Welcome Back Forms

Name:_____ Date: _____
Address: _____ Home # _____
City, Zip:_____ Work # _____
Email: _____ Cell # _____
D.O.B: _____

Communication Preference (circle): Email Phone Text

Marital Status:_____ Employment Status: Full Time Part time Student
Employer :_____ Occupation:_____

Are you interested in contacts □ No □ Yes Are you interested in Lasik □ No □ Yes

Any changes in medications or medical history ? □ No □ Yes

If yes please explain:_____
_____

Policy & Procedures

Financial Agreement and Policy:

I understand that I'm **fully responsible** for the total cost of payment for all procedures and services performed at this office. I agree to pay my balance in full at the time of services, this includes unmet deductibles and Copays. We do require a **50% deposit** on any optometric materials before an order can be placed. Deposits for materials not picked up **within 90 days** will be forfeited. In our continued commitment to provide excellent and convenient service, we will first apply any insurance benefits to the best of our ability. **Care Credit** is also accepted.

All transactions are final NO REFUNDS.

Sign:_____ **Date:**_____

Receipt of Notice of Privacy Policies & Consent Form (Laminated Form):

I have read and understood the Notice of Privacy Practices from Advanced Family Eye Care. I consent to the use and disclosure of my health information for purposes of treatment, payment and healthcare operations.

Sign:_____ **Date**:_____

Fundus Photo / I-Wellness Scan
Release Of Liability Authorization:

Dr. Hosaka and Dr. Parfenova recommends that all patients have their retina evaluated annually to detect eye diseases, such as **Macular degeneration, glaucoma, diabetes and cholesterol.**

(Option.1) Fundus Photo. This would include **<u>one</u>** image of the retinal vasculature (blood Vessels), the optic nerve, where retinal blood vessels enter the eye. Your ***copay*** would be ***<u>$20</u>***

(Option.2) I-Wellness scan*.** This would include ***<u>two</u> digital images similar to an (**MRI/Ultrasound**) of your retina. It detects early stages of eye diseases that would otherwise go undetected.
Your ***<u>Co-pay</u>*** would be ***<u>$39</u>***.

Both options provide a digital record of your eye health that will be compared year to year.

<u>Please Choose one option below:</u>

(Option.1) Fundus Photo: Yes / No

(Option.2) I-Wellness Scan : Yes / No

Initial:_____ **Date**:_____

Soft Contact lens fitting and evaluation policies and fees

Soft contact **lens fitting** and **evaluation Exams** are a **separate** professional service. Soft contact lens prescriptions are valid for one year from the date of finalized prescription. Fitting and evaluation fees are based on the complexity of your prescription and lifestyle needs.

(Prices listed below do not include contact lens benefits/Insurance)
(The Doctor will determine the benefit level)

Level 1 - **$95** Established patient evaluated with spherical contact lenses previously fitted at this office with no changes in lens type or material. Finalized the same day.

Level 2 -$120 New or established patient fitted and evaluated with spherical contact lens; single powered lens includes **2 follow-up** evaluations within **30 days** from the initial exam

Level 3- $140 New or Established patient fitted & evaluated with toric lens (astigmatism) **(example: colored contact lenses, daily and monthly replacements)** includes **2 follow up** visits with in **30days** from initial visi**t**

Level 4- **$165** New or established patient fitted & evaluated with multifocal lens. (For the correction of distance and near vision) Includes **3 follow up** visits within **45 days** from the initial contact lens exam.

Level 5- **$275** New or established patient exam & evaluation of multifocal-toric contact/ monovision (For the correction of distance/near with patients that have astigmatism. Includes **5 follow** up evaluations with **insert removal training: $30**
You must return to the office for contact lens follow-ups. Be sure to be **wearing** the **contact lenses** that you received from this office when you return for your **follow-up visit.** This is so the doctor can evaluate the lenses after they have been in your eyes for a period of time. If for some reason you're not able to wear contact lenses to the appointment please call the office before your follow-up visit and a new set of contact lenses will be given to you.

Additional contact lens follow up exams are $45 per visit. Office visits that fall outside the prescribed timelines for each level will be subject to additional exam fees.
Lenses purchased cannot be returned or exchanged after 30 days. Contact lens **boxes** must be **unopened and unmarked** for us to return to the manufacturer. **Custom** orders cannot be returned.
We are not responsible for the accuracy or quality of lenses purchased outside of the office. Patients who purchase outside of the office are not eligible for courtesy contact lens replacements.

I have read and understand the above policies:

Print Name: _____