PERSONAL INFORMATION

Name (First MI Last): _____ Salutation: Mr. Ms. Mrs. Dr. Rev.

Parent/Guardian (if child): _____ ☐ Male ☐ Female

Address: _____ Date of Birth: ____/____/____

City: _____ ST: _____ Zip:_____ How did you find out about us? _____

Occupation/Hobbies: _____ _____

PERSONAL HEALTH HISTORY

Reason for today's visit: _____ **Last eye exam:** _____

Do you wear glasses? YES NO **Contact lenses?** YES NO **Are you interested in contact lenses?** YES NO

Do you have any of the following eye-related problems? (PLEASE CIRCLE)

BLURRY VISION	EYESTRAIN / HEADACHES	EYE ITCHING / IRRITATION
SPOTS / FLOATERS	FLASHES OF LIGHT	HISTORY OF EYE INJURY
DRY EYES	DOUBLE VISION	HISTORY OF EYE SURGERY

Do you have high blood pressure? YES NO **Do you have diabetes?** YES NO

Do you have any problems with any of these systems? (PLEASE CIRCLE)

CARDIOVASCULAR	ENDOCRINE (GLANDS)	ALLERGIC/IMMUNE	EAR/NOSE/THROAT
RESPIRATORY	BLOOD/LYMPH	GASTROINTESTINAL	MUSCULOSKELETAL
NERVOUS	MENTAL/PSYCH	GENITOURINARY	INTEGUMENT (SKIN)

List any medications you take: _____

List any allergies you have to medicines: _____

List any environmental allergies you have: _____

Do you use any of the following? (PLEASE CIRCLE) Cigarettes/E-Cigarettes/Tobacco Alcohol

If yes to either/both of the above, please indicate amount/frequency: _____

FAMILY HEALTH HISTORY

Have any of your blood relatives had any of the following conditions? (PLEASE CIRCLE)

GLAUCOMA	CATARACTS	MACULAR DEGENERATION
LAZY EYE	RETINAL DETACHMENT	OTHER EYE DISEASE: _____
DIABETES	HIGH BLOOD PRESSURE	HEART DISEASE / STROKE

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have reviewed a copy of the Eola Eyes Notice of Privacy Practices.

Authorized Signature: _____ Date: _____

FINANCIAL POLICY

Full payment for professional services is due at the time services are rendered for any fees not expected to be covered at our office by your insurance company (if you have insurance). No eyeglasses, contact lenses, or other products will be dispensed until they are paid in full.

Eyeglass lenses are custom made to your unique prescription, frame specifications, and facial measurements. We work with lens labs that operate around the clock to provide exceptional and efficient service. We electronically submit your order immediately once it is placed and orders cannot be cancelled or refunded once submitted.

Insurance information must be provided prior to the visit in order for us to utilize your benefits; we cannot bill your insurance if you do not inform us of your plan in advance.

A $35 fee will be assessed for returned checks. Past due balances will be subject to a finance charge and will be sent to collections after 90 days.

I HAVE READ, UNDERSTAND, AND AGREE TO EOLA EYES' FINANCIAL POLICY.

Authorized Signature: _____ Date: _____

INSURANCE INFORMATION

Do you have vision insurance? YES NO If so, name of vision insurance plan: _____

Member Name: _____ Member Social Security No.: _____

Patient's Relationship to Insured/Member (PLEASE CIRCLE): SELF SPOUSE DOMESTIC PARTNER CHILD OTHER

Do you have medical insurance? YES NO If so, name of medical insurance plan: _____

Member Name: _____ Member Social Security No.: _____

Patient's Relationship to Insured/Member (PLEASE CIRCLE): SELF SPOUSE DOMESTIC PARTNER CHILD OTHER

Eola Eyes Policy for Patients with Insurance

As your eye care provider, our relationship is with you, our patient, not with your insurance company. Our practice is committed to providing the best quality care and products, regardless of what an insurance company deems as a covered service or material. We will do our best to help you receive the maximum benefits allowed and minimize your out-of-pocket expense. We will file claims on your behalf with all companies for which we are providers. Insurance coverage, however, is often not as comprehensive as you or we would like, nor are benefits quoted by your insurance company a guarantee of payment. The patient (or guarantor for a child) is responsible for payment if the insurance company does not pay the claim or if your insurance company does not cover necessary procedures to diagnose and treat eye health conditions. It may be necessary to bill vision and/or medical insurance plans depending on the services required.

I AUTHORIZE THE PAYMENT OF VISION AND/OR MEDICAL INSURANCE BENEFITS TO EOLA EYES FOR THE SERVICES I RECEIVE. I AUTHORIZE THE RELEASE OF ANY NECESSARY MEDICAL OR OTHER INFORMATION TO MY INSURANCE COMPANY TO PROCESS MY INSURANCE CLAIM(S). I UNDERSTAND I AM RESPONSIBLE FOR FEES NOT PAID BY MY INSURANCE COMPANY.

Authorized Signature: _____ Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices, but was unable to do so, as documented below.

Date _____ Initials _____ Reason: _____

COMMUNICATION AUTHORIZATION

Eola Eyes would like to communicate with you in the ways you prefer and we are committed to protecting the privacy and security of your health information. By signing below, you allow us to disclose your Protected Health Information (PHI) as described on this form. PHI includes all information regarding your care.

Patient Name:_____ **DOB**:_____ **Date**: _____

I hereby request the following regarding the use and sharing of my PHI:

1. **Phone Calls/Messages:** I consent to receive calls regarding clinical, optical, billing, or other information from Eola Eyes at the numbers listed below. Eola Eyes may leave messages on voicemail or with individuals answering the phone at the numbers provided below.

   Preferred Phone Numbers:
   ☐home ☐work ☐cell _____

   ☐home ☐work ☐cell _____

   ☐home ☐work ☐cell _____

2. **Email/Text Communication:** Eola Eyes uses an automated notification system of text messages and emails to communicate with patients about recalls, appointments, eyewear, and practice news; these messages do not contain PHI. I consent to receive automated notices through this system. I acknowledge that if I choose to send my PHI by email, this carries risk that an unencrypted email may be accessed by unauthorized individuals.

   Preferred Email Address: _____

3. **Sharing Your PHI with Others:** In addition to anyone who may be handling messages left as allowed in Section 1 above, I give permission to Eola Eyes to discuss my PHI with the following individuals listed below:

Printed Name	**Relationship**	**Phone Number**
1._____		_____
2._____		_____

_____ _____

Authorized Signature (Patient or Legal Representative) **Date**

You may request a copy of this form.