The EyePlace OPTOMETRY, PC
Dr. Jennifer Bowman
Dr. Charné Ellis
Dr. Brian Spittle
Dr. Norma Spittle

Welcome! Thank you for allowing us to participate in your healthcare!

PLAN ahead:

- Plan on a 90-minute visit. We are comprehensive.
- Wear your contact lenses if you have them.
- Your eyes may be dilated, slightly blurring your vision for a few hours afterward.
  - Bring sunglasses for your comfort. You may want to bring a driver with you.
  - Persons with diabetes and children should expect to be dilated at least yearly.

BRING with you:

- THIS form (**or fax: 804-794-9216 / email: office@theeyeplace.com**)
  - COMPLETE + SIGN the registration form.

- LIST of all medications, supplements, and eye drops you use
  - Many common medications have significant effects on the eyes.
  - Bring your eye drops.

- MEDICAL insurance cards
  - Cheaper: Copays may be *less* than vision insurance.
  - Limitations: Vision insurance *does not cover* injuries, pink eye, glaucoma, diabetes, etc.
  - Convenience: Kept on-file in case of emergency visits.

- Driver's License or ID card
  - This helps us protect your identity.

- All eyeglasses, sunglasses, and contact lenses
  - Misalignment and scuffed lenses are a major reason for vision difficulty.
  - BRING prescriptions from other offices, especially for contact lenses.

Locally owned and operated!

Mr	LAST NAME	FIRST NAME	MI	NICKNAME	The EyePlace OPTOMETRY, PC

ADDRESS	CITY	ZIP	HOME PHONE ☐ Preferred

PLACE OF EMPLOYMENT/SCHOOL	JOB / GRADE	DATE OF BIRTH	AGE	CELL PHONE ☐ Preferred

SPOUSE / PARENT NAME	SOCIAL SECURITY NUMBER	EMAIL ADDRESS	WORK PHONE ☐ Preferred

MY PRIORITIES

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- ◯◯ I plan to order new glasses today.
- ◯◯ My driving sunglasses have my current prescription.
- ◯◯ I am considering LASIK (laser eye surgery).
- ◯◯ I plan to order contacts today. (+Free Shipping)
- ◯◯ I need an itemized receipt for my Flex Spending Account.
- ◯◯ I allowed time to be dilated today (+20 minutes)

We ship ALL contacts to your work/home for free!

MY HEALTH

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◯◯	Detached Retina	◯◯	Diabetes
◯◯	Cataracts	◯◯	I am Pregnant/Nursing
◯◯	Glaucoma	◯◯	I use tobacco
◯◯	Macular Degeneration	◯◯	I Had Eye Surgery
◯◯	Eye Injury	◯◯	I have sunglasses

MY DOCTORS

Name of Physician/Pediatrician:____________________

Name of Specialist(s):____________________

NEW PATIENTS ONLY

Date of Last Eye Exam: ____________________

Last Eye Doctor/Location:

How did you find our office?

CONTACT LENSES

- ☐ I wear or want contact lenses
- ☐ I was told I cannot wear contacts
- ☐ I want color contacts

ADVANCED EXAMINATION

We will take pictures of the inside of your eye and test side vision to better detect melanoma, glaucoma, diabetes, high blood pressure, and macular degeneration. Your doctor will review new images each year. The fee for this is $40.

Additional Contact Lens Services

Contact lenses are medical devices that require additional time and testing versus a routine eye exam. The fees for this service depend on the type of lens worn. Insurance may lower these fees.

Lens Types	Examples	Soft Contacts Starting at	Hard (RGP) Contacts Starting at
Distance Only		$99	$199
Distance and Near	Multifocal, Monovision, Bifocal	$189	$289
Myopia Care for Kids	Slows prescription changes	$129/mo	$129-$199
3D-Printed Lenses	Keratoconus, Sclerals	Up to $1200	Up to $1200

Included:
- ALL demonstration lenses
- ALL related check-up visits for 60 days

Excluded:
- †Contact lens lessons ($49 per half hour)
- Your yearly eye exam
- Contact lenses and lens supplies
- Visits and demos after your prescription is finalized

My signature acknowledges that a copy of The Eye Place Optometry, P.C.'s Notice of Privacy Practices has been made available to me. I consent to examination and treatment and agree to pay for the care and goods I receive. This includes any copays, deductibles, and fees for not paying, like returned checks ($50), certified mail, collections, arbitration, and attorney fees. If I do not pay my bill within 60 days of notice, the office can charge a credit card used for previous payment on my account. I give permission for the office to share the information needed to process my insurance claims and I assign payments from my insurance company. I allow The Eye Place Optometry, P.C. to share medical information from my other doctors or medical facilities when important for my care. This office will decide which of my insurance plans should cover my services. I understand that payments for services are non-refundable. My medical records will be stored electronically indefinitely, and any paper documents with my personal information will be shredded to protect my privacy. I have read and understood these terms and agree to follow them.

PATIENT'S SIGNATURE ____________________ **DATE** ____________________

(parent or guardian if patient is a minor) Please use reverse if you need more space →