Brier Creek Vision Care

Welcome to Our Office
Patient Information

Last Name First Name Middle Initial Nickname

Birthdate: _____ SocialSecurity#: _____

Sex: (Circle) Male / Female Marital Status: (Circle) S M D W Race: (Circle) White African American Hispanic Asian Other

Address Apartment# City State ZipCode

Home Phone Cell Phone Work Phone

Email Address: _____

How did you hear about our office? _____

Employer: _____ Occupation: _____

Insured Information

Vision Insurance Provider: _____ Insurance ID Number: _____

Primary Insured's Full Name: _____
Last Name First Name Middle Initial

Primary Insured's DOB: _____ Relationship to Patient: (Circle) Self Spouse Parent

Major Medical Insurance Provider: _____ Insurance ID Number: _____

Primary Insured's Full Name: _____
Last Name First Name Middle Initial

Primary Insured's DOB: _____ Relationship to Patient: (Circle) Self Spouse Child

Authorization For Release of Information

I authorize the following information **(initial each that is appropriate)** to be released for the above name patient

_____ Financial or billing information
_____ Medical information including test results
_____ Pick up of glasses or contact lenses

Authorized Persons:

_____ Relationship: _____

_____ Relationship: _____

Payment Information

It is the patient's responsibility to provide all insurance information at the time services are rendered. Failure to provide this information will result in being responsible for service costs out of pocket. At that time it will be the responsibility of the member to file their insurance for reimbursement. I authorize Brier Creek Vision Care to file my insurance on my behalf and directly collect payment. I understand that payment in full is expected at the time professional services are rendered and/or materials are ordered; this includes all non-covered services, cop-pays, and deductibles that insurance does not cover. A charge of 1.5% per month will be added to all accounts 30 days past due. Failure to pay balances in the allotted time will result in patient occurring additional costs including, but not limited to attorney or legal fees, collection agency fees, and finance charges.

_____
Signature Date

Consent for Dilation

During the course of an examination, the doctor may determine it is necessary to dilate the pupils of your eyes. This allows a more thorough examination of the health of the inside of the eye. To dilate the pupils, eye drops are administered. Once the pupils are dilated, it is common to be sensitive to light. To help cope with this sensitivity, a disposable pair of sunglasses will be provided to you. Another common symptom is blurred vision, especially at near. It will require about 2-3 hours for your vision to return to normal. During this time, you must exercise caution when walking down steps, driving a vehicle, operating dangerous machinery, or performing other tasks that may present a risk of injury.

I have read and understand the benefits and side effects of pupillary dilation.

_____ Yes, I consent to dilation _____ No, I do NOT consent to dilation

Patient/ Parent Signature _____ Date _____

Optomap Ultra-Wide Digital Retinal Imaging

Brier Creek Vision Care recommends Optomap Retinal Imaging for all of our patients. This non-invasive procedure allows the doctor to see a much broader detailed view of the retina than is possible with conventional methods. When reviewed, the scan becomes a permanent part of your medical file, enabling your doctor to make important comparisons should potential vision threatening conditions appear during a future examination. As a part of your pre-test work up, we will capture Optomap images for review during your examination today. The $39 fee for this procedure is generally a non-covered service unless being used to actively follow disease. Any questions you have about Optomap Retinal Imaging can be directed to the doctor when she reviews the images with you during your examination.

_____ Yes, I consent to Retinal Imaging _____ No, I do NOT consent to Retinal Imaging

Patient/ Parent Signature _____ Date _____

Cancellation Policy/ No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. If an appointment is not cancelled at least 24 hours in advance or you fail to cancel an appointment and do not show up, you will be charged a twenty-five dollar ($25) fee; this will not be covered by your insurance company.

By signing below, you understand and agree to this policy.

Patient/ Parent Signature _____ Date _____

HIPAA Privacy Policy

Located in our waiting area, is a copy of our HIPAA privacy policy. Please review this policy carefully. If you have any questions regarding this policy, please feel free to ask one of our staff members. If you would like a copy of this policy for your own records, please ask a staff member and we will provide one for you.

A HIPAA privacy policy was made available to me today. I have read and understand the HIPAA privacy policy.

Patient/ Parent Signature _____ Date _____