



{MYCOMPANYINFORMATION_COMPANYNAME}
 {MYCOMPANYINFORMATION_ADDRESSLINE}
 {MYCOMPANYINFORMATION_CITY}
 {MYCOMPANYINFORMATION_STATE}
 {MYCOMPANYINFORMATION_ZIPCODE}
 TEL: {MYCOMPANYINFORMATION_PHONENUMBER} • FAX:
 {MYCOMPANYINFORMATION_FAXNUMBER}
 {MYCOMPANYINFORMATION_WEBSITE} •
 {MYCOMPANYINFORMATION_EMAILNAME}

WELCOME LETTER

Account No.:	{PATIENT_PATIENTID}
Printed:	{DATE_TODAY} {TIME_STAMP}

Dear patient:

We welcome you to our practice and ask that you kindly complete or correct all information on this form.

PATIENT INFORMATION		
PATIENT NAME: {PATIENT_NAME_FULL}	SEX: {PATIENT_SEX}	SOCIAL SECURITY NUMBER:
ADDRESS:	DATE OF BIRTH: {PATIENT_BIRTHDATE}	MARITAL STATUS: {PATIENT_MARITAL_STATUS}
CITY, STATE & ZIP: {PATIENT_CITY} {PATIENT_STATEORPROVINCE} {PATIENT_ZIPCODE}	EMAIL: {PATIENT_EMAILNAME}	
HOME PHONE: {PATIENT_HOMEPHONE}	WORK PHONE: {PATIENT_WORKPHONE} {PATIENT_WORK_PHONE_EXT}	MOBILE PHONE: {PATIENT_CELLULARPHONE}
EMPLOYER: {PATIENT_EMPLOYERNAME}	OCCUPATION: {PATIENT_OCCUPATION}	
EMPLOYER'S ADDRESS: {PATIENT_EMPLOYERADDRESSLINE}	PRIMARY CARE PHYSICIAN: {PRIMARY_PHYSICIAN}	
EMPLOYER'S CITY, STATE & ZIP: {PATIENT_EMPLOYERCITY} {PATIENT_EMPLOYERSTATE} {PATIENT_EMPLOYERZIP}	PRIMARY CARE PHYSICIAN'S PHONE: {PRIMARY_PHYSICIAN_PHONE}	
Do you or your family have any history of the following conditions (check all that apply)?: Self Family <input type="checkbox"/> <input type="checkbox"/> Glaucoma <input type="checkbox"/> <input type="checkbox"/> Cataracts <input type="checkbox"/> <input type="checkbox"/> Diabetes <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> <input type="checkbox"/> Heart Problems <input type="checkbox"/> <input type="checkbox"/> Retinal Degeneration <input type="checkbox"/> <input type="checkbox"/> Stroke <input type="checkbox"/> <input type="checkbox"/> Thyroid Condition <input type="checkbox"/> <input type="checkbox"/> Crossed/Lazy Eyes <input type="checkbox"/> <input type="checkbox"/> Asthma/ Allergies <input type="checkbox"/> <input type="checkbox"/> Color Blindness <input type="checkbox"/> <input type="checkbox"/> Arthritis <input type="checkbox"/> <input type="checkbox"/> Tuberculosis <input type="checkbox"/> <input type="checkbox"/> HIV/Hepatitis <input type="checkbox"/> <input type="checkbox"/> Cancer <input type="checkbox"/> <input type="checkbox"/> Neuromuscular <input type="checkbox"/> <input type="checkbox"/> Blindness Other: _____	Do you currently have any of the following symptoms (check all that apply)?: <input type="checkbox"/> Blurry distance vision <input type="checkbox"/> Poor night vision <input type="checkbox"/> Eye Strain <input type="checkbox"/> Blurry Near Vision <input type="checkbox"/> Trouble Reading <input type="checkbox"/> Itchy Eyes <input type="checkbox"/> Discharge <input type="checkbox"/> Watering <input type="checkbox"/> Pain in the eye <input type="checkbox"/> Burning eyes <input type="checkbox"/> Sandy/dry eyes <input type="checkbox"/> Red Eyes <input type="checkbox"/> Glare/reflections <input type="checkbox"/> Discomfort in sunlight <input type="checkbox"/> Double vision <input type="checkbox"/> Floaters or spots in vision <input type="checkbox"/> Flashes of light <input type="checkbox"/> Eye injury <input type="checkbox"/> History of wearing an eye patch <input type="checkbox"/> History of eye surgery <input type="checkbox"/> Headaches <input type="checkbox"/> Dental Abscess	Are you interested in any of the following (check all that apply)?: <input type="checkbox"/> New spectacles <input type="checkbox"/> A new prescription <input type="checkbox"/> Light weight glasses <input type="checkbox"/> Anti-reflective lens <input type="checkbox"/> Ortho K <input type="checkbox"/> Colored contact lens <input type="checkbox"/> Sunglasses <input type="checkbox"/> Clip-ons <input type="checkbox"/> Safety glasses <input type="checkbox"/> Lasik <input type="checkbox"/> Contact lenses <input type="checkbox"/> Dry eye therapy <input type="checkbox"/> Myopia control How were you referred to us? <input type="checkbox"/> Family doctor <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Insurance company <input type="checkbox"/> Another patient _____
MEDICATIONS:	ALLERGIES:	SOCIAL HISTORY: <input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Drug use <input type="checkbox"/> Tobacco use <input type="checkbox"/> Other: _____ _____ _____



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INSURANCE INFORMATION

Patient Name:	{PATIENT_NAME_FULL}
Account No.:	{PATIENT_PATIENTID}
Printed:	{DATE_TODAY} {TIME_STAMP}

GUARANTOR		
GUARANTOR NAME: {PATIENT_GUARANTOR_NAME_FULL}	GENDER: {PATIENT_GUARANTOR_SEX}	SOCIAL SECURITY NUMBER:
ADDRESS: {PATIENT_GUARANTOR_ADDRESSLINE1} {PATIENT_GUARANTOR_ADDRESSLINE2}	DATE OF BIRTH: {PATIENT_GUARANTOR_BIRTHDATE}	
CITY, STATE, ZIP: {PATIENT_GUARANTOR_CITY} {PATIENT_GUARANTOR_STATE} {PATIENT_GUARANTOR_ZIPCODE}	PATIENT'S RELATIONSHIP TO GUARANTOR: {PATIENT_GUARANTOR_RELATIONSHIP}	
HOME PHONE: {PATIENT_GUARANTOR_HOMEPHONE}	WORK PHONE: {PATIENT_GUARANTOR_WORKPHONE}	
PRIMARY VISION INSURANCE	SECONDARY VISION INSURANCE	
COMPANY NAME: {PATIENT_INSURANCE_VISION_PRIMARY_COMPANY}	COMPANY NAME: {PATIENT_INSURANCE_VISION_SECONDARY_COMPANY}	
POLICY ID NO.: {PATIENT_INSURANCE_VISION_PRIMARY_ID}	POLICY ID NO.: {PATIENT_INSURANCE_VISION_SECONDARY_ID}	
POLICY GROUP: {PATIENT_INSURANCE_VISION_PRIMARY_POLICYGROUP}	POLICY GROUP: {PATIENT_INSURANCE_VISION_SECONDARY_POLICYGROUP}	
INSURED PARTY: {PATIENT_INSURANCE_VISION_PRIMARY_NAME}		
PRIMARY MEDICAL INSURANCE	SECONDARY MEDICAL INSURANCE	
COMPANY NAME: {PATIENT_INSURANCE_MEDICAL_PRIMARY_COMPANY}	COMPANY NAME: {PATIENT_INSURANCE_MEDICAL_SECONDARY_COMPANY}	
POLICY ID NO.: {PATIENT_INSURANCE_MEDICAL_PRIMARY_ID}	POLICY ID NO.: {PATIENT_INSURANCE_MEDICAL_SECONDARY_ID}	
POLICY GROUP: {PATIENT_INSURANCE_MEDICAL_PRIMARY_POLICYGROUP}	POLICY GROUP: {PATIENT_INSURANCE_MEDICAL_SECONDARY_POLICYGROUP}	
INSURED PARTY:	INSURED PARTY:	
<p>MEDICAL INSURANCE POLICY: As part of our services at this practice we are happy to assist you in determining the benefits of your individual policy and in collecting your reimbursement of insurance benefits for medical services. To avoid any misunderstandings please read the following statements carefully:</p> <ol style="list-style-type: none"> The legal obligations of your insurance provider are between yourself and your provider, not between this practice and your provider. When your insurance provider (s) has settled your plan's covered items, you will be notified by a monthly statement if there were any unpaid balances. Unpaid balances can include non-covered items or services, co-pays, deductibles, lapses, ineligibility or termination of coverage's. Unpaid balances are the sole responsibility of the patient. To keep the cost of records and collections down any patient portion amounts on your order will be due at the time of service. I authorize the use of this form on all insurance submissions as well as authorizing the release of information to all my insurance companies as well as allowing the doctor to act as my agent to help me in obtaining payment from my insurance companies. I authorize payment to be made directly to the provider and permit a copy of this authorization to be used in place of the original. <p>REFUND/RETURN POLICIES: No refund can be made on clinical procedures or services, including comprehensive eye examination, refraction, contact lens fitting, and medical office visits. Refunds for optical products, which include frames, lenses, and unopened boxes of contact lenses can only be made within 30 days of receiving the product, provided that the product is returned to the store without damage at the time that the refund is issued. Opened boxes of contact lenses are non-refundable. After the 30 days period, only 50% of the original payment made by the patient (private-pay or with insurance) can be issued back to the patient as store credit with the return of the product. 90 days after a product is dispensed, no refund, no exchange, no return can be made on any goods purchased at this store.</p> <p>CONSENT FOR TREATMENT: I hereby authorize {MYCOMPANYINFORMATION_COMPANYNAME} to administer diagnostic and medical procedures as may be necessary for proper health care.</p>		
Signature of patient or authorized representative Name of Patient: {PATIENT_NAME_FULL}	Date	
Authorized representative's name		



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HIPAA CONSENT

Patient Name:	{PATIENT_NAME_FULL}
Account No.:	{PATIENT_PATIENTID}
Printed:	{DATE_TODAY} {TIME_STAMP}

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION	
<p>Permission to Use and Disclose My Health Information: By signing this form, I give {MYCOMPANYINFORMATION_COMPANYNAME} permission to use and/or disclose my health information to provide treatment, obtain payment, and/or conduct health care operations.</p> <p>Right to Refuse: I have the right not to sign this consent. If I refuse to sign this consent, {MYCOMPANYINFORMATION_COMPANYNAME} has the right to refuse to treat me. However, treatment required by law –such as emergency care– can be provided to me whether or not I sign this consent.</p> <p>Right to Review Notice of Privacy Practices: I have been provided with a copy of the Notice of Privacy Practices for {MYCOMPANYINFORMATION_COMPANYNAME} which describes how {MYCOMPANYINFORMATION_COMPANYNAME} may use and disclose my health information. I have the right to review this Notice before signing this consent.</p> <p>Changes to the Notice of Privacy Practices: {MYCOMPANYINFORMATION_COMPANYNAME} may change the Notice of Privacy Practices as needed. I may obtain a current copy of the Notice of Privacy Practices for {MYCOMPANYINFORMATION_COMPANYNAME} by contacting {MYCOMPANYINFORMATION_COMPANYNAME}.</p> <p>Right to Request Restrictions on Use/Disclosure: I have the right to request that the usage of my protected health information by {MYCOMPANYINFORMATION_COMPANYNAME} be restricted in how it is used and/or disclosed for the purpose of providing treatment, obtaining payment, and/or conducting health care operations. However, {MYCOMPANYINFORMATION_COMPANYNAME} is not required to agree to any restriction that I request. If {MYCOMPANYINFORMATION_COMPANYNAME} does decide to agree to my request, the use and/or disclosure of my health information by {MYCOMPANYINFORMATION_COMPANYNAME} must be restricted as I requested. If I wish to request restrictions I can contact {MYCOMPANYINFORMATION_COMPANYNAME}. {MYCOMPANYINFORMATION_COMPANYNAME} will notify me on whether my restrictions have been accepted or declined.</p> <p>Right to Withdraw Consent: I have the right to withdraw this consent at any time. I must do so in writing by contacting {MYCOMPANYINFORMATION_COMPANYNAME} at {MYCOMPANYINFORMATION_ADDRESSLINE}, {MYCOMPANYINFORMATION_CITY}, {MYCOMPANYINFORMATION_STATE} {MYCOMPANYINFORMATION_ZIPCODE}. My withdrawal of this consent will not be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then {MYCOMPANYINFORMATION_COMPANYNAME} may refuse to provide to me further treatment or follow-up, other than required emergency services.</p> <p>Effective Period: This consent is good unless and until I withdraw it in writing.</p> <p>References to "I" or "me": References to "I" or "me" in this Consent include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, it is because I am that person's parent, legal guardian, or agent under an active Power of Attorney for Health Care; and I am legally authorized to sign this Consent on behalf of that person.</p>	
Signature of patient or authorized representative Name of Patient: {PATIENT_NAME_FULL}	Date
Authorized representative's name	
FOR OFFICE USE ONLY	
Complete this section if this form is not signed and dated by the patient or an authorized representative for the patient.	
<p>I have made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices for {MYCOMPANYINFORMATION_COMPANYNAME} but was unable to for the following reason:</p> <p><input type="checkbox"/> Patient refused to sign</p> <p><input type="checkbox"/> Patient is unable to sign</p> <p><input type="checkbox"/> Other _____</p>	
Signature of employee	Date
Employee's name	