is received from our office. As of July 1, 2014 Desert View Eye Care will charge 1.5 ***% INTEREST PER MONTH*** or ***an ANNUAL PERCENTAGE RATE of 18%*** on any outstanding balance over 60 days.

******ALL SALES ARE FINAL******

***BY MY SIGNATURE BELOW, I HEREBY AGREE TO AND UNDERSTAND DESERT VIEW EYE CARE'S FINANCIAL POLICY AS STATED ABOVE.***

_____ _____

***Signature (Patient or Responsible Party)*** ***Date***

# Acknowledgment of Notice of Privacy Practices

**Desert View Eye Care, LC**
**170 Commerce Dr., Ste. C Green River Wyoming 82935**
**307-875-3399**

**The law requires that Desert View Eye Care, LC make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:**

☐____ I was given the opportunity to read, have read or had explained to me Desert View Eye Care, LC's 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 Desert View Eye Care, LC to release my personal health information to the following individuals:**

☐_____ _____ _____

**My vision plan requests that all diagnoses related to any medical condition I may have be released to them. As a non-traditional disclosure, release of this information requires my specific authorization:**

☐____ I authorize the release of medical information to my vision plan

☐____ I do not authorize release of medical information to my vision plan

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

☐_____

Patient Signature

☐_____

Date

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

_____

Representative Signature

_____

Relationship to Patient

# Desert View Eye Care

**Patient Name**_____

**DOB: ___/___/____** **Gender:** (Circle one): Male / Female

**Smoking Status** (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

**Packs per day**_____ **Years Smoking**_____

**Are you currently taking any medications?** (Please include regularly used over the counter medications)

| Medication Name | Dosage and Frequency (i.e. 5mg once a day, etc.) |
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**Do you have any medication allergies?**

| Medication Name | Reaction | Onset Date | Additional Comments |
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**Patient / Guardian Signature** _____

**Print Name** _____

# Desert View Eye Care

## Informed Consent / Refusal for Dilated Fundus Examination

Dilation involves instilling eye drops for the purpose of enlarging the pupils of the eyes to better check the health of the inside of the eyes.

The pupils are simply an entry way/opening to the inside of the eye. Looking through an undilated pupil is similar to looking into a room through a keyhole in the door; the doctor may see only about 20% to 50% of what is inside. However, looking through a dilated pupil is like looking into a room through an open door; the doctor gets a complete view of the inside of the eye.

A dilated fundus exam is recommended routinely at the time of your initial exam for baseline recording and usually every other full eye exam thereafter (about every 2 to 3 years). It should be done annually if you have any of the conditions listed under **Benefits** below.

### Benefits

Dilation allows the doctor a better view of the peripheral retina for disease. It is highly recommended if you or your family has a history of high blood pressure, diabetes, past retinal problems (i.e., retinal detachment/tears), or extreme nearsightedness. It is also recommended if you have experienced sudden cloudiness of vision, especially in one eye, "curtain or veil-like" obstruction of vision, a sudden onset of many "floaters" or flashing lights off to the side of your vision.

### Risks

- Some blurring of vision and glare because of enlarged pupils for about 2 (but up to 6) hours. You should not operate heavy equipment or drive an automobile unless you are comfortable with your vision.
- Difficulty with near reading for 1 to 2 hours. The focusing ability is impaired and may cause a slight headache if you try to read.
- Induced ocular hypertension. Rare cases have been reported in which redness and sharp pain are experienced because of increased eye pressure. If this happens, contact the doctor immediately

### Check one:

____ I understand the above and decline dilation at this time. I understand that potential for partial or total loss of vision may exist and, without dilation, may go undetected.

____ I understand the above and consent to have the dilation done.

**Signature:**_____**Date**_____