Welcome to River City Vision Center

(**Print the answers to all questions. Your information will remain confidential per HIPAA policy**)

Name: ____ **Nickname:** ____________________
First Middle Last

If minor, PARENT/GUARDIAN name: ____

Street Address: ______________________________ **Apt** _____ **City** ____________ **State** _____ **Zip** _______

Cell Phone: ____________________ **Home Phone:** __________________ **Email address:** ________________

Date of Birth: __________________ **Sex:** ❑ Male ❑ Female **SSN:** _________________________

Occupation (or Grade): ______________________ **Employer (or School):** ____________________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other

Who may we thank for telling you about our office? ❑ Insurance website ❑ Internet Search ❑ Previous Patient
❑ Walk By/Signage ❑ Referral from Friend or Family Member ____________________________

Race: ❑ African American ❑ Asian ❑ Caucasian ❑ Hispanic ❑ Native American ❑ Other

Preferred Language: ❑ English ❑ Other: ____________________

The name of your Medical Doctor is: ______________________________ **Phone:** ______________________

Emergency Contact: __________________ **Phone:** ____________ **Relationship to Patient:** ________________

Insurance Information
Medical Insurance:____________________________ Medical Insurance ID#:____________________________
Vision Insurance:____________________________ Vision Insurance ID#: ____________________________

Checking the Health of Your Eyes

The doctor strongly recommends all patients have the health of their eyes checked using our Retinal Screening Technology. This procedure involves capturing a scan of the back of the eye to detect ocular damage. This allows the doctor to evaluate for ocular diseases in more detail. We will also be able to track any changes that may occur through time. The screening is side effect free and may reduce exam time. It is NOT covered by any insurance and is an additional cost of $39.
*Disclaimer: If any abnormalities are detected, the doctor may dilate the pupils for further investigation.

_________**I elect the Bundle Advance Screening Technology for a full health check of my eyes ($49)**

_________ **I elect the Retinal Screening Technology to check the health of my eyes. ($39)**

_________ **I elect Dilation for the health check of my eyes.**

The Florida Board of Optometry has established that a comprehensive eye examination for a new patient includes a Dilated Fundus Exam. This procedure involves putting one or more drops in each eye that will dilate the pupils. The doctor will study the internal structures of your eye to ensure proper health. The drops administered will cause light sensitivity and some degree of blurred vision, especially near vision (effects can last up to 5 hours). Driving may be affected and should be done with extreme caution. Because your safety is of utmost importance to us, we prefer that you have someone with you to drive.

Personal Eye History

What is the reason for your visit today? Glasses / Contacts / Both / Other: ______________________

Do you have any of the following problems? ❑ Eye Pain or Soreness ❑ Chronic Infection of Eye or Lid
❑ Loss of Vision ❑ Blurred Vision ❑ Distorted Vision/Halos ❑ Loss of Side Vision
❑ Double Vision ❑ Dryness ❑ Mucous Discharge ❑ Redness
❑ Sandy/Gritty Feeling ❑ Itching ❑ Burning ❑ Floaters/Flashes
❑ Excess Tearing/Watering ❑ Glare/Light Sensitivity ❑ Tired Eyes
❑ Sties or Chalazion ❑ Foreign Body Sensation ❑ Other ______________

Had any Eye surgery: ❑ None ❑ Lasik ❑ RK ❑ Cataract ❑ Retina ❑ Glaucoma ❑ Eyelid ❑ Other __________

When was your last exam? (Approximately) ____________ **Doctor's Name/Location:** ________________

Do you wear GLASSES? ❑ Yes ❑ No **If YES, do you have them with you TODAY?** ❑ Yes ❑ No

When do you wear your GLASSES? ❑ Full time ❑ Part time ❑ Reading ❑ Distance/Driving ❑ Computer Use ❑ Safety

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If you wear CONTACTS, please answer: **Lens Type**: ❑ Soft Disposable ❑ Soft Yearly ❑ Color ❑ RGP (Hard)
❑ Monovision ❑ Bifocal/Multifocal ❑ For Astigmatism

If you know the Brand and Power of your contacts, please indicate: ______________________________

Personal Medical History (Many general medical conditions affect the eye and your vision)

❑ Please check this box if you DO NOT have any medical conditions.

Do you have problems with the following medical systems? (Please check all that apply in each box)

Constitutional ❑ **None** ❑ Weight loss ❑ Fatigue ❑ Trauma ❑ Fever ❑ Cancer ❑ Other ________	**Neurological** ❑ **None** ❑ Multiple sclerosis ❑ Epilepsy/Seizures ❑ Headaches ❑ Other ________	**Gastrointestinal** ❑ **None** ❑ Crohn's disease ❑ Colitis ❑ Ulcer ❑ Digestive concern ❑ Other ______
Allergic/Immunologic ❑ **None** ❑ Drug allergy ❑ Environmental Allergy ❑ Rheumatoid arthritis ❑ Lupus ❑ Other ________	**Endocrine** ❑ **None** ❑ Type 1 Diabetes ❑ Thyroid Dysfunction ❑ Type 2 Diabetes ❑ Hormonal Dysfunction ❑ Other ________	**Musculoskeletal** ❑ **None** ❑ Fibromyalgia ❑ Muscular dystrophy ❑ Osteoarthritis ❑Other________
Cardiovascular ❑ **None** ❑ Heart disease ❑ Stroke ❑ Vascular disease ❑ High Blood Pressure/HTN ❑ High cholesterol	**Blood/Lymphatic** ❑ **None** ❑ Anemia ❑ Leukemia ❑ Other ________	**Integumentary/Skin** ❑ **None** ❑ Eczema ❑ Rosacea ❑ Psoriasis ❑ Other________
Genitourinary ❑ **None** ❑ Urinary tract infections ❑ Kidney concerns ❑ Herpes ❑ Chlamydia ❑ HIV ❑ Other ________	**Psychiatric** ❑ **None** ❑ Depression ❑ Panic Disorder ❑ Schizophrenia ❑ Other ________	**Respiratory** ❑ **None** ❑ Asthma ❑ Bronchitis ❑ Emphysema ❑ Upper respiratory tract infection ❑ COPD ❑ Other ________
Ears, Nose & Throat ❑ **None** ❑ Sinus Problem ❑ Dry Throat/Mouth ❑ Other ________	List other medical conditions not mentioned here:	

Medication History

Do you take any prescription or non-prescription medicines regularly? ❑ yes ❑ no If yes, please list all medicines:

____

____

Do you have any medication allergies: ❑ None known ❑ Penicillin ❑ Sulfa drugs ❑ Other: ______________

Family Medical History

Is there any family medical history of any of the following? (If yes, please list their relationship to you)

❑ None ❑ Corneal disease ____________
❑ Blindness ____________ ❑ Lazy Eye ____________
❑ Cataracts ____________ ❑ Diabetes ____________
❑ Glaucoma ____________ ❑ Heart Disease ____________
❑ Macular ____________ ❑ Hereditary Disease ____________
❑ Retinal ____________ ❑ Other Eye Disorders ____________

Social History

Use tobacco? ❑ Yes ❑ No **Alcoholic Beverages?** ❑ Yes ❑ No **Illegal Drugs?** ❑ Yes ❑ No
Are you pregnant? ❑ Yes ❑ No **Breast feeding?** ❑ Yes ❑ No

River City Vision Center PA
12961 North Main Street, Unit 203
Jacksonville, FL 32218

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We welcome you to our practice and ask that you kindly complete all information below:

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HIPPA/CONSENT FOR THE RELEASE OF INFORMATION/RESPONSIBILITY FOR PAYMENT

I consent to the use and disclosure by the Office any information, e.g. health information concerning my vision examinations and products, to any party and/or agent, including, but not limited to my employer, medical or optical provider, health plan or plan sponsor ("plan"), as needed for the treatment, the payment of my vision benefit claims, and related customer communications regarding health care services provided by the Office (e.g. mailings of exam reminder/recall cards or explanations of services/products provided by the Office).

If I desire to seek third party reimbursement for the services received, I authorize the Office to submit a vision benefit claim for payment to any third party as identified. I understand that I am responsible for all charges incurred, including any portion not paid by any third party.

I understand that this consent for release of information is voluntary and I may revoke my consent at any time by notifying the Office in writing, except for any disclosure already taken in reliance of my consent to release of information. I understand that I may request the Office to restrict the use and disclosure of my information; however, the Office is not required to agree to my request.

ACKNOWLEDGEMENT OF PRECEIPT OF THIS NOTICE:

This Practice is concerned about the privacy of our patients health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your healthcare services will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment and will use and disclose your protected health information for treatment, payment and health care operations when necessary.

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VISION AND MEDICAL INSURANCE POLICY:

As part of our services at this practice we are happy to assist patient in determining the benefits of your individual policy and in collecting your reimbursement of insurance benefits for medical and vision services. To avoid any misunderstandings please read the following statements carefully:

1) The legal obligations of your insurance provider are between you and your provider, not between this practice and your provider.
2) When your insurance provider (s) has settled your plan's covered items, you will be notified by a monthly statement if there were any unpaid balances. Unpaid balances can include non-covered items or services, co-pays, deductibles, lapses, ineligibility or termination of coverage's. Unpaid balances are the sole responsibility of the patient.
3) To keep the cost of records and collections down any patient portion amounts on your order will be due at the time of service.
4) I authorize the use of this form on all insurance submissions as well as authorizing the release of information to all my insurance companies as well as allowing the doctor to act as my agent to help me in obtaining payment from my insurance companies.
5) I authorize payment to be made directly to the doctor and permit a copy of this authorization to be used in place of the original.

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REFUND/ RETURN POLICIES:

Frame Warranty:

All prescription frames are warranted against manufacturer's defects for 30 days. You can extend this frame warranty for one year by purchasing the Eyeglass Protection plan for $39.00. If a frame is discontinued, the frame will be replaced with a different model of equal or lesser value. The extended warranty allows coverage for one full year from the date of the original order. Frame and/or lens replacement under warranty for breakage or damage have a $20.00 copay for either frame or lens when used. Frame and/or lens warranties can only be used once per order. Patient's Own Frame (POF) does not have any warranty. River City Vision Center and the Lab used to make **the POF glasses will not be responsible for any breakage or damage of the frame during adjusting, repairing, cleaning, or glasses processing.**

Frame/Lens Warranty:

Frame and lens warranties vary based on insurance and lab used for processing. All self pay purchases will have the same 30 Day warranty available with the option to purchase the **Eyeglass Protection Plan for $39.00**. The extended warranty allows coverage for one full year from the date of the original order. Frame and/or lens replacement under warranty for breakage or damage have a $20.00 copay for either frame or lens when used. Frame and/or lens warranties can only be used once per order.

Prescription Lens Returns:

If the prescription lenses you ordered are not correct due to lab error or our doctor's error, please return within 30 days of your receipt of the product and they will be remade at no charge. Please note that since prescription lenses are customized and made especially for you, they are **NOT** refundable.

Contact Lens Returns:

If you wish to exchange or return contact lens, please return them within 30 days of your receipt of the product. ONLY unopened and unaltered contact lens vials or boxes may be returned or exchanged. Any boxes directly written on and/or marked by the customer will not be refunded or exchanged.

Cancelling an Eyeglasses Order:
There are no cancellations or returns on eyeglass orders unless approved by management. No refunds will be made unless approved by management.

MISC:
No refund will be made on clinical procedures, services, or prescription lenses. Eyeglasses/Contact lay-away must be paid in full before it is sent to be fabricated. Paid lay-away monies and eyeglasses/contacts will be forfeited if the amount is not paid in full within 2 months of original ordered date.

I acknowledge that I have received this Notice of Privacy Practices, Vision and Medical Insurance Policy, and Refund/Return Policies for River City Vision Center

Name of Patient (print): ____

____ ____
Signature of patient or authorized representative Date

TRIAL CONTACT LENS PERIOD

As with any drug or device, the use of daily wear or extended wear contact lenses is not without risk. A small, but significant percentage of individuals wearing daily wear or extended wear lenses develop potentially serious complications which can lead to permanent eye damage and vision loss.

The trial contact lens period is a time frame that trial contact lenses are dispensed to evaluate their comfort and vision. Generally, they are not to be worn for more than four weeks with removal every day before bedtime. The doctor REQUIRES you to return for a second visit, usually 1 to 2 weeks after the initial visit, with your contacts on (for at least an hour prior to the visit). THIS VISIT IS VERY IMPORTANT so that the doctor can assess the fit and is required in order for you to purchase contacts. There is **NO ADDITIONAL CHARGE** for follow-up visits if they are done within a 60 day period from the initial exam. If the follow-up is performed after 60 days then an office visit charge will apply. The following statements apply to all contact lens wearer:

1. **THE FOLLOW-UP VISIT IS ABSOLUTELY REQUIRED**
2. **YOU MUST WEAR YOUR CONTACTS TO YOUR APPOINTMENT**
3. **IF YOU CANCEL YOUR APPOINTMENT, THEN YOU ARE RESPONSIBLE FOR RESCHEDULING. AFTER 60 DAYS, AN OFFICE VISIT FEE APPLIES ($35).**

I understand that:

- I should notify the office if I lose, tear, or otherwise render the trial lens(es) unusable so that I may receive a new trial lens BEFORE the follow-up appointment.
- If I want to change brands or wearing modality (i.e. color contacts or 2 wk wear to 1 month wear), I may do so at no extra charge within the two (2) month period. This may require an extra visit to assess the fit of the new trial lenses.
- I should remove my contacts every day before bedtime/napping for cleaning and disinfection
- Improper use (sleeping in contacts) and inadequate care of contact lenses can lead to eye infections, corneal scarring, and blindness.

I , ____ (print name), understand that I must return to my eye doctor for insertion of my contact lenses, as well as training on contact lens insertion and proper care. I also understand that my eye doctor will determine whether this contact lens is the right lens for me.

I understand that if I do not return to my eye doctor after I receive my contact lenses, then my eye doctor is not responsible for any damages of injury resulting from the lenses my eye doctor prescribed for me.

I have been informed of this information, both orally and in writing.

____ ____
Signature of patient or authorized representative Date

Contact Lens Agreement

Contact Lens Prescription Signed Acknowledgment Form Included below is important information to review prior to receiving your contact lens prescription. The Centers for Disease Control and Prevention (CDC) makes clear, "Contact lenses can provide many benefits, but they are not risk-free—especially if contact lens wearers don't practice healthy habits and take care of their contact lenses and supplies. If patients seek care quickly, most complications can be easily treated by an eye doctor.
However, more serious infections can cause pain and even permanent vision loss, depending on the cause and how long the patient waits to seek treatment." The CDC recommends the following for contact lens wearers:

1. Schedule a visit with your eye doctor at least once a year.
2. Take out your contacts and call your eye doctor if you have eye pain, discomfort, redness, or blurry vision.
3. Understand that eye infections that go untreated can lead to eye damage or even blindness.
4. The Food and Drug Administration (FDA) indicates:

   "To be sure that your eyes remain healthy you should not order lenses with a prescription that has expired or stock up on lenses right before the prescription is about to expire. It's safer to be re-checked by your eye care professional annually.

5. Symptoms of Eye Infection include:
   • Irritated, red eyes
   • Worsening pain in or around the eyes—even after contact lens removal
   • Light sensitivity
   • Sudden blurry vision
   • Unusually watery eyes or discharge.

6. Sign below to acknowledge that you were provided with a copy of your contact lens prescription at the completion of your contact lens fitting. Patient

Patient Signature:_________________________________

Date:____