ACTIVE EYE CARE OF SURPRISE CHECK-IN

I am here for:

☐ Eye Health check
☐ Glasses only
☐ Glasses and contact lenses
☐ Eye/Medical Issue
☐ Vision Therapy or Neuro Rehab referral
☐ Concussion referral

☐ Other: _____

My last eye exam was:

☐ 1-2 years ago ☐ More than 3 years ago ☐ Other: _____

Where was your last eye exam/name of practice:

☐ Active Eye Care ☐ Other/ please list: _____

If interested in contacts, please answer which of these apply:

☐ Yes, I am a previous wearer and know my contact lens brand and prescription.

☐ Yes, I am a previous wearer and do not know my brand or prescription.

☐ Yes, I am interested in contacts but have never worn them (contact lens training required)

Ocular symptoms I am experiencing:

☐ Blur at near
☐ Itchy eyes
☐ Blur in the distance
☐ Loss of parts of your vision
☐ Superimposed images/shadows
☐ Eye Turn/Lazy eye
☐ Glare or halos/light sensitivity
☐ Eye Pain
☐ Double vision/2 separate images
☐ Words moving around on the page
☐ Dryness, irritation, or foreign body sensation
☐ Headaches
☐ Eye Fatigue/Strain

Amount of hours spent on screens or on a phone daily:

☐ None to 3 hours ☐ 3 - 6 hours ☐ 7 or more

IF you are an established patient and have been seen in the last 1-2 years at this practice, WITHOUT any changes in your medical history you can skip this page.

Physical History: I personally have been diagnosed with:

☐ High blood pressure
☐ High Cholesterol
☐ Auto-Immune condition
☐ Stroke or Brain Injury
☐ Cancer
☐ Concussion
☐ ADHD or Dyslexia
☐ Migraines or Ocular Migraines
☐ Anxiety
☐ Diabetes: If diagnosed, please answer the questions below

Last A1c: _____ Last Blood Sugar: _____ How long has this been diagnosed: _____

Personal Ocular History: I have been diagnosed personally with:

☐ Macular Degeneration
☐ Cataracts
☐ Retinal Detachment, Retinal Hole or tear
☐ Color Vision deficiency
☐ Lazy eye, Eye Turn or Amblyopia
☐ Cornea Scarring
☐ Lasik
☐ Cataract surgery
☐ Other: _____

☐ Glaucoma, list of meds and dosage: _____

There is a family ocular history of:

☐ Glaucoma ☐ Macular Degeneration ☐ Other, please list: _____

If you are on medications or seeking treatment for any ocular or physical condition, please let our technicians know which ones so we can list it in your medical record.

Medical Consent to Treatment

The Doctor/s at Active Eyecare of Surprise is licensed to provide both routine vision exams and medical eye exams. If you are here today for a routine vision exam and your complaint or initial assessment indicates that there is a significant medical condition that requires treatment, you will be either provided with appropriate treatment today; referred to the appropriate specialist for treatment; or rescheduled for a medical examination. Active Eyecare is not a contracted provider for some medical plans so the charges for your visit will be payable at the time of service, you have the option to fill it with your insurance as out of network. The doctor will discuss any such condition with you prior to initiating medical treatment, and it is your responsibility to consent to treatment or request referral to the appropriate specialist.

If you are a patient with Diabetes and need a diabetic eye exam and/or report to be sent to your medical doctor this is considered a medical exam under your medical insurance and can not be done under your vision insurance plan. This usually requires a visit on a separate day as a medical exam and requires dilation. Vision insurance can not be billed on the same day as a medical visit per insurance rules.

Acknowledgements and Signature

I acknowledge that the health and insurance information I have provided above is true and correct to the best of my ability. I authorize payment of any vision or medical benefits I may be eligible for directly to Active Eyecare of Surprise. I agree that if my employer, insurance carrier, or plan sponsor denies payment to all or any part of my claim, I will be financially responsible for all outstanding charges. I acknowledge that authorization obtained at the time of service does not guarantee payment, and any services not covered by insurance will be billed to me. In the event it becomes necessary to place any unpaid balances I am responsible for in collection, I agree to pay any collection fees, reasonable attorney fees, filing fees, and other costs the court determines are proper. I understand all services and eyewear purchases (this includes contacts if needed) are due at time of service. For glasses purchases you have 60 days for any Dr/rx changes from the time of purchase, this is standard lab policy. After 90 days of examinations, prescriptions can naturally change and are subject to refraction fee if deemed necessary. If an rx is filled elsewhere Active Eyecare is not responsible if the rx is filled incorrectly, we can only guarantee products and warranty lenses purchased from us.

I have read the conditions of service, and as the Patient or the Patient's Authorized Representative I hereby accept all of the terms and policies listed above for Active Eyecare of Surprise.

Signature of Patient or Guardian: _____

Date: _____

CONTACT LENS FITTING AND EVALUATION AGREEMENT

The contact lens evaluation and or fitting is an additional fee NOT included in your comprehensive examination unless you qualify as medically necessary contacts per your vision insurance parameters. The price for this extra service depends on the type of contact lens and complexity of the contact lens fit decided by the doctor. The fee includes the initial visit, contact lens training, if needed and all follow-ups.

POLICIES:

Fitting fees are due at time of service:

- All follow-ups extending past 60 days from your initial exam are subject to normal office visit rates and is part of your vision insurance policy.
- We will be happy to confirm your insurance benefits in relation to the contact lenses and fitting. Any uncovered expenses become the patient's responsibility.
- You are responsible for keeping all follow-up appointments to finalize your prescription.
- Your prescription will not be released until the doctor has finalized it.
- All fees are non-refundable.
- All prescriptions are valid for one year of fitting exam date

I have read and agree to the policies outlined above for Active Eyecare of Surprise.

Signature of Patient or Guardian: _____

Date: _____