EYE PRIORITY

Medical VS Vision Insurance and Understanding Your Coverage

Vision insurance includes the coverage of a comprehensive eye exams and the purchase of glasses or contact lenses. Most plans do not cover 100% of expenses and thus you should expect some out-of-pocket costs such as co-pays or deductibles as required by your insurance policy. At Eye Priority the patient's portion and co-pays must be paid at the time of visit and before materials (glasses or contacts) can be ordered. Your insurance is a contract between you, your employer, and the insurance company, not with our staff. We cannot alter or change your co-pays.

Medical concerns (Glaucoma, Dry Eyes, Macular Degeneration, Floaters, Allergic Conjunctivitis, Etc…) will be treated first or concurrently with a vision problem. Sometimes a medical condition needs to be treated or corrected before vision for glasses and contact lenses can be accurately evaluated. Medical issues do not fall under vision insurance coverage. Eye Priority is not contracted with medical insurance, however, we ask for information on your medical insurance in the event we need to make a referral to a specialty provider.

Retinal Examination:

Our doctors are concerned about your retinal health. Retinal diseases such as Macular degeneration, glaucoma, retinal detachments, diabetic retinopathy, and systemic diseases such as diabetes and high blood pressure can be detected with a retinal examination. The Optomap Digital Retinal Imaging allows us to thoroughly evaluate your internal eye health with dramatically improved precision that includes views not seen with regular dilation. With an annual Optomap our doctors can track your eye health for concerns, comparison, and treatments.

The co-pay for the Optomap is $40. Depending on your insurance, certain plans do offer a lower co-pay ranging from $25-$39.

Missed or Cancellation of an Appointment:

Cancellation of an Appointment: We understand that situations arise in which you must cancel your appointment. In order to be respectful it is requested that you provide our office with a 24 hour notice of a cancellation. Appointments are in high demand, and your early cancellation will allow another patient access to timely medical care. If an appointment is canceled 3 times with less than 24 hour notice you will be subject to a $25 charge in order to re-book.

Missed Appointment Policy: Patients who do not show up for their appointment without a call to cancel will be considered as a no show. A $20 no show fee may be charged. If an appointment is missed 2 times you will be charged a $50 fee to re-book an appointment.

Please sign that you read, understand and agree to the Cancellation and No Show Policy.

Patient Signature:_____ Date:_____

Patient Registration

Last:_____ First:_____ MI_____ Sex: M/F

Address:_____

Date of birth: _____Age:_____Email:_____

Cell Phone:_____ Home Phone:_____

Preferred method of contact: Email Cell Home

Marital Status: Single Married Divorced Widowed Separated

Last Eye Exam:_____Name of Doctor:_____

How did you hear about Eye Priority_____

Household family member's that are patients: (Names & Age)

_____

Occupation:_____ Employer:_____

Vision Insurance Information

Circle One: VSP Eyemed Avesis Spectera Medicare or Private Pay

Person responsible for account: _____Relationship to patient:_____

Policy Holders Name(Last, First):_____ Policy Holder DOB: ____/_____/_____

Policy Holders SSN:_____ Relationship to Patient:_____

Member ID Number:_____ Group ID:_____

Medical Insurance Information

Medical Insurance:_____ PPO / HMO

Member ID:_____ Group ID:_____

Claims Address (located on back of insurance card):_____

Policy Holders Name (Last, First):_____ Policy Holder DOB: ____/_____/_____

Policy Holders SSN:_____

I authorize the release of my medical and/or information pertaining to my care at Eye Priority to my insurance.

Print Name: _____ Signature: _____

Date:_____

Emergency Contact

Emergency Contact:_____ Relationship to patient:_____

Phone Number:_____

Visual Needs Assessment

Hours of computer usage (per day):_____ Hours of outdoor activity:_____

Hobbies:_____ Sports:_____

Do you currently wear glasses? Yes / No Reading Computer Distance Sunglasses Progressive Bi-focal

Patient Medical History

Please list all medications/supplements you are currently taking and for what condition (including cold medications):

_____

_____

Do you smoke: No Yes Weekly amount: _____

Do you use alcohol: No Yes Weekly amount: _____

Do you use drugs: No Yes Weekly amount: _____

Allergies to prescriptions and non prescription medications:_____

_____

Surgical History: (list any prior surgeries/list any prior ocular surgeries):_____

_____

Have you even been diagnosed or treated for any of the following health problems? (Please circle)

Autism	Ear/Nose/Throat	Stroke
Cancer	Endocrine	Seizures
Cholesterol	Heart Disease	Thyroid
Diabetes	High Blood Pressure	
Digestive/Gastric	Seasonal Allergies	

Personal Ocular History: (Please circle)

Blurry Vision	Floater/Spots	Macular Degeneration
Burning	Glaucoma	Occasional Dryness
Cataracts	Grittiness	Retinal Detachment
Corneal Abrasions	Headaches	Sunlight Sensitivity
Eye Injury	Iritis/Uveitis	Tearing
Eye Infections	Itchiness	
Flashes of Light	Lazy Eye	

Family Ocular History: (Please circle & list who: parents, grandparents, siblings, children)

Blindness	Diabetes	Macular Degeneration
Cataracts	Glaucoma	Retinal Issues
Corneal Problems	Lazy Eye	

Contact Lens Agreement

Contact lenses are a medical device that have the potential for serious complications if not used and fitted properly. The standard of care from the Arizona State Board of Optometry requires an annual examination for renewal of a contact lens prescription. The ***estimated fee*** for services range between $60 - $175 which include any training for insertion and removal and follow up visits for up to a 60 day period.

By signing, you acknowledge that you understand the policies regarding your contact lens services and agree to the associated fees, these fees are subject to changes based on the doctors final assessment. Any improper usage of contact lenses as prescribed can lead to vision loss and permanent eye damage. If an infection is present you will need to be treated prior to being fitted with contact lenses.

Signature:_____ Date:_____

If you currently do not wear contact lenses, are you interested in contacts?_____

Current user of Contact Lens Questionnaire: (circle one) Spherical / Astigmatism / Multifocal

Specifications:
Brand of Contacts: _____ Solution Name:_____

LifeStyle:
Do you swim in your contact lenses? Yes / No
How would you describe your wear schedule: (circle one)
Occasional (1-2 days) Average (3-4 days) Everyday (6-7 days)
How many hours do you wear your lenses: (circle one)
Average (less than 8 hours) Long (9-16 hours) Extended (overnight)
Do you use eye makeup? Yes / No
What type of eye make up remover do you use? _____

Comfort:
Do you experience dryness with your contact lenses? Yes / No
Do you have difficulty with seasonal allergies: Yes / No

Vision:
Can you see **distance** comfortably with your contact lenses? Yes / No
Can you see **near** comfortably with your contact lenses? Yes / No

Hygiene:
Do you have a backup pair of glasses that you can see clearly with? Yes / No
Do you clean your contact lenses? Yes / No
How often do you change your contact lens solution? Daily Weekly Monthly
How often do you wash your case? Daily Weekly Monthly
How often do you change your contact lenses? Daily Bi-Weekly Monthly

How can we improve your experience with your contact lenses? _____
_____

Myopia Control (Control of near nearsightedness) questions:

How old is your child: (circle one)
Younger than 8 8-12 years old Over 12 years old
Is your child already myopic (nearsighted)? Yes / No / Not Sure
At what age did they become nearsighted?_____
How many hours per day does your child spend on close work (reading, tablet/phone, coloring) outside of school?
1 hour / 2-4 hours / 5-8 hours / 8+ hours