RETURNING PATIENT FORM

Advanced Family Eye Care Optometry

22809 Hawthorne Blvd, Torrance, CA 90505

PATIENT INFORMATION:

Name: D.O.B.:

Address: Home #

City, ZIP: Work #

E-mail: Cell #

Social Security: Marital Status: Race/Ethnicity:

Employment status: Employer: Occupation:

Would you like to be contacted by: phone text, or email (circle option)

Do you wear glasses? □ Yes □ No Do you wear contacts? □ Yes □ No

Are you interested in contacts? □ Yes □ No Are you interested in LASIK? □ Yes □ No

Preferred Pharmacy (phone and address):_____

Are there any changes in medications or medical history? □ No □ Yes

If yes, please explain:_____

_____

Any, changes in your insurance policies (vision and medical) since your last visit? If yes, please fill out:

INSURANCE POLICY HOLDER (if different than patient):

Name: D.O.B.:

Patient relationship:

Address: Home#

City, Zip: Work#

E-mail: Cell #

Social Security: Employer:

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PLEASE READ THE BELOW AGREEMENTS CAREFULLY; YOUR SIGNATURE IS ACKNOWLEDGEMENT AND AGREEMENT.

POLICIES & PROCEDURES, FINANCIAL AGREEMENT AND POLICY:

I understand and agree that I am fully responsible for the total amount for all procedures and services performed at this office and will make in full & prompt payments, including any unmet deductibles and copayments. **Deposits for materials not picked up within 90 days will be forfeited**. ***All transactions are final. No refunds.***

RECEIPT OF NOTICE OF PRIVACY POLICIES & CONSENT 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.

APPOINTMENT RESERVATION POLICY:

Should you need to cancel or reschedule an appointment please contact our office 2 business days before your scheduled eye appointment. Patients who fail, to show, or cancel/reschedule an appointment without a 2 business days notice will be charged a $25 fee for weekday appointments and a $50 fee for a Saturday appointment.

YOUR SIGNATURE BELOW IS AN AGREEMENT AND ACKNOWLEDGEMENT OF THE ABOVE POLICIES AND FEE AGREEMENTS.

Patient/Guarantor Signature: _____

Date:_____

I-WELLNESS SCAN RELEASE OF LIABILITY AUTHORIZATION:

Doctors recommend that all patients have the inside of their eye health evaluated annually to detect any eye health diseases. This procedure will not cause blurry vision or side effects, results are reviewed at the same visit.

I-Wellness Scan: Two picture images **(similar to an ultrasound or X-ray)** can show **drusen, abnormal bleeding, scar tissue, Macular Degeneration, Glaucoma, Diabetes, High blood pressure, and cholesterol.** **Your copay would be $39.**

□ **Yes, I agree** □ **No, I decline to have the health of my eyes examined today**

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PLEASE READ THIS CONTACT LENS FINANCIAL AND POLICY AGREEMENT CAREFULLY.

A contact lens is a medical device that rests on the front surface of the eye. The shape and the prescription of the eye can change, we require additional annual testing and evaluation of the contact lenses on your eyes to check the fit and vision before releasing a prescription. This contact lens evaluation and fitting process is a professional service separate from your annual eye examination. Contact evaluation fees are based on the complexity of your prescription and lifestyle needs which can affect the contact lens levels determined by the doctor. Contact lens prescriptions are valid for one year from the date of the finalized prescription. **The contact lens evaluation/fitting fees are below**

Soft Contact Lenses	**up to $315.00**, including 2 follow-up visits within 30 days from the initial visit.
Rigid Gas Permeable lenses, Scleral lenses, Custom contacts	**$1,000 to $2000.00;** includes 5 follow-up visits within 30 days from the initial visit.
Contact lens insertion & removal training, first-time wearer or established re-training	**$30.00**

You must return to the office for contact lens follow-ups. Be sure to wear the contact lenses that you received from this office when you return for your follow-up visit.

Additional contact lens follow-up exams are $45 per visit. Office visits outside the prescribed timelines will be subject to additional exam fees. All professional fees must be paid promptly on the date of service.

Lenses purchased cannot be returned or exchanged after 30 days. Contact lens boxes must be unopened and unmarked for return to the manufacturer. Custom orders cannot be returned and will not be refunded.

Advanced Family Eye Care Optometry is not responsible for the accuracy or quality of lenses purchased outside the office. Patients who buy outside the office are not eligible for courtesy contact lens replacements.

Deposits for material not picked up within 90 days will be forfeited, no refunds are available.

I have read, understand, and agree to the above policies and fee agreements:

Print Name: _____

Signature: _____

Date: _____