# Welcome to Fall Creek Vision Center!

## PATIENT INFORMATION

Name: _____ Birth Date: _____ / _____ / _____

Nickname: _____ Title: _____ Suffix: _____ SSN: _____ - _____ - _____

Address: _____ Married Divorced Single Other: _____

City: _____ State: _____ Zip: _____ Please circle: Full-time Part-time Not employed Student

Home: (____)_____Day: (____)_____Cell: (____)_____ Retired Active duty Self-Employed

e-mail: _____ Employer: _____

(used for appt confirmation, glasses & contacts notifications, and recall purposes) Occupation: _____

Who referred you to us? _____

## INSURANCE

☐ Same as above

Policyholder's Name: _____ Birth Date: _____ / _____ / _____ SSN: _____-_____-_____

Policyholder's address (if different from above): _____City: _____ State: ____ Zip: _____

## SIGNATURES

***Insurance Billing:*** **We do our best to work with your insurance company to maximize your benefits and save you money. However, the authorizations we receive are not guarantees of payment. By initialing below, you acknowledge that any unpaid balances left after insurance has been filed will become the responsibility of the patient or guarantor after 90 days.** **INITIALS:** _____

***HIPAA:*** I acknowledge that I have received or been offered a copy of Fall Creek Vision Center's HIPAA privacy policies

**SIGNATURE:** _____ **DATE:** _____

***Records Release Authorization:*** I authorize Fall Creek Vision Center to release my exam records (if requested) to the following:

☐ Any and all providers ☐ Certain providers: _____

☐ Myself (email/mail) ☐ Parent/Guardian: _____ Other: _____

**SIGNATURE:** _____ **DATE:** _____

## MEDICAL HISTORY

Last eye exam: _____ Last medical exam: _____ Name of Medical Doctor: _____

Do you wear glasses? ☐ Yes ☐ No

How old is your current pair of glasses? _____

Do you wear contacts? ☐ Yes ☐ No

Do you sleep in your contacts? ☐ Yes ☐ No

What brand of CLs do you wear? _____

Do you have a recent onset of headaches? ☐ Yes ☐ No

Are you interested in Laser Eye Surgery? ☐ Yes ☐ No

Are you **allergic to any medications**? ☐ Yes ☐ No If yes, please list: _____

List **current** medications you take: _____

Women: Are you pregnant or nursing? ☐ Yes ☐ No

Have you ever, or are you currently experiencing the following? If yes, please check the box.

| | | | |
|---|---|---|---|
| ☐ blurred vision | ☐ eye pain | ☐ eye infection/pink eye | ☐ double vision |
| ☐ eye injury or surgery | ☐ light sensitivity | ☐ floaters | ☐ light flashes |
| ☐ watery eyes | ☐ dry eyes | ☐ eye redness | ☐ vision loss |

**Please note any family history (parents, grandparents, siblings) for the following medical conditions. *Please list their relationship to you.***

| | Self | Family | | Self | Family | | Self | Family |
|---|---|---|---|---|---|---|---|---|
| Allergies | ☐ | ☐ _____ | Heart disease | ☐ | ☐ _____ | Amblyopia/lazy eye | ☐ | ☐ _____ |
| Anemia | ☐ | ☐ _____ | High cholesterol | ☐ | ☐ _____ | Cataracts | ☐ | ☐ _____ |
| Arthritis | ☐ | ☐ _____ | Hypertension | ☐ | ☐ _____ | Glaucoma | ☐ | ☐ _____ |
| Asthma | ☐ | ☐ _____ | Migraines | ☐ | ☐ _____ | Macular degeneration | ☐ | ☐ _____ |
| Cancer | ☐ | ☐ _____ | Stroke | ☐ | ☐ _____ | Retinal disease | ☐ | ☐ _____ |
| Crohns | ☐ | ☐ _____ | Thyroid disease | ☐ | ☐ _____ | Strabismus/crossed eye | ☐ | ☐ _____ |
| Diabetes | ☐ | ☐ _____ | HIV | ☐ | ☐ _____ | | | |

At Fall Creek Vision Center, we strive to provide exceptional service and premium products at the best value for our patients. In an effort to maintain these standards, we have structured our policies to be as flexible and fair as possible.

**FRAMES**

***Non-prescription frames***: If, for any reason, a patient is not satisfied with his/her frame, it may be returned in the original condition within **30** days of purchase. There will be a $25.00 restocking fee. If exchanging a frame, the returned amount, minus the $25.00 restocking fee, shall be applied to the sale of a new frame; the patient is responsible for any additional frame costs.

***Prescription frames***: No returns. A patient may exchange a prescription frame within the first **30** days from pick up. There will be a $75.00 restocking and re-edging fee, and there are no free lens exchanges if the patient has Eyemed or are self-pay.

***Manufacturers' warranties***: We follow each manufacturers' policy for warranty exchanges. The warranties are 1-year and cover manufacturing defects, not normal wear and tear.

**LENSES**

***Prescription lenses:*** Prescription lenses are custom-made to the patient's specifications and cannot be re-used. There are no refunds on prescription lenses. If, within the first **90** days from ordering, it is discovered that the lenses were not made to ANSI industry standards, or if the lenses were ordered incorrectly, they will be replaced at no cost.

***Progressive lenses***: In the case that a patient cannot adapt to progressive lenses within **90** days of ordering them, the lenses can be remade into a second pair of lenses at no cost. There is no refund on the difference between the progressive lens and the new lens. **All remake transactions must occur within 90 days of ordering the initial pair.**

**ORDER CANCELLATIONS**

If a patient requests to cancel a glasses order after he/she has already paid a deposit, we will immediately call the lab to stop the order. However, if the lenses order has already been started by the lab, no refunds can be given on the lenses.

**CONTACT LENSES**

In a situation where a prescription changes while the patient's contact lens prescription is still valid, we can only exchange unopened, non-expired boxes that were purchased through our office.

We understand that everyone does not have material coverage with their insurance. In these instances, we will do our best to negotiate with the labs/manufacturers on charges – but the fees are ultimately determined by their policies. All charges accrued by the lab/manufacturer due to cancellations will be the responsibility of the patient, as explained in each scenario above.

All warranties and exchanges are null and void in the event of improper care or abuse.

Any situations not included above will be handled on a case by case basis.

I understand and agree to these policies that have been set forth by Fall Creek Vision Center:

Patient name: _____

Responsible Signature: _____ Date: _____