



Patient's First Name: _____
 Middle: _____ Last Name: _____
 Address: _____
 City _____ State _____ Zip _____
 Date of Birth: _____ Last 4 of SSN: _____
 Marital Status: S / M / D / W
 Home: (____) _____
 Cell: (____) _____
 Email: _____
 Communication Preference:
 Phone Email Postal

Insurance Information

Primary Cardholder Name: _____
 Policy Holder DOB: _____

Authorization for Disclosure of PHI

I hereby authorize Cary Family Eye Care to disclose my protected health information to the following trusted party:

Name of Trusted Party: _____
 Relationship to patient: _____
 Patient Signature: _____

Financial Responsibility

Please Note: Most Vision Plans only cover refractions and routine, non-medical eye exams. Visits involving medical problems fall under your medical coverage. If you have any questions about your coverage, be sure to contact your insurance company before your scheduled appointment.

By signing below, you are authorizing Cary Family Eye Care to bill your insurance for services provided and to release all necessary medical information to process the claim. You authorize payment to be made directly to Cary Family Eye Care. **The insurance carrier presented at the time of service will be the only insurance billed. No exceptions can be made.** If your insurance company has not reimbursed our office in full within 90 days, you will be billed for your visit.

Signature: _____
Date: _____

Established Patient Information

Pupil Dilation

A thorough exam with dilation is often the first step in diagnosing a condition that could possibly have devastating effects on your vision. Drops are used to give your doctor a larger view of the inside of your eye and retina periphery. We look for tumors, retinal detachments, macular degeneration, and other diseases or defects. You may experience light sensitivity and decreased vision for 2-6 hours. We will supply you with disposable sunglasses for your comfort. **This will only be performed if the doctor determines it to be indicated.**

Initial: _____ I accept dilation today
Initial: _____ I do NOT accept dilation today

Ocular History

Have you recently experienced, been diagnosed with, or treated for any of the following:

- Blurry Vision Cataracts
- Floaters/Spots Trouble seeing at night
- Eye Injury Iritis/Uveitis
- Headaches Corneal Abrasions
- Double Vision Crossed eye/Eye turn
- Flash of light Glaucoma
- Sunlight Sensitivity Macular Degeneration
- Retinal Detachment

1. Do you currently wear contacts? If yes, what kind?

2. Any problems with your current glasses/contact?

3. Please list any changes to your medical history since your last visit:

4. Please list any changes to your medications since your last visit to our office:

Primary Physician: _____
 Date of last physical exam: _____

HIPAA Compliance Acknowledgement of Receipt

I acknowledge that I am familiar with the privacy policy statement of Cary Family Eye Care.

Signature: _____

Contact Lens Evaluation Agreement

Contact lenses are medical devices that require additional testing to ensure safety and an accurate prescription. To receive a contact lens prescription, an ANNUAL contact lens evaluation is required for ALL contact lens wearers. The fee for this evaluation is separate from the fee for the routine eye exam and is non-refundable. Some vision plans do cover all or part of this fee, while others do not. Any amount not covered by your vision plan is due in full at the time of service.

Contact Lens Evaluation Fee:

- ❖ New patient soft lens evaluation: \$109-\$139
- ❖ Established patient soft lens evaluation: \$79-\$99
- ❖ New Patient RGP/Duette evaluation: \$195-\$225 **
- ❖ Established patient RGP/Duette evaluation: \$125-\$145 **

The exact fee within these ranges depends on the type of lens and complexity of the exam and will be determined by your doctor. If you have questions about the expected fee for your evaluation, you may discuss that with your doctor.

** Please note that trial lenses are not available for custom products like rigid gas permeable (RGP) and Duette Lenses, as well as for some conventional replacement soft lenses. Therefore, you must purchase a pair of lenses at the time of your evaluation and these will be used to evaluate the fit and performance. In the event you are not satisfied with custom lenses, they can be exchanged with the lab or returned for a refund within 60 days; however, the evaluation fee itself is non-refundable.

The contact lens evaluation fee includes:

1. All the necessary measurements required to determine the right fit and prescription for you.
2. Any training necessary for the insertion and removal of your lenses.
3. Any follow ups needed to finalize the prescription of your contact lenses or to address issues you may be having with your lenses.
4. Trial pair (if needed/indicated).

The contact lens evaluation does **not** include your annual supply of contact lenses, which can be ordered after the prescription has been finalized. It also **does not** include medical office visits for issues unrelated to the evaluation of your contact lenses, like dry eye, eye infection, injuries and ocular disease.

By signing this form, you are acknowledging that:

- ❖ Contact lens evaluation fees are non-refundable and payment is due at time of service.
- ❖ Your prescription is valid for one year.
- ❖ Proper care of your lenses is expected. Failure to properly care for your lenses may result in numerous eye problems, such as corneal ulcers and potential loss of vision.

Patient/Guardian Signature: _____

Date: _____