



## WELCOME TO OUR OFFICE

### Patient Information

Today's Date \_\_\_\_\_

Last \_\_\_\_\_  
 First \_\_\_\_\_ MI \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_  
 Zip Code \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Work Phone \_\_\_\_\_  
 Patient's SSN \_\_\_\_\_  
 Employer (or School) \_\_\_\_\_  
 Occupation (or Grade) \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Sex M F  
**Email Address** \_\_\_\_\_  
 Spouse (or Parent's Name) \_\_\_\_\_  
 Spouse (or Parent's Work) \_\_\_\_\_  
 What is the major purpose of this visit?  
 \_\_\_\_\_

Any problems with your current contact lenses or glasses? \_\_\_\_\_

### **VERY IMPORTANT! NEW PATIENTS ONLY:**

Who may we thank for referring you to our office?  
 Name of friend or relative \_\_\_\_\_  
 If not referred, how did you choose our office?  
 Another Dr. \_\_\_\_\_  
 Insurance List  
 Saw Sign/Building  
 Newspaper/Radio/TV/Magazine  
 Yellow Pages: Which directory? \_\_\_\_\_  
 Internet: Website \_\_\_\_\_ Search Engine \_\_\_\_\_  
 Health Fair: Which Company \_\_\_\_\_  
 Other \_\_\_\_\_

### ***Our mission is to:***

- *Provide our patients with the highest level of health care in both services and products*
- *Continue in our professional education to provide the most technologically advanced eye care by the use of state-of-the-art equipment and products*
- *Enhance, maintain, and preserve our patients' vision through the highest quality products and procedures*
- *Optimize the quality of life of each of our patients through better vision*

### Insurance Information

*Although you are responsible for knowing your own benefits, we will do our best to help you understand them.*

**Vision Insurance** \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_  
 Subscriber SSN \_\_\_\_\_  
 Subscriber Birth Date \_\_\_\_\_  
**Primary Medical Insurance** \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_  
 Subscriber SSN \_\_\_\_\_  
 Subscriber Birth Date \_\_\_\_\_  
**Secondary Insurance** \_\_\_\_\_

Do you participate in a flex spending account?

Yes  No

How will you settle your account today?

Cash  Check  Credit Card

### Lifestyle Questions

**Do you.....(check box if your answer is yes)**

- ..work at a computer? If yes, how many hours/day? \_\_\_\_  
 Please complete computer questionnaire.
- ..think you might benefit from thinner, lighter lenses?
- ..have interest in a "test drive" of the latest contact lens designs
- ..spend time outdoors? How much? \_\_Hrs/week
- ..have prescription sunwear?
- ..prefer not to wear your glasses at times?
- ..want information on LASIK?
- ..have interest in a non-surgical approach to vision correction?
- ..have more than 1 pair of current Rx eyewear?
- ..have children?
- ..have family members in need of eyecare?

**Have you ever experienced, been diagnosed or treated for any of the following?**

- |  |  |
|--|--|
| <input type="checkbox"/> Blurry Vision             | <input type="checkbox"/> Burning                 |
| <input type="checkbox"/> Cataracts                 | <input type="checkbox"/> Corneal Abrasions       |
| <input type="checkbox"/> Crossed eye/Eye turn      | <input type="checkbox"/> Double Vision           |
| <input type="checkbox"/> Eye Infections            | <input type="checkbox"/> Eye Injury              |
| <input type="checkbox"/> Flash of light            | <input type="checkbox"/> Floaters/Spots          |
| <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Grittiness              |
| <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Iritis/Uveitis          |
| <input type="checkbox"/> Itchiness                 | <input type="checkbox"/> Lazy Eye                |
| <input type="checkbox"/> Macular Degeneration      | <input type="checkbox"/> Occasional dryness      |
| <input type="checkbox"/> Retinal Detachment        | <input type="checkbox"/> Sunlight Sensitivity    |
| <input type="checkbox"/> Tearing                   | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Uncomfortable glasses     |  |
| <input type="checkbox"/> Other eye disorders _____ |  |

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History	
Name of Family Physician _____	
Town _____	
Date of Last Physical Check-up _____	
<b>CURRENT MEDICATIONS (Rx or Over the Counter)</b> (List name of medications including eye drops, vitamins, & birth control pills) _____	
_____	
_____	
Allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, what medications? _____	
_____	
Are you allergic to Latex? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had any surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, please list _____	
_____	
Do you use cigarettes/tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Have you ever been diagnosed or treated for the following health problems?</b>	
	<b>Yes</b> <b>No</b>
Allergies	<input type="checkbox"/> <input type="checkbox"/>
Arthritis	<input type="checkbox"/> <input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/> <input type="checkbox"/>
Bronchitis	<input type="checkbox"/> <input type="checkbox"/>
Cancer	<input type="checkbox"/> <input type="checkbox"/>
Cholesterol	<input type="checkbox"/> <input type="checkbox"/>
Diabetes	<input type="checkbox"/> <input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/> <input type="checkbox"/>
Fevers	<input type="checkbox"/> <input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>
Neurological	<input type="checkbox"/> <input type="checkbox"/>
Psychological	<input type="checkbox"/> <input type="checkbox"/>
Respiratory	<input type="checkbox"/> <input type="checkbox"/>
Sinus	<input type="checkbox"/> <input type="checkbox"/>
Thyroid	<input type="checkbox"/> <input type="checkbox"/>

**Dilation** is recommended to allow a more thorough examination of your eyes. Side effects include sensitivity to light and blurred near vision for several hours following your exam. Please initial in appropriate area below.  
I agree to have my eyes dilated today: \_\_\_\_\_ Refused \_\_\_\_\_

Patient Eye History	
Date of Last Eye Exam _____	
By Whom? _____	
Have you ever tried contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you currently wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What kind? _____	
Solutions used _____	
Are you satisfied with the vision and comfort of your contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Would you prefer clear contact lenses or colored contact lenses? <input type="checkbox"/> Clear <input type="checkbox"/> Colored	
If you wear bifocals, do the lines or head tilting bother you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Family Medical/Eye History (Check all that apply)	
Is there a family medical history of any of the following: <input type="checkbox"/> No <input type="checkbox"/> Yes (Please check boxes)	
	Relationship (Who?) (Mother's or Father's side)
Blindness	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____

Please be advised if you are using insurance benefits for today's visit, this is a contract between you and your insurance company...not Premier Eyecare.

If your insurance company has not reimbursed our office in full within 60 days, you will receive a statement and will be responsible for payment. You may be entitled to reimbursement from your insurance company and therefore should follow up with them.

## VISUAL FIELD TESTING & DIGITAL RETINAL PHOTOGRAPHY

We are excited to announce that we have incorporated into our practice new, state-of-the-art computerized instruments that allow us to provide a more thorough medical analysis of your eyes. Our automated visual field instrument measures retinal function and sensitivity. Digital photographic imaging of the retina (back of the eye) can provide invaluable information for early detection, treatment, and monitoring of retinal and optic nerve changes. Retinal and optic nerve health is vital in maintaining good vision.

Unfortunately, routine eye exams may not always detect ocular diseases in their early stages. These instruments can assist us in the early detection of many disorders, including brain tumors, glaucoma, macular degeneration, diabetic retinopathy, retinal detachments, optic nerve diseases, and retinal disturbances due to vascular problems or medications.

We strongly recommend that **all of our patients receive these screenings annually**. It is especially important for people who have:

1. Headaches/ Migraines
2. See spots or flashes of light
3. Have **Diabetes, High Blood Pressure, Glaucoma, Macular Degeneration** or a family history of any of these
4. Have retinal problems or a family history of retinal problems
5. A strong eyeglass prescription
6. Over the age of 35

**Please check the appropriate line below.**

\_\_\_\_\_ **I DO** \_\_\_\_\_ **I DO NOT want** the visual field testing exam (\$15.00)

\_\_\_\_\_ **I DO** \_\_\_\_\_ **I DO NOT want** the digital retinal photography & scanning laser (\$40.00)

**Please Note:** While these tests are recommended for all patients as preventative health care, for some, more extensive tests are medically necessary due to certain eye conditions that may be present or need to be ruled out. These more extensive tests may be billed to your insurance company.

## COMPUTER VISION TESTING

Computer Vision Syndrome is caused by the constant effort it takes for your eyes to focus on a computer screen. Unlike an easy-to-read book, the images on a computer screen are made up of tiny, glowing dots called pixels. Without clearly defined edges or background contrast, your eyes can lock the images into focus. They continually drift out of their natural focal resting point and then strain to regain focus on the screen. This constant refocusing can occur in thousands of times an hour — overworking your eye muscles and causing painful eyestrain symptoms including **tired and sore eyes, headaches, blurred vision, and general fatigue**. If you **work at a computer more than 2 consecutive hours in a day**, we strongly recommend evaluating your eyes with the **PRIO** computer test during your visit today. With the results of this test, Dr. Fry will be able to prescribe the most accurate prescription designed specifically for your computer vision needs. The fee for the **PRIO** test is (\$30.00) which is **not** covered by vision benefits or insurance.

I want the PRIO computer test: \_\_\_\_\_ YES \_\_\_\_\_ NO Initials: \_\_\_\_\_



# PREMIER EYECARE

*“Committed To Your Family’s Vision Health”*

Patient Name: \_\_\_\_\_ Person responsible for today’s payment \_\_\_\_\_

Today’s payment will be: \_\_\_\_\_

Cash  Check  Credit Card  Care Credit

### **I. Third Party Benefit Plans:**

When making a third party claim, I authorize the release of my medical information to process my third party claim. I authorize Premier Eyecare to file complaints in my behalf if my third party carrier does not properly handle my claim. I authorize the release of any information pertinent to my case to any third party, adjuster, or attorney involved in resolving the financial status of my account. I authorize my third party plan to pay Premier Eyecare directly. If this is not permitted by my policy, then send the check made out to me at the following address:

Premier Eyecare  
11121 Kingston Pike, Ste. A  
Knoxville, TN 37934

**Patient Initials:** \_\_\_\_\_

### **II. Consent for Treatment**

By signing this form, I Consent to treatment for myself and/or on behalf of the Minor for which this Medical History information pertains. I give permission for the doctor(s) to examine, diagnose and initiate treatment as deemed appropriate. I further, attest that I am the Parent or Legal Guardian of the Minor and have the authority to authorize care and treatment.

**Patient Initials:** \_\_\_\_\_

#### **THE FINANCIAL POLICY OF PREMIER EYECARE**

1. All fees are due the day services are rendered or materials are ordered.
2. We accept the following forms of payment: Cash, Check, American Express, Visa, MasterCard, and Discover. We also participate in Care Credit and Tradebank.
3. The patient who seeks care is responsible for the payment of all fees.
4. The person who brings a child into the office is responsible for all fees.
5. When we are not a provider for a third party, the patient who seeks care is responsible for the payment of all fees. We will provide a fee slip to submit to your third party for reimbursement directly to you.
6. When we are a provider for a third party, any deductibles, co-payments or patient responsibility fees are due when services are rendered or materials are ordered.
7. Interest will be charged in cases where outstanding fees occur.

\_\_\_\_\_  
Patient/Parent or Guardian

\_\_\_\_\_  
Today’s Date

## Please Read and Sign if Interested in Contact Lenses

Professional Standards of Care recommend that all people who wear contact lenses have a full comprehensive exam **and** contact lens evaluation at least once every year. This form is intended to make clear any misconceptions concerning the professional services and material costs of contact lenses. Your vision benefits may not cover or only cover a portion of the charges for a contact lens evaluation. **Please read carefully** and sign at the bottom:

- We will **not** dispense contact lenses or write a contact lens prescription without a comprehensive exam **and** contact lens evaluation, including all necessary follow-up visits, each and every year.
- A **comprehensive exam** consists of tests which include:
  1. Determination of refractive status of your eyes (myopia, hyperopia, astigmatism, presbyopia.)
  2. Evaluation of ocular tissues internal and external and any diagnosis of diseases or disorders relating to the eye.
  3. Assessment of the functional ability of the visual system.

A **CONTACT LENS EVALUATION** must be done **IN ADDITION** to the comprehensive exam, regardless of whether or not you have a change in your contact lens prescription.

- These tests are for contact lens wearers **only** and include:
  1. Measurement of the curvature of the cornea to determine the proper parameters of a contact lens which will best fit each eye, and for previous wearers, to assure that your current contact lenses are still the proper fit.
  2. Evaluation of the performance of both the current and/or new contact lenses on each eye (visual acuity, coverage, centration, movement, tear exchange, cleanliness, etc...)
  3. Assessment of the ocular tissues involved in contact lens wear and determination if these tissues are responding favorably to contact lens wear.
  4. Choosing the correct lens materials and designs for your individual needs.
  5. Ongoing follow-up visits as needed up to **3 months**. Any additional follow-up visits outside of the initial 3 months will be charged \$40 per visit.

There is an **ADDITIONAL PROFESSIONAL FEE** associated with the **Contact Lens Evaluation**. This fee is dependent on the level of complexity of the fitting process and does **not** include the price of the contact lenses.

Level 1	\$ 55	soft spherical CL requiring no follow-up visit
Level 2	\$ 95	soft spherical CL requiring follow-up visit(s) or Level 3 w/o follow-up
Level 3	\$125	soft toric CL requiring follow-up visit(s) or Level 4 w/o follow-up
Level 4	\$175	multi-focal soft CL or Synergeyes Duette requiring follow-up or Level 5 w/o follow-up
Level 5	\$250	rigid gas-permeable (RGP) or Synergeyes A SV or Level 6 w/o follow-up
Level 6	\$325	multi-focal RGP, soft toric multi-focal CL, or Synergeyes MF
Level 7	\$425	post-RK surgery fit; RGP or Synergeyes PS
Level 8	\$795	keratoconus fit or CRT refit including 2 sets of CRT lenses
Level 9	\$1200	Corneal Refractive Therapy (Includes 2 sets of contact lenses)

### VISION BENEFITS

If you have vision benefits, your **exam co-pay** is only for the comprehensive portion of the exam. Contact lenses are considered an elective form of vision correction; therefore, the contact lens evaluation is **NOT** covered by the comprehensive exam coverage under your vision benefits. Unless your vision carrier provides some reimbursement toward your contact lens evaluation and/or contact lenses, you are responsible for the full amount of the contact lens evaluation fee on the date of service.

I have read and by signing, I understand that if **I choose to be fit with contact lenses**, I am financially responsible for all fees not covered by my vision benefits.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Consent For Use Or Disclosures Of Health Information**

**Our Privacy Pledge**

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

**Your Right To Limit Uses or Disclosures**

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

**Your Right To Revoke Your Authorization**

You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice.

**Appointment Reminders and Health Care Information Authorization**

Dr. Fry and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home or at work, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you by phone, e-mail, mail, or fax with these reminders and information.

\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Authorized Provider Representative

\_\_\_\_\_  
Personal Representative (Printed)

\_\_\_\_\_  
Personal Representative Signature

\_\_\_\_\_  
Description of Personal Representative's Authority to Act for the Patient