Today's date: _____

Boyce Family Eye Care, Ltd.
Pam Boyce, O.D., F.A.A.O.

Welcome to our office! To comply with medical record requirements, please answer the following questions to the best of your ability so we may better serve you. Thank you.

Patient Name_____ □ Male □ Female

Address _____ Birthdate _____

City_____State_____ Zip+ 4 digits _____ Home Phone_____

Email_____ Cell Phone _____

Employer_____ Work Phone_____

Occupation _____ Hobbies/Sports_____

Last Eye Exam/Dr. _____ Primary Care Physician_____

What is your reason for today's eye exam? Please mark all that apply.

- □ blur at distance
- □ blur at near
- □ double vision
- □ computer strain
- □ headache
- □ other
- □ glaucoma
- □ lazy eye
- □ red eyes
- □ flashes/spots
- □ tears/discharge
- □ eye pain/discomfort
- □ itching
- □ broken glasses
- □ contact lenses
- □ cataracts

Are you interested in new glasses? □ Yes or □ No
Are you interested in contact lenses? □ Yes or □ No
How old are your current glasses? _____
Have you had an eye injury? □ Yes or □ No
Have you had eye surgery? □ Yes or □ No

Are you interested in sunglasses? □ Yes or □ No
Are you interested in refractive surgery? □ Yes or □ No
How old are your current contact lenses? _____
If yes, explain: _____
If yes, explain: _____

Medical History
Do you have, or have you ever been treated for:

_____diabetes (high sugar)
_____high blood pressure
_____heart disease
_____stroke
_____stomach problems
_____thyroid/glands
_____other_____
_____arthritis/joint pain
_____kidney/urinary
_____STD
_____cancer
_____HIV
_____headache
_____breathing problems
_____depression/anxiety
_____sinus/allergy
_____skin condition
_____hearing loss
_____high cholesterol

Do you have any allergies? □ Yes or □ No If yes, explain: _____
Do you take any medications? □ Yes or □ No If yes, explain: _____
Are you now pregnant? □ Yes or □ No
Do you smoke? □ Yes or □ No If yes, how much? _____
Do you drink alcohol? □ Yes or □ No If yes, how much? _____
Do you have a history of recreational drug use? □ **Yes or** □ **No**

Please mark the people in your immediate family who have the following medical problems:

_____diabetes
_____high blood pressure
_____heart disease
_____blindness
_____arthritis
_____sickle cell disease
_____glaucoma
_____other
_____ macular degeneration
_____retinal disease
_____crossed eyes

Boyce Family Eye Care, Ltd.
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I,_____, have received a copy of this office's Notice of Privacy Practices.

_____ I am signing this on behalf of:

(Please Print Name)

_____

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our notice of Privacy Practices, but acknowledgement could not be obtained because:

- **Individual refused to sign.**
- **Communication barriers prohibited obtaining the acknowledgement**
- **An emergency situation prevented us from obtaining acknowledgement**
- **Other (please specify)**

FINANCIAL POLICIES OF BOYCE FAMILY EYE CARE, LTD.

Should you have vision insurance, your plan may not cover all expenses incurred during your examination or for the glasses or contact lens materials you order. What is and is not covered depends on the plan your employer contracted with the vision insurance company.

- Payment of any examination service(s) not covered by vision insurance or co-payments/deductibles for non-Medicare services are due at the time they are rendered**. I accept full financial responsibility if my vision insurance carrier denies or does not cover my claim for these services**.
- **If your insurance status and/or carrier is unknown, insurance claims cannot be postdated to the date of your eye exam and/or purchase of glasses or contact lenses. I accept full financial responsibility for my exam and purchase of glasses or contact lenses.**
- Payments for unreimbursed Medicare services will be due after the claim has been processed by Medicare and any secondary insurance carrier.
- Since we are not a provider for Medicaid, all fees for services and materials will be the responsibility of the patient.
- **If my insurance determines that I have not met my deductible, I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by insurance and/or provider.** Yearly deductibles cannot be waived at any time by the provider of service of Boyce Family Eye Care, Ltd.
- An annual contact lens assessment is in addition to a regular eye exam. The fee for this service is due at the time of examination. Any new fitting fees are due prior to ordering contact lenses. These fees cover professional services provided to determine if your current lenses and prescription continue to be best for you, or to upgrade your lenses to improve your vision or eye health. These fees are non-refundable even in the event contact lenses are not ordered or an order is cancelled.
- If you order glasses or contact lenses, their costs may not be covered fully by your vision insurance. For those costs, which are determined to be covered under the provisions of your policy, we will process your claim with your vision insurance. However you will be responsible for any remaining monies due and any follow-up to ensure your insurance provider is administering coverage consistent with that arranged by your employer. This may involve talking with the human resource or benefits person at your employer. If glasses, contact lenses, or other optical devices are not covered, payment will be due at the time of ordering.
- A 100% deposit is required on all optical orders: i.e: frames, lenses, or contact lenses prior to placing the order. There are no refunds provided.
- If the doctor has recommended vision therapy services, it may not be covered fully by vision insurance or major Medical Insurance. You should check directly with your insurance carrier to determine your coverage. If medical codes or more information is needed to make a claim, we will gladly provide that for you. If this service is covered, we will submit claims to your medical insurance. However, you will be responsible for any remaining monies due and any follow-up to endure your insurance provider is administering coverage consistent with that outlined in your policy manual. If this service is not covered you will be responsible for payment at the time of service. Once a program of vision therapy has been completed, all fees must be paid in full within 30 days of completion.
- We accept the following forms of payment for your convenience: cash, check, money order, MasterCard, Visa, or Discover Card.
- Checks returned for insufficient funds will be charged a service fee of $50.00. Future payments will only be accepted if made by certified check, cash, or credit card.

Boyce Family Eye Care, Ltd.

_____ _____