The EyePlace OPTOMETRY, PC
Dr. Brian Spittle
Dr. Norma Spittle
Dr. Roy Mittmann
Dr. Jennifer Bowman

Your Appointment With Us:

- Your appointment may take up two hours, however most last only one hour.
- Your eyes may be dilated, slightly blurring your vision for a few hours afterward.
  - You may want to bring a driver with you.

Bring the Following to Your Appointment:

- These forms, completed (**print, fax, or email to office@theeyeplace.com**)
  - Sign the history form.
  - Consent to "Advanced Testing" (your doctor highly recommends this test)
  - Sign the Contact Lens Service Agreement (if you wear or are considering contact lenses)

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

- All **medical** insurance cards (they may save you money)
  - Medical insurance often has lower copays than vision insurance
  - Vision insurance does not cover injuries, pink eye, glaucoma, diabetes, etc.
  - We keep this information on file in case of emergencies throughout the year

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

- All eyeglasses, sunglasses, and contact lenses
  - We want to test your sunglasses to ensure they block UV Radiation
  - We clean and adjust eyewear from our office free of charge

We are excited that you have chosen us for your eye care!

Now relax and check us out on Facebook! facebook.com/eyeplace

Mr	LAST NAME FIRST NAME MI	PREFERRED NAME	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

Y	N	
◯	◯	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!

NEW PATIENTS ONLY

Date of Last Eye Exam: _____

Last Eye Doctor/Location:

How did you find our office?

MY HEALTH

Y	N		Y	N	
◯	◯	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): _____

CONTACT LENSES

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

ADVANCED MEDICAL TESTING

Enhance today's exam. 3 minutes could save your vision!

- Recommended for all patients
- Includes baseline digital photos and side-vision testing
- No blurred vision, quick, pain-free
- Assists with earlier detection of eye diseases

** ** Click this box to ACCEPT or DECLINE this important testing. ** **

By signing below, I acknowledge that a copy of The Eye Place Optometry, P.C.'s Notice of Privacy Practices has been made available to me. I hereby authorize any necessary medical treatment by the optometrists in the practice of The Eye Place Optometry, P.C., and agree to be financially responsible for my bill and any necessary collections and attorneys fees made necessary to collect payment for materials and/or services rendered. I authorize this office to release any information necessary to expedite insurance claims. I further authorize The Eye Place Optometry, P.C. to release or obtain any required medical information from my attending physicians or any medical facility as necessary for my care and to decide which insurance plan should be billed for my services. I also authorize my insurance provider to make payments on my behalf to The Eye Place Optometry, P.C. Payments for services rendered are non-refundable. Your medical records will be electronically archived indefinitely, and all discarded documents are shredded to protect personal information.

PATIENT'S SIGNATURE _____ **DATE** _____

(parent or guardian if patient is a minor)

Please use reverse if you need more space ⟶

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CONTACT LENS SERVICE AGREEMENT

Contact lenses are medical devices that require counseling, technical expertise, additional testing, and physician time. The fee for this service depends on the type of contact lenses you wear. The fees are as follows:

		Soft Contacts	Hard (RGP) Contacts
Distance Only Lenses		$85	$175
Distance and Near Lenses	(Bifocal, Multifocal, Monovision)	$160	$225
Overnight Vision Retainers	(Clear daytime vision without glasses/contacts/surgery)	---	$2400 ($750 after year one)
Specialty and Medically Necessary Lenses	(Keratoconus, etc)	$225 - $1200	$450 - $1200

Included: All diagnostic soft lenses
All related check-up visits for up to 60 days *(12mos for Overnight Vision Correction)*
A prescription for contact lenses, valid for 12 months, once finalized by your doctor and your account settled

Excluded: Contact lens lessons ($25 per session)
The cost of a routine eye examination *(included with Overnight Vision Correction)*
The cost of contact lenses *(included with Overnight Vision Correction)*
Visits after 60 days or those after your prescription is finalized are assessed at the rates listed above
Medical office visits (like red eyes or conjunctivitis)

- I acknowledge that I have had an opportunity to ask questions about the agreement and services provided.
- I understand that this fee must be paid at the time services are started.
- I understand that contact lenses increase the amount of UV light exposure to my eye and should be paired with polarized sunglasses.

SIGNED:_____ DATE:_____
Patient or Parent/Guardian