Child & Family EyeCare Center

Welcome to our office!

Patient Information

Name: _____ Date of Birth:_____/_____/_____

Address:_____ Home Phone: _____

City, State, ZIP_____ Cell Phone:_____

Parent / Guardian:_____ Preferred Contact Method:
□ Home Phone □ Cell Phone
□ Email □ Text

Email: _____

Would you like to receive our quarterly e-newsletter, *The Vision & Learning Connection* ? □ Yes □ No

Please tell us how you heard about our office?
□ Friend/Family Member □ Doctor Referral □ Insurance □ Internet □ Other

Please specify the name so we may thank them: _____

Medical Insurance and Vision Plan Information

Medical Insurance:_____ Vision Plan *(VSP or EyeMed)*: _____

Policy/ID # _____ SSN/Policy ID # _____

Name of Policy Holder_____ Name of Policy Holder _____

Date of Birth _____ Date of Birth_____

Contact Lens Fitting & Evaluation

A contact lens evaluation is defined as measurement of the size and shape of the cornea, prescription to maximize visual acuity, and an assessment of the contact lens on the eye. A contact lens evaluation is necessary to prescribe contact lenses. The contact lens evaluation also includes an insertion and removal instructional appointment (if necessary) and one month of follow up care (as recommended by the doctor). The follow-up care visits are for appointments related to contact lens evaluation issues only. If a visit is due to another condition, there will be a separate charge. A contact lens evaluation charge is in addition to routine eye exam, the contact lens supply, or any other charges/services performed by the doctor. All contact lens fitting and evaluation fees are for time spent with the doctor and are non-refundable.

$30 - Current contact lens wearers
$69 - New contact lens wearers, multifocal lens fitting, RGP lenses
$499 and up – Keratoconus, CRT, scleral lenses, and other specialty contact lenses

Authorization & Release

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: (1) conduct, plan and direct my treatment and follow-up among healthcare providers who may be involved in my treatment directly and indirectly, (2) obtain payment from third party payers, (3) conduct normal healthcare operations such as quality assessments and doctor certifications.

Eye care services and products are recommended for your optimum eye health and vision needs. While we are happy to bill your insurance we do not guarantee they will cover the services we provide or any optical goods you may purchase. It is your responsibility to determine the nature and extent of your coverage. Any service or product not covered by your insurance will be your responsibility. The fact that your insurance company may not cover a particular service or product does not mean you should not receive it.

I have read and understand the above information.

Printed Name_____ Signature_____
Date_____