Eye-Deal Vision
OPTOMETRIST / OPTICAL

Patient Name: _____ **Patient Date of Birth:** _____

Pt Height: _____ **Pt Weight:** _____ **Do you have secondary insurance? YES NO**

Is this visit a result of a work related injury? YES or NO

If so, what is your case #_____ **Date of Injury:**_____ ___

What is the reason for today's visit? _____

Are you experiencing any eye pain, flashes of light, floaters, or loss of vision? YES NO

If you answered yes, your exam will be considered a medical exam and billed to your medical insurance plan not your vision insurance plan. If you have any questions regarding this information, please bring it to the attention of our staff immediately.

****Due to NEW GOVERNMENT MONITORING, we are required to collect the following data.****

- **Preferred Language**: ENGLISH SPANISH OTHER:_____
- **Race**: *WHITE* *HISPANIC* *BLACK/AFRICAN AMERICAN* *ASIAN* *NATIVE AMERICAN/ALASKAN NATIVE* *NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER*
- **Ethnicity:** *HISPANIC OR LATINO* *NOT HISPANIC OR LATINO* *NATIVE HAWAIIAN/OTHER ISLANDER*
- **How do you prefer to be contacted: (Please circle one):** EMAIL PHONE MAIL TEXT

FINANCIAL RESPONSIBILITY: SELF PARENT NON-CUSTODIAL PARENT GUARDIAN

***If you are over 18, you are financially responsible for yourself. If you would like us to be able to discuss your information with your parents, please indicate that below..*

Name:_____ DOB:_____/ _____/_____

SS #: _____ Address:_____

Best Contact #: (_____)_____-_____Email: _____@_____

- Please list a person/persons that we may discuss your exam treatment, financial information for payment collection, etc. For more information, please review our "Privacy Practices."

_____ Relation: _____ _____ Relation: _____

The Different Types of EXAMS…

***MEDICAL EXAM*:** This exam is to evaluate and diagnose overall eye health where there are underlying systemic, medicinal, or vision issues to include red eyes, dry eye syndrome, allergic disorders, diabetic retinopathy, glaucoma, etc. If any type of prescription other than for vision correction is provided, the exam will be considered a medical exam.

ROUTINE VISION*:** A basic vision exam to provide an overall eye health evaluation and refraction. NO other vision problems exist.***

CONTACT LENSES FITTING & EVALUATION: An additional exam and fee for a contact lenses fitting and evaluation to include a trial pair of contact lenses and up to 2 follow-up visits to confirm the proper fit and comfort of contact lenses.

DILATION OF THE EYES: If the doctor feels it is necessary, the doctor will dilate your eyes. Dilation is a procedure where drops are instilled in the eyes to enlarge your pupils. This provides the doctor with a more thorough evaluation of the structures inside your eyes, for the detection of eye diseases such as Glaucoma, Cataracts, Tumors, Retinal Detachment, Diabetes, Hypertension, etc. Dilation may temporarily blur your vision and make you more sensitive to light (disposable sun shades will be provided). This process is included in the exam price and there is no extra charge if performed the same day. If rescheduled for another day, a $20.00 re-scheduling fee may apply.

Is it okay to dilate your eyes? YES RESCHEDULE DECLINE

DISCLAIMER: During your eye exam it is possible the doctor may desire to perform a pupillary dilation. Should you elect to receive such treatment, you acknowledge the fact Joseph R. Rogalinski, O.D., Elizabeth T. Nguyen, O.D., Jeffrey N. Legrande, O.D., other contracted Optometrists, and Eye-Deal Vision, P.A. STRONGLY RECOMMEND YOU DO NOT DRIVE A VEHICLE OR OPERATE ANY MACHINERY FOR A PERIOD OF AT LEAST TWO (2) HOURS thereafter. Dilation affects individuals in different ways, and in some patients can continue to adversely alter vision beyond such period of time. As a condition of performing a pupillary dilation, you agree to INDEMNIFY and DEFEND Joseph R. Rogalinski, O.D., Elizabeth T. Nguyen, O.D., other contracted Optometrists, Eye-Deal Vision, P.A. and all its agents and employees from any and all claim(s) and/or lawsuit(s) from third parties allegedly attributable to this procedure. Further, also as a condition of the dilation, you agree to RELEASE, ACQUIT, and FOREVER DISCHARGE Joseph R. Rogalinski, O.D., Elizabeth T. Nguyen, O.D., Jeffrey N. Legrande, O.D., other contracted Optometrists, Eye-Deal Vision, P.A., and all its agents and employees from any and all liability to third parties alleged to be attributed to this procedure.

Acknowledged and Agreed: _____SELF PARENT GUARDIAN

Insurance Assignment

- I certify that I, and/or my dependent(s) have insurance coverage and assign directly to Eye-Deal Vision, P.A. all benefits, for services rendered**.** Eye-Deal Vision, P.A. DOES NOT GUARANTEE that my insurance will pay my claim even if benefits are verified before the appointment.
- I further expressly agree & acknowledge that my signature on this document authorizes Eye-Deal Vision, P.A. to submit claims for services rendered without obtaining my signature on each and every claim to be submitted for myself and/or my dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim dated today or in the future until further notice has been expressed in writing.
- Eye-Deal Vision, P.A. may use my health care information and may disclose such information to the insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services.

Financial Responsibility

- I understand that I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES whether or not paid by insurance, and I am responsible to pay any copayments/co-insurance at the time of my visit.
- I understand that I am responsible for late fees of $10.00 per month for each month payment is not received, as well as, a finance charge of 1.5% per month of the amount outstanding.
- I understand that if I do not pick up my glasses, contact lenses, or other merchandise within 90 days of the date of purchase, I will forfeit any deposits made towards the purchase, and no refunds will be given. Any amounts paid by your insurance company on your behalf will not be refunded or reversed.

Warranty

- I understand Eye-Deal Vision, P.A. offers a one-time, one year warranty on all frames due to manufacturer defect, at no cost. Gross negligence or loss is not covered under this warranty. Eye-Deal Vision, P.A. also offers a one-time, one year warranty on all lenses that have at least a TD2 or glare free coating.

I have read, and I understand the *DISCLAIMER*, *FINANCIAL POLICY* and *WARRANTY POLICY for* Eye-Deal Vision PA. I further understand that if I have any questions, I am able to speak to an associate who can answer my questions while I am in the office or by sending an email to info@eye-dealvision.com.

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Signature of Patient, Parent/Guardian (Circle ONE): SELF PARENT GUARDIAN) Date