Receipt of Notice of Privacy Policies & Consent Form
Insurance Responsibility Consent Form
Contact Lens Consent Form

Patient Name: ____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our *Notice of Privacy Practices*, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our *Notice of Privacy Practices*. Our *Notice of Privacy Practices* will be updated whenever our privacy practices change. You can get an updated copy here at the office or at www.stamfordvisioncare.com.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our *Notice of Privacy Practices*. You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our *Notice of Privacy Practices*, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our *Notice of Privacy Practices* describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Stamford Vision Care, LLC.

PATIENT SIGNATURE ______________________________ **DATE** ____ / ____ / ____

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

RELATIONSHIP TO PATIENT ______________________ **PRINT NAME** ______________________

I certify that the insurance information provided by me is accurate. I authorize the use of this information in helping me obtain payment for the services provided to me. I authorize payment directly to my doctor. A copy of this authorization may be used in place of the original. I understand that the accuracy of this information is my responsibility. I also acknowledge that all fees for services and materials provided to me are my responsibility. I agree to pay all fees for services or materials should my insurance company reject the claim for any reason.

Medicare pays for 80% of **covered** services, but does not pay routine vision examinations or the refraction portion of any eye examination. In addition, some ancillary testing may not be covered. Medicare does not pay for frames or lenses except a portion of the first pair after cataract surgery. By law Stamford Vision Care, LLC. I understand that some services may require prior approval from my primary care physician for coverage and that, if I do not obtain that approval, I am financially liable for the services. I understand that my insurance carrier may not cover some services and products and benefit information does not constitute approval of payment. Deductibles, co-insurance or fees not paid by my insurance carrier including the refraction charge will be my responsibility. I understand I will receive a monthly statement for any balance due by me. Outstanding balance over Ninety (90) days may be transferred to collections.

PATIENT SIGNATURE ______________________________ **DATE** ____ / ____ / ____

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

RELATIONSHIP TO PATIENT ______________________ **PRINT NAME** ______________________

Contact lens wearers require an additional service or exam to evaluate and ensure that the proper fit, vision and ocular health is maintained. Contact lens services are required for a valid contact lens prescription, expiring annually. This service or exam is separate and **NOT** included in a routine eye examination.

PATIENT SIGNATURE ______________________________ **DATE** ____ / ____ / ____

REV 110215

STAMFORD VISION CARE

WELCOME TO STAMFORD VISION CARE

PATIENT INFORMATION

☐ Mrs. ☐ Ms. ☐ Dr. ☐ Mr. ☐ Miss LAST NAME ____ FIRST NAME ____ MIDDLE (INITIAL) ____ ☐ M ☐ F

ADDRESS ____ CITY ____ STATE ____ ZIP CODE ____

PREFERRED PHONE NUMBER ( ) ____ ☐HOME ☐WORK ☐CELL SECONDARY PHONE NUMBER ( ) ____ ☐HOME ☐WORK ☐CELL

WE USE PHONE CALLS AND/OR EMAILS TO REMIND PATIENTS OF THEIR APPOINTMENTS.

BIRTH DATE / / SSN # ____ MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ PARTNER ☐ DIVORCED ☐ WIDOWED

E-MAIL ADDRESS ____ HOW DID YOU HEAR ABOUT US / REFERRED BY ____

EMPLOYER OR SCHOOL ____ OCCUPATION ____

INSURANCE INFORMATION

IF NOT SELF

INSURED NAME ____ SSN # ____ BIRTH DATE / / RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ PARENT ☐ PARTNER

MEDICAL PLAN NAME ____ GROUP ____ INSURED ID# ____

VISION PLAN NAME ☐DAVIS ☐VSP ☐OTHER ☐EYEMED ☐NONE ____ GROUP ____ INSURED ID# ____

MEDICAL AND OCULAR HISTORY

PRIMARY CARE PHYSICIAN ____ PHYSICIAN PHONE NUMBER ( ) ____ LAST MEDICAL EXAM (MM/YY) /

LAST EYE EXAM (MM/YY) / FROM DR. ____ NEW PATIENT ☐ YES ☐ NO

DO YOU EVER EXPERIENCE ANY OF THE FOLLOWING?

☐ BLURRED VISION-DISTANCE ☐ ITCHING ☐ HEADACHES ☐ DRYNESS ☐ PAIN
☐ BLURRED VISION-NEAR ☐ TEARING ☐ FLASHING LIGHTS ☐ LIGHT SENSITIVITY ☐ MUCUS DISCHARGE
☐ FLUCTUATING VISION ☐ BURNING ☐ FLOATING SPOTS ☐ TEMPORARY LOSS OF VISION ☐ SQUINTING
☐ DOUBLE VISION ☐ REDNESS ☐ EYE STRAIN ☐ DISTORTED VISION ☐ NONE OF THE ABOVE
☐ FOREIGN BODY SENSATION ☐ GLARE ☐ LOSS OF SIDE VISION ☐ OTHER ____

DO YOU OR ANY OF YOUR BLOOD RELATIVES (I.E. GRANDPARENTS, PARENTS, BROTHER OR SISTER) **HAVE ANY OF THESE CONDITIONS?**

	SELF	RELATIVE	NONE		SELF	RELATIVE	NONE		SELF	RELATIVE	NONE
DIABETES	☐	☐	☐	ASTHMA	☐	☐	☐	KIDNEY DISEASE	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	LUPUS	☐	☐	☐	THYROID PROBLEMS	☐	☐	☐
HEART DISEASE	☐	☐	☐	CHOLESTEROL	☐	☐	☐	ARTHRITIS	☐	☐	☐
BLINDNESS	☐	☐	☐	CANCER	☐	☐	☐	GLAUCOMA	☐	☐	☐
EYE INJURY / EYE SURGERY	☐	☐	☐	CROSSED EYES	☐	☐	☐	RETINAL PROBLEMS	☐	☐	☐
MACULAR DEGENERATION	☐	☐	☐	CATARACTS	☐	☐	☐	OTHER ____	☐	☐	☐

HAVE YOU EVER BEEN EXPOSED TO ANY OF THESE CONDITIONS? ☐HEPATITIS ☐LYME ☐ GONORRHEA ☐ HIV ☐ SYPHILIS ☐ CHLAMYDIA ☐ HERPES ☐ NONE

ARE YOU TAKING ANY MEDICATIONS /EYE DROPS (PRESCRIPTION OR OVER THE COUNTER)? ☐NO ☐YES, PLEASE LIST ____

DO YOU HAVE ALLERGIES (TO MEDICATION OR OTHER)? ☐NO ☐YES, PLEASE EXPLAIN ____

ARE YOU PREGNANT? ☐ YES ☐ NO (AND/OR NURSING) **DO YOU SMOKE?** ☐ YES ☐ NO ☐ FORMER **DO YOU DRINK ALCOHOL?** ☐ YES ☐ NO **DO YOU DRIVE?** ☐ YES ☐ NO

DO YOU WEAR GLASSES? ☐ NONE ☐READING ☐COMPUTER ☐DISTANCE ☐ PROGRESSIVE ☐ BIFOCALS ☐ SUN ☐ USED TO

AGE OF PRESENT GLASSES ____ **ARE YOU PLANNING TO GET NEW GLASSES TODAY?** ☐ YES ☐NO

DO YOU WEAR CONTACT LENSES? ☐ NONE ☐DISPOSABLE ☐TORIC ☐MULTIFOCAL ☐DAILY WEAR ☐OVERNIGHT WEAR ☐ HARD/RPG/HYBRID ☐ USED TO

AGE OF PRESENT CONTACT LENSES ____ **ARE YOU PLANNING TO GET NEW CONTACT LENSES TODAY?** ☐ YES ☐NO **WHAT METHOD OF DISINFECTION ARE YOU USING?** ____

PLEASE SIGN BELOW THAT YOU HAVE REVIEWED ALL INFORMATION ABOVE AND IT IS CORRECT TO THE BEST OF YOUR KNOWLEDGE.

PATIENT SIGNATURE (IF MINOR, PARENT/GUARDIAN) ____ **DATE** / /