20/20 EYE WELLNESS OPTOMETRY

Last Name: _____ **First Name:** _____ **Nickname:** _____

SECTION ONE : PERSONAL INFORMATION

* Required if using any insurance coverage or Medicare

***Date of Birth** ____/____/_____ ***Sex:** ☐ Male ☐ Female ***Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Driver's License number _____ **State** _____ ***SSN** _____ - _____ -_____

***Home Address:** _____ ***City**_____ ***State** ____ ***Zip Code** _____

Home Phone Number: _____ **Cell Phone Number:** _____

Employer Name:_____ **Work Phone Number:** _____

Email Address _____

***Contact Preference:** ☐ Home phone ☐ Cell phone ☐ Work phone ☐ Email

***Preferred Language:** ☐ English ☐ Spanish ☐ Mandarin ☐ Cantonese ☐ Other: _____

***Race:** ☐ American Indian ☐ Asian ☐ African American ☐ Pacific Islander ☐ White ☐ Other ☐ Decline to Answer

***Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic nor Latino ☐ Decline to Answer

INSURANCE:

Vision Insurance _____ **Subscriber Name** _____ **DOB** ____/____/____

SSN _____ - _____ -_____ **Member ID** _____

Medical Insurance _____ **Subscriber Name** _____ **DOB** ____/____/____

SSN _____ - _____ -_____ **Member ID** _____ **Group #** _____

EMERGENCY CONTACT:

Name: _____ **Relationship to Patient:** _____

Phone Number: _____ **Email Address:** _____

May we release your patient health information to this Emergency Contact? ☐ Yes ☐ No

REFERRAL SOURCE: *(Check all that apply)*

☐ Friend/Family Member and their name:_____☐ Another Physician and name: _____

☐ Google ☐ Facebook ☐ Yelp ☐ Pinterest ☐ Yellow Pages ☐ Insurance

☐Other_____

SECTION TWO: LIFESTYLE QUESTIONNAIRE

Current Occupation: _____

Hours per day spent on computer/mobile devices: _____

Hobbies: *(i.e.: Piano, Golf, Tennis, Swimming, Reading)*_____

Drive at night: ☐ Yes ☐ No **If yes, are you experiencing glare?** ☐ Yes ☐ No

Spending in the sun over 2 hours/ day? ☐ Yes ☐ No

Are you currently happy with your glasses? ☐ Yes ☐ No If no, why?_____

Do you own a pair of sunglasses? ☐ Yes ☐ No

(TURN OVER)

***SECTION THREE: MEDICAL HISTORY**

How can we help you today? What's the main reason of your visit today?

_____

_____

Eye History: *(Check off any box that applies to you)*

□ Dry Eyes

□ Injury / Trauma – If so, which eye? _____

□ Retinal diseases _____

□ Eye infections Right/Left Eye

□ Corneal diseases_____

□ Lasik – If so, how many years ago: _____

□ Contact lens – If so, what brand of contacts and prescription?_____

Family Eye History: *(Check the box that applies to your family member and indicate which family member)*

☐Glaucoma _____

☐Macular Degeneration _____

☐Cataract _____

☐Corneal/Retinal Disease_____

HEALTH WELLNESS: *(Check any box that applies to you or your family. If you select "Family Member", please indicate who in your family)*

Patient	Family Member(s)	Condition(s)
□	□ _____	**Diabetes** _____ years
□	□ _____	**Hypertension/ High Blood pressure**
□	□ _____	**Thyroid Diseases**
□	□ _____	**Autoimmune Diseases** *(i.e.HIV, Lupus, Rheumatoid Arthritis)* _____
□	□ _____	**Heart Disease**
□	□ _____	**Asthma**
□	□ _____	**Cancer Type:** _____
□	□ _____	**Pregnant/Breast feeding**
□	□ _____	**Cholesterol**
☐	☐_____	**Anxiety/Depression**
□	□ _____	**Smoker If no, Former smoker** □ Yes □ No
□	□ _____	**Alcohol/Tobacco**

Other: _____

_____

_____

CURRENT MEDICATION(S): _____

_____

_____

ALLERGY TO MEDICATION: _____

_____

20/20 EYE WELLNESS OPTOMETRY

FINANCIAL POLICY AND PATIENT PAYMENT AGREEMENT

Our financial relationship is with you, the Patient. You, not your insurance company, are ultimately responsible for the payment of all fees charged. If you have insurance, we will accept assignment from your insurance company for any covered product or service. You agree to assign payment from your insurance company for any covered product and service. We require payment in full for any uncovered portion of your care and any deductible. Due to the personal nature of our products, ALL SALES ARE FINAL. There are no exchanges or refunds. The average turnaround time for prescription eye wear is 10 to 15 business days (2 to 3 weeks). All completed orders should be picked up within 60 days following notification. For any order not picked up with sixty days, Patient authorizes 20/20 Eye Wellness Optometry to discard or donate the order. There is no charge for one prescription re-check within 60 days of the initial exam date. Additional prescription re-check(s) will be charge a fee of $50.00 per re-check. A fee of $25.00 per page will be charged for any forms filled out or letters written by our doctor(s).

LIMITED MANUFACTURER'S WARRANTY

20/20 Eye Welness Optometry does not provide any warranty for any frames or lenses. Only frames with a retail price above $100 are warranted against manufacturer's defects and are only warranted during the first twelve months from the date of purchase. In the event of a manufacturer's defect, the frame is generally replaced at no charge during the warranty period. Frame warranties do not apply to any loss, accidental damage, or normal wear. Frames on clearance and frames that are part of “Package Deals” have no warranty and are sold as is. Lenses are generally warranted against manufacturer's defects and are only warranted during the first sixty days from the date of purchase. In the event of a manufacturer's defect, the lenses are generally replaced at no charge during the warranty period. There is no warranty for lens coatings, except for premium anti-reflective coatings and anti-scratch coatings. Premium anti-reflective coatings and anti-scratch coatings are generally warranted against manufacturer's defects, but are only warranted during the first twelve months from the date of purchase. Lens warranty and lens coating warranties do not apply to any loss, accidental damage, or normal wear. There are no lens or lens coating warranties provided by lenses made through Davis Vision or Spectera. Prescription lenses may be replaced once within 60 days of the original purchase date at no charge if there is difficulty adapting to a new prescription. Additional replacements will be charge at 20/20 Eye Wellness Optometry's usual and customary rates.

WAIVER ON FRAMES NOT PURCHSED AT 20/20 EYE WELLNESS OPTOMETRY OR OUT OF WARRANTY

20/20 Eye Wellness Optometry does not accept any responsibility for frames or lenses not purchased at 20/20 Eye Wellness Optometry. 20/20 Eye Wellness Optometry does not accept any responsibility for frames or lenses purchased at 20/20 Eye Wellness Optometry more than one year ago. By providing us with your frame or lenses, you accept all risk for any damage that may occur and agree to hold harmless 20/20 Eye Wellness Optometry and its agents for any liability that may arise. This paragraph applies to all services provided by 20/20 Eye Wellness Optometry including frame adjustments, lens removals and lens insertions.

HIPAA CONSENT TO ELECTRONIC COMMUNICATION

By providing your email address or mobile phone number to our office, you consent to receiving your protected health information from 20/20 Eye Wellness Optometry through electronic communication, including but not limited to email and SMS text messaging. You may withdraw your consent at anytime by asking us to remove both your email address and mobile phone number from our records.

MISSED APOINTMENTS – LATE CANCELLATIONS – LATE ARRIVAL

When you schedule an appointment with us we reserve this time exclusively for your care. We will do our best to confirm your appointment; however, it is your responsibility to keep the appointment. A fee will be charged for consistently missed appointments, late arrivals, or late cancellations. We require 48 hours notice for all cancellations.

I, the undersigned, understand and agree to the terms and conditions stated above.

_____ Date _____
Signature of the Patient

_____
Printed Name of the Patient

_____ Date _____
Signature of Parent or Guardian *(if Patient is under 18)*

_____
Printed Name of Parent or Guardian *(if Patient is under 18)*

02/19

20/20 EYE WELLNESS OPTOMETRY

Contact Lens Evaluation and Fitting Fees*

	Renewal Fees [1]	New Fit Fees [2]
Basic Soft Spherical Contacts	$50	$120
Advanced Soft Contacts with Astigmatism/ Basic Ridge Gas Permeable (RGP) Contacts	$75	$145
Multifocal/Monovision Soft Contacts Advanced RGP, RGP Bitoric, RGP Multifocal	$95	$165
Medically Necessary Contacts	Starts at $400	$400

*All fees are due at the time of service and are non-refundable

[1] Renewal Fees - Include the following:

* Detailed history of vision needs as pertains to the choice of contact lens
* Full slit lamp microscopic examination of the cornea, conjunctiva and contact lenses on both eyes
* Determination of contact lens power, base curve, and diameter on both eyes (different from glasses prescription)
* Microscopic evaluation of the fit, centration, movement of contact lens
* One contact lens follow up made within sixty (60) days of the initial contact lens fitting date

[2] New Fit Fees- Include the following:

* Education and training on insertion, removal, and care of contact lenses
* Starter set of contact lens solution, contact lens case, and prescription trial contact lenses
* Two contact lens follow up visits made within ninety (90) days of the initial contact lens fitting date

Additional contact lens follow ups will be charges at the renewal rate above. If there is difficulty adapting to the new contact lens prescription, undamaged and unopened contact lenses boxes may be replaced within sixty (60) days of the original purchase date and is subject to a 15% restocking fee. Damage is considered to be any marks, dents, tears, rips and/or punctures.

I, the undersigned, have read and understand all of the above information.

_____ Date _____
Signature of the Patient

_____
Printed Name of the Patient

_____ Date _____
Signature of Parent or Guardian *(if Patient is under 18)*

_____
Printed Name of Parent or Guardian *(if Patient is under 18)*