PT ID # _____

LAKE RIDGE EYE CARE WELCOME FORM

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Dr.

First Name _____ M.I. _____ Last Name _____ Nickname _____

Address _____ City _____ State _____ Zip _____ Date of Birth _____

Social Security Number _____ Primary Phone # _____ Secondary Phone # _____

Parent(s) Name (if minor) _____ Employer/School _____ Occupation/Grade _____

WHAT IS THE MAIN REASON FOR TODAY'S EXAM? _____

Do you currently use: ☐ Glasses ☐ Contact Lenses

Please note that the time frame to finalize your contact lens prescription is 60 days from your initial visit. If you do not return for follow-up visits (when applicable) before then, there will be an additional fitting fee. Also note that all glasses orders have a 30-day remake window for any cosmetic changes. A frame change will result in an automatic $25 restocking fee. Additional fees determined by insurance and the lab may also apply. The 30-day remake window begins the day the glasses are ordered. **Patient initials** _____

VISION INSURANCE: _____

Insured's Name _____

Insured's I.D. Number _____

Group Number _____

Insured's Date of Birth _____

MEDICAL INSURANCE: _____

Insured's Name _____

Insured's I.D. Number _____

Group Number _____

Insured's Date of Birth _____

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

PLEASE READ: I authorize Lake Ridge Eye Care to release any information required to process my/my dependent's insurance claim when applicable within 90-days from the date of service. **I also authorize my insurance benefits be paid directly to this office and understand that I am financially responsible for any non-covered or denied services. Payments are due at the time services are rendered.** Please note that we only accept cash, Visa, Mastercard, Discover, or Debit cards as forms of payment (checks and American Express are not accepted).

Signature of patient (or parent if minor) _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT: I acknowledge that I have had full opportunity to read the Notice of Privacy Practices posted in the office.

Signature of patient (or parent if minor) _____ Date _____

OPTOMAP / DILATION: Our doctors recommend that ALL patients have a thorough examination of their retina each year. Without the Optomap or a dilated exam, the health and wellness of your eye cannot be fully assessed. **Please select one of the following options**:

DILATED EXAM	**VS.**	**OPTOMAP EXAM**
1. Drops administered to enlarge pupils		1. Retinal images taken of each eye
2. Light sensitivity for 4-6 hours		2. No side effects
3. Blurred near vision for 4-6 hours		3. Permanent record of retina for viewing
4. No permanent record of retina		4. Additional fee of $35 applies as the Optomap screening is not covered by most insurance plans
5. Not recommended for women who are nursing / pregnant		5. In some rare cases, dilation may still be required

☐ I WISH TO HAVE RETINAL IMAGING WITH THE OPTOMAP ($35 fee applies).

☐ I WISH TO HAVE MY EYES DILATED WITHOUT RETINAL IMAGING (no additional fee).

☐ I DO NOT WISH TO HAVE RETINAL IMAGING OR MY EYES DILATED AND ASSUME THE RESPONSIBILITY OF HAVING AN EYE EXAMINATION WITHOUT DILATION OR RETINAL IMAGING.

Signature of patient (or parent if minor) _____ Date _____

Lake Ridge
EYE CARE

No Show Policy:

A "No Show" is considered to be any missed or cancelled appointment with less than 24 hours' notice. Each scheduled appointment will receive a confirmation call prior to their appointment. All Saturday appointments are required to return a **verbal confirmation** within 24 hours of their appointment. A "No Show" on a Saturday will result in an automatic No Show fee of $25 and all future appointments being scheduled Monday – Friday with no exceptions.

Failure to report at the time of a scheduled appointment will be recorded in your chart as a "No Show". Each patient is allowed two (2) "No Shows" within a 12-month period without penalty. A third (3) "No Show" in a 12-month period **will result in a $25.00 fee**.

Penalty fees will need to be paid in full prior to scheduling any future appointments or ordering product.

By signing this policy, I indicate that I have read and understand the appointment "No Show" policy. I further understand that I will be responsible for any fees assessed to my account for each "No Show" and may be declined future appointments until I have paid in full the outstanding fees.

Signature of patient (or parent if minor) _____ Date _____