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## Welcome to 20/20 Image Eye Centers

### Patient Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 E-mail: \_\_\_\_\_ My last eye exam was: \_\_\_\_\_ years and \_\_\_\_\_ months ago.  
 Marital Status: \_\_\_\_\_ Employer/Employment Status: \_\_\_\_\_

### Major Medical Insurance Information

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_  
 Primary Insurance Co.: \_\_\_\_\_ Group #: \_\_\_\_\_ Member ID: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Deductible: \$ \_\_\_\_\_ Has the deductible been met?:  Yes  No  
 Referred by: \_\_\_\_\_

### Secondary Insurance or Vision Plan Information

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_  
 Primary Insurance Co.: \_\_\_\_\_ Group #: \_\_\_\_\_ Member ID: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Deductible: \$ \_\_\_\_\_ Has the deductible been met?:  Yes  No

### Medical History (Please circle all that apply)

	<u>You</u>	<u>Family Member</u>		<u>You</u>	<u>Family Member</u>
High Blood Pressure:	Yes / No	Yes / No	Seasonal Allergies:	Yes / No	Yes / No
Diabetes:	Yes / No	Yes / No	Cataracts:	Yes / No	Yes / No
Heart Condition:	Yes / No	Yes / No	Glaucoma:	Yes / No	Yes / No
Lung Condition:	Yes / No	Yes / No	Macular Degeneration:	Yes / No	Yes / No
Cancer:	Yes / No	Yes / No	Retinal Detachment:	Yes / No	Yes / No
Thyroid Disease:	Yes / No	Yes / No	Lazy Eye:	Yes / No	Yes / No

List any other conditions: \_\_\_\_\_

List any eye surgeries: \_\_\_\_\_

Are you pregnant?:  Yes  No Do you smoke?:  Yes  No Do you socially drink?:  Yes  No

Medical Allergies?:  No  Yes: \_\_\_\_\_

List medications you take regularly:  
*(if unknown, list what you're taking it for)* \_\_\_\_\_

# 20/20 Image Eye Centers Patient Information / Consent Form

## **HIPAA NOTICE of PRIVACY PRACTICES**

The below signature acknowledges that I received and understood the HIPAA Notice of Privacy Practices form. I understand that I may contact the HIPAA compliance officer at 20/20 Image Eye Centers with any questions.

## **VSP PATIENT CONSENT FORM (VSP MEMBERS ONLY)**

The below signature acknowledges that I have received and understood the "VSP Patient Consent Form" and authorize 20/20 Image Eye Centers and VSP to access my medical records for the purpose of health care operations.

## **PERSONAL CHECK PROCESSING**

Should your check be dishonored by your bank for any reason, you agree to authorize 20/20 Image Eye Centers and its agents to electronically debit your checking account or savings account for the amount of the returned check, state service charges, processing fees, bank fees, and damages as allowed by law. Should your check not be collected electronically, 20/20 Image Eye Centers can forward your check to a collection agency, attorney or law enforcement agency for processing, prosecution and collections.

## **INSURANCE / BILLING**

ASSIGNMENT and RELEASE: I assign directly to 20/20 Image Eye Centers and its doctors, all medical and vision benefits, if any, otherwise payable to me for services rendered. I hereby authorize 20/20 Image Eye Centers to release all information necessary to secure payment of benefits. I authorize the use of the below signature on all my insurance submissions. The below signature authorizes 20/20 Image and its doctors on my behalf.

**PROFESSIONAL FEES ARE NOT REFUNDABLE**

## **RETURN POLICY OF OPTICAL PRODUCTS**

**EYEGASSES: (FRAMEE / LENSES):** Our eyeglass lenses are custom made for the frame selected as well as the individual prescription. As such, any changes to eyeglass orders or returns must be discussed with the office manager within 30 days of delivery.

**CONTACTS:** only UNOPENED / UNMARKED boxes may be returned / exchanged within 30 DAYS of delivery.

**I HAVE READ AND UNDERSTOOD THE ABOVE AND HAVE NO FURTHER QUESTIONS.**

**SIGNATURE of PATIENT or GUARDIAN:** \_\_\_\_\_ **DATE:** \_\_\_\_\_