Last Name: _____ **First Name:** _____ **Preferred Name:** _____
Date of Birth: _____ **Email:** _____
Address: _____ **City:** _____ **State:** ____ **Zip:** _____
Numbers: Home_____ **Work** _____ **Cell** _____

INSURANCE/FINANCIAL RESPONSIBILITY:
(please read carefully, and please ask if you have questions!)
While Triangle Visions Optometry attempts to obtain accurate insurance information and benefits for each patient, we need you to provide up-to-date information and documentation to facilitate this process. Filing insurance is not a guarantee of payment. Any amount not covered and paid by your insurance, regardless of the reason, will be your responsibility and is due at the time of service. In such a case, after you pay for appropriate co-payments, coinsurance, deductibles, or other fees not covered by your insurance, we will file an insurance claim for the balance; this will be paid from your insurance directly to Triangle Visions Optometry. If your insurance company is not one that we have contracted with or if you have not provided us with the proper information/documentation to file your insurance prior to your appointment time, it is your responsibility to pay us for your fees at the time of service; we will gladly assist you in attempting to be reimbursed yourself by providing the necessary documents to enable you to file with your insurance company for "out of network" coverage. PLEASE BE AWARE: in either scenario, the ultimate responsibility and financial obligation lies with you, the patient. If at any time you have questions regarding insurance or billing, do not hesitate to contact our office. We value you, and will make every reasonable effort to assist. Thank you!

I understand and agree to the above Insurance/Financial Responsibility Policy:

Patient Signature: _____ **Date:** _____

If you are signing as a personal representative of the patient, please indicate your relationship: _____

Representative Signature: _____ **Date:** _____

PERSONAL HEALTH INFORMATION PRIVACY INFORMATION:
(Please read careful, check the appropriate areas, and ask questions before you sign.)
The law requires that Insight Eyecare, LLC (dba Triangle Visions Optometry) make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:
___ I was given the opportunity to read, have read or had explained to me Insight Eyecare, LLC's Notice of Privacy Practice prior to any services offered
___ The Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible
___ I authorize Insight Eyecare, LLC to release my personal health information to the following individuals:
_____ _____ _____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient Signature: _____ **Date:** _____

If you are signing as a personal representative of the patient, please indicate your relationship: _____

Representative Signature: _____ **Date:** _____

Last Name: _____ **First Name:** _____

MEDICAL HISTORY

Do you have any allergies to medications? _____ If yes, please explain:

_____

List any medications that you take (including over-the counter meds, home remedies, aspirin, and oral contraceptives): _____

_____

What is your Pharmacy of choice: _____

List all major injuries, surgeries, and/or hospitalizations that you have had:

_____

Are you currently pregnant or nursing? _____

Smoking status (circle one): current every day / current some days / former / never

If you drink alcohol, approximately how much do you drink per week? _____

Do you wear glasses? _____ If yes, how old is the current pair? _____

Do you wear contact lenses? _____ If yes, what brand? _____

How long do you keep each pair? _____ Are they comfortable? _____

Do you have specific or unusual visual requirements (hobbies/occupations/sports/etc.)?

_____

How many hours per day do you spend on the computer? _____ How many monitors? _____

With your best visual correction, do you struggle with any of the following (please circle):

Near Vision blur	Red eyes	Seeing spots/lines floating in vision
Distance vision blur	Dry eyes	Seeing flashes in your vision
Midrange blur (computer)	Watery eyes	Seeing halos in your vision
Double vision	Outdoor glare	Pain in/around eyes
Headaches	Indoor glare	Glare around lights

PERSONAL & FAMILY HISTORY: (Please note any pertinent family history for the following conditions, listing **yourself**, parent(s), grandparent(s), sibling(s), children.)

DISEASE/CONDITION	NO	YES	UNKNOWN	RELATIONSHIP TO YOU
Blindness	___	___	___	_____
Cataract	___	___	___	_____
Crossed Eyes / Lazy Eye	___	___	___	_____
Glaucoma	___	___	___	_____
Macular Degeneration	___	___	___	_____
Retinal Detachment/Disease	___	___	___	_____
Arthritis	___	___	___	_____
Autoimmune Disease	___	___	___	_____
Cancer	___	___	___	_____
Crohn's Disease / GI Disorder	___	___	___	_____
Diabetes	___	___	___	_____
Heart Disease	___	___	___	_____
High Blood Pressure	___	___	___	_____
High Cholesterol	___	___	___	_____
Kidney Disease	___	___	___	_____
Lung Disease	___	___	___	_____
Lupus	___	___	___	_____
Thyroid Disease	___	___	___	_____
Other: _____	___	___	___	_____

Last Name: _____ First Name: _____

CONTACT LENS EVALUATION AND EXAM FEES:

Q: Why is there a contact lens evaluation fee in addition to the standard eye exam fee?
A: Contact lens patients require additional testing and monitoring over and above what is done during a routine eye exam. The FDA closely regulates contact lens prescriptions and requires them to be renewed annually per Federal Law. Contact lenses are medical devices, and even though they may feel fine, there are health risks that must be taken seriously. To renew your contact lens prescription today, your doctor will perform the following additional tests:

• Slit lamp microscope examination of the contact lens on the eye to check the lens fit.
• Slit lamp microscope examination of the cornea, conjunctiva, and eyelid tissues, to check eye health and to look for adverse effects from contact lens wear.
• Contact lens refraction to determine the correct contact lens prescription power (contact lens prescriptions are different than eyeglass prescriptions)
• Review new lens designs and materials that may improve comfort and/or health.

The contact lens evaluation fee is determined by the overall complexity of the contact lens fit. This complexity is determined by, but not limited to, factors such as type of contact lens, change in prescription, change in brand, the new or established wearer. These additional charges may apply to your visit today. Insurance typically does NOT cover these fees. However, we will apply any insurance or discounts that may apply.

Routine evaluation with little to no change: $80-130
Complex evaluation with large power change or a change in the type of lenses: $130-175
New simple contact lens fit: $175
New complex contact lens fit: $225
Specialty contact lens fit/evaluation: starting at $300

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

Patient Signature: _____ Date: _____

If you are signing as a personal representative of the patient, please indicate your relationship: _____

Representative Signature: _____ Date: _____

Last Name: _____ **First Name:** _____

OPTOMAP RETINAL IMAGING:

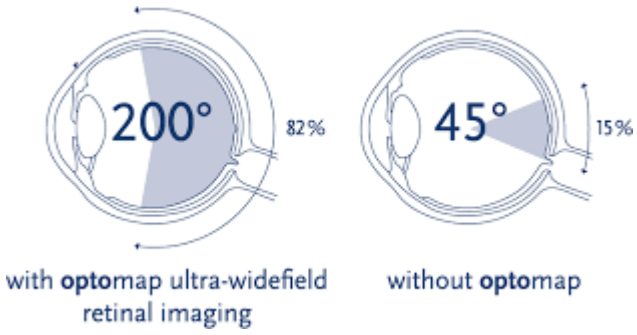
At Triangle Visions Optometry, it is our goal to provide you with the best eye care services available. Please take a minute to carefully review this information on retinal imaging.

Retinal imaging is a non-invasive procedure used for the early detection of retinal problems and diseases such as those associated with glaucoma, macular degeneration, diabetes, and optic nerve disorders.

Our doctors use Optomap retinal imaging to document patient's retinal conditions and provide excellent baseline data that can be used to follow the progression of ocular health over time.

The test is highly recommended for all of our patients, especially those with a history of diabetes, high blood pressure, headaches, floaters or flashing lights, high cholesterol, and retinal problems such as detachment or tears.

Many patients choose Optomap imaging instead of dilation as the Optomap provides 200 degree ultra-wide field imaging without the use of eye drops or dilation drops.



We would like to offer this service to you for $39.00. We can bill the photos medical for certain conditions.

Please take a minute to let us know your preference below.

_____ YES, I would like to have digital retinal photography.
Please check here if you have a history of seizures_____ ?

_____ NO, I am choosing NOT to have this test performed, I further agree NOT to hold Triangle Visions Optometry or any of its doctors responsible for any disease or pathology that goes undetected due to the lack of diagnostic information that could have been obtained through this retinal imaging.

Patient Signature: _____ **Date:** _____

If you are signing as a personal representative of the patient, please indicate your relationship: _____

Representative Signature: _____ **Date:** _____