

# Welcome to Moderne Eye Optometry

Are you a returning patient? Y/N

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Birth Date \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Our office system utilizes text messages to cell phones and appointment confirmations via email:

( ) \_\_\_\_\_ cell ( ) \_\_\_\_\_ home/work

Email address \_\_\_\_\_

Referred by \_\_\_\_\_ Last examination \_\_\_\_\_ By whom? \_\_\_\_\_

Are you interested in new **glasses/contact lenses/both?** (Circle)

Any specific eye concerns at this time? \_\_\_\_\_

Emergency Contact/Relation \_\_\_\_\_ phone \_\_\_\_\_

## PERSONAL EYE INFORMATION

Have you had any eye operations? Y/N Type \_\_\_\_\_ Year \_\_\_\_\_

Have you had an eye injury? Y/N Kind \_\_\_\_\_ Year \_\_\_\_\_

Do you have glaucoma? Y/N Cataracts? Y/N Macular Degeneration? Y/N

Blurred vision? Y/N Dry eyes? Y/N Do you nap in contacts? Y/N

Other eye problems? Y/N What kind? \_\_\_\_\_

## MEDICAL INFORMATION

What is your general health? \_\_\_\_\_

Do you have problems with any of these systems? (Please circle all that apply)

Eyes Y/N Ear/Nose/Throat Y/N Cardiovascular Y/N

Gastrointestinal Y/N Nervous Y/N Mental Y/N

Respiratory Y/N Genitourinary Y/N Endocrine (glands) Y/N

Musculoskeletal Y/N Blood/Lymph Y/N Skin Y/N

Allergic/immunological Y/N COVID-19 Y/N High Blood Pressure Y/N

Diabetes Y/N Obstructive Airway Disorders Y/N

If yes, please explain: \_\_\_\_\_

Name of family doctor: \_\_\_\_\_ Last exam? \_\_\_\_\_

List current medications? \_\_\_\_\_

Medication allergies? Y/N Allergic to? \_\_\_\_\_ What happens? \_\_\_\_\_

Surgical operations? Y/N What kind? \_\_\_\_\_ Date \_\_\_\_\_

Seasonal Allergies? Y/N To what? \_\_\_\_\_ What happens? \_\_\_\_\_

Do you use: cigarettes/tobacco? Y/N Alcohol? Y/N

## FAMILY HISTORY

Hypertension: Y/N Who? \_\_\_\_\_ Diabetes: Y/N Who? \_\_\_\_\_

Retinal Detachment: Y/N Who? \_\_\_\_\_ Glaucoma: Y/N Who? \_\_\_\_\_

Unexplained blindness: Y/N Who? \_\_\_\_\_ Other eye conditions Y/N Who? \_\_\_\_\_

### **SPECTACLE PRESCRIPTION WARRANTY**

If you have any questions about your new glasses purchased at Moderne Eye Optometry, please schedule an appointment with our optician to verify the adjustment of the glasses and for further demonstration of the optics of specialty lenses. We do not verify glasses purchased elsewhere. The examining optometrist, at no additional cost, can verify your spectacle prescription within 60 days of the original eye examination. Thereafter a refraction fee will be charged.

### **CONTACT LENS PRESCRIPTIONS**

A contact lens prescription will be provided to you at the conclusion of the exam only if you come to your appointment wearing your current lenses and bring your contact lens prescription or packaging (if we do not already have that information). A contact lens evaluation or refitting fee will be charged, as these services are not included in the general eye examination fee. By accepting contact lens trials, you agree that a follow-up visit is required to finalize a new contact lens material fitting. You will receive a copy of your contact lens prescription after appropriate follow-up visits have been completed. Contact lens prescriptions are valid for one year.

### **OPTICAL SERVICES**

Optical services such as optical center measurements, pupillary distance, dispensing/fitting of prescription glasses, frame adjustments, one-time prescription redo at no additional cost within 90 days of purchase, frame warranty, and some minor repairs are covered when you purchase your prescription and non-prescription glasses at Moderne Eye. If you want us to provide an adjustment for glasses purchased elsewhere, at your own risk, the charge is \$50 per eyeglass for an adjustment.

### **SPECTACLE FRAMES**

New frames purchased at Moderne Eye Optometry are covered by lifetime adjustments, minor tune-ups/repairs, and are warranted by the frame manufacturer for **defects** up to 12 months after purchase date. Frames that are being reused or purchased elsewhere aka Patient's Own Frame (POF) are not guaranteed from any breakage or damage during the lens replacement process or frame adjustments. Frames purchased elsewhere will be charged a dispensing fee beginning at \$50 per frame. A signed release is required by the fabricating laboratory for POFs.

### **PAYMENT AND CANCELLATION POLICY**

A no-show fee of \$75 will be assessed unless you cancel 48 hours in advance of scheduled appointment. Payment for materials and services are due when services are rendered. We require payment in full for materials in advance of processing an order (this includes all extra charges not covered by vision plans). If you choose to cancel your prescription spectacle or contact lens order after your payment has been made, a 50% cancellation fee will be charged to cover our optical and administrative services. Orders will not be placed without payment in advance. We accept all forms of payment including Zelle, checks with CDL, credit cards. If you have any questions, please ask.

### **ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)**

I acknowledge that I have been given the opportunity to review and/or have received a copy of Moderne Eye Optometry's Notice of Privacy Practices.

HIPAA Signature:\_\_\_\_\_Date:\_\_\_\_\_

### **INSURANCE/FINANCIAL RESPONSIBILITY**

☐ Vision Service Plan (VSP)      ☐ Tri-Care      ☐ Medicare      ☐ Other

### **Advance Beneficiary Notice (ABN)**

I authorize Moderne Eye Optometry to submit my claim to VSP or Tricare or Medicare for eye care and materials services rendered. Depending on the benefits selected by your employer, your plan may not pay for a particular service or material. This does not mean that you should not receive these services or materials. We will provide an explanation of covered and non-covered benefits and it is your choice to receive these materials and services or to decline. An itemized bill is provided for your information and records. If Moderne Eye Optometry is not a participating provider for your specific insurance plan, your signature below is an agreement to pay for exam services and/or materials privately. *By signing this form I acknowledge I have read and agree to the policies stated above.* We are happy to provide the information necessary to help complete your insurance forms.

ABN Signature:\_\_\_\_\_Date:\_\_\_\_\_