

Your Appointment With Us:

- Your appointment may take up to 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 and prevent insurance fraud
- 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](https://www.facebook.com/eyeplace)



	LAST NAME	FIRST NAME	MI	PREFERRED NAME	
ADDRESS			CITY	ZIP	HOME PHONE <input type="checkbox"/> Preferred
PLACE OF EMPLOYMENT/SCHOOL	JOB / GRADE		DATE OF BIRTH	AGE	CELL PHONE <input type="checkbox"/> Preferred
SPOUSE / PARENT NAME		SOCIAL SECURITY NUMBER	EMAIL ADDRESS		WORK PHONE <input type="checkbox"/> 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!	

MY HEALTH			
Y	N	Y	N
Detached Retina Cataracts Glaucoma Macular Degeneration Eye Injury		Diabetes I am Pregnant/Nursing I use tobacco I Had Eye Surgery 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
<input type="checkbox"/> I <u>wear</u> or want contact lenses <input type="checkbox"/> I was told I cannot wear contacts <input type="checkbox"/> I want color contacts

ADVANCED MEDICAL TESTING
<div style="border: 1px solid black; padding: 5px; margin: 10px auto; width: 80%;"> <p><u>Enhance today's exam. 3 minutes could save your vision!</u></p> </div> <ul style="list-style-type: none"> 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 <div style="border: 1px solid black; height: 40px; width: 80%; margin: 10px auto;"></div>

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 →

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:

<u>Lens Types</u>	<u>Examples</u>	<u>Soft Contacts</u>	<u>Hard (RGP) Contacts</u>
Distance Only		\$99 [†]	\$199 [†]
Distance and Near	Monovision, Bifocal, Multifocal	\$189 [†]	\$289 [†]
Myopia Care for Kids	MiSight, Ortho-K, Atropine	\$129/mo (includes lenses)	\$129-\$199/mo (includes lenses)
Specialty or Medically Necessary Lenses	Keratoconus, Sclerals	Up to \$1200	Up to \$1200

Included: All diagnostic soft lenses
All related check-up visits for up to 60 days
A prescription, valid for up to 12 months, once finalized by your doctor and your account settled

Excluded: †Contact lens lessons (\$25 per session)
Your yearly eye exam
Contact lenses and supplies
Visits and demos after your prescription is finalized
Medical office visits (like red eyes or conjunctivitis)

- I understand that this fee must be paid at the time services are started.
- I understand that contact lenses increase the my UV light exposure to my eye and should be paired with polarized sunglasses.

SIGNED: _____
Patient or Parent/Guardian

DATE: _____