BRIER CREEK VISION CARE & THE CENTER FOR VISUAL LEARNING & REHABILITATIVE THERAPY
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WELCOME TO OUR OFFICE

PATIENT INFORMATION

First Name: ____________ Middle Initial: ____ Last Name: ____________ Nickname: ____________

Birth Date: ____________________________ Last 4 digits Social Security #: ____________________

Gender: Male ☐ Female ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Race: White ☐ African American ☐ Latino ☐ Asian ☐ Other ☐

Address: ____

City: ____ State: _____________ Zip Code: __________

Home Phone: _________________ Cell Phone: __________________ Work Phone: ________________

Email address: ____

How did you hear about our office? ____

Occupation: ________________________________ Employer: ________________________________

INSURANCE INFORMATION

Vision Insurance Provider: _____________________ Insurance ID Number: _____________________

Primary Insured's Full Name: ____

Primary Insured's birth date: _____________ Relationship to Patient: Self ☐ Spouse ☐ Parent ☐

Major Medical Insurance Provider: __________________ Insurance ID Number: __________________

Primary Insured's Full Name: ____

Primary Insured's birth date: _____________ Relationship to Patient: Self ☐ Spouse ☐ Parent ☐

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the following information to be released to the authorized person(s) below:

☐ Financial or billing information
☐ Medical information including test results
☐ Pickup of glasses or contact lenses

Authorized Person: ___________________________________ Relationship: _____________________

Authorized Person: ___________________________________ Relationship: _____________________

PAYMENT INFORMATION

It is the patient's responsibility to provide all insurance information at the time services are rendered. Failure to provide this information will result in the patient being responsible for service costs out of pocket as well the patient being responsible for filing their insurance for reimbursement. I authorize Brier Creek Vision Care to file my insurance on my behalf and directly collect payment. I understand that payment in full is expected at the time professional services are rendered and/or materials are ordered; this includes all non-covered services, co-pays, and deductibles that insurance does not cover. A charge of 1.5% per month will be added to all

accounts 30 days past due. Failure to pay balance in the allotted time will result in patient occurring additional costs including, but not limited to, attorney or legal fees, collection agency fees, and finance charges.

☐ Yes, I understand. Initials: ___________

CONSENT FOR DILATION

During the course of an examination, the doctor may determine it is necessary to dilate the pupils of your eyes. This allows a more thorough examination of the health of the inside of the eye. To dilate the pupils, eye drops are administered. Once the pupils are dilated, it is common to be sensitive to light. To help cope with this sensitivity, a disposable pair of sunglasses will be provided to you. Another common symptom is blurred vision, especially at near. It will require about 2-3 hours for your vision to return to normal. During this time, you must exercise caution when walking down steps, driving a vehicle, operating dangerous machinery, or performing other tasks that may present a risk of injury.

☐ Yes, I consent to dilation Initials: ________
☐ No, I do not consent to dilation

OPTOMAP ULTRA-WIDE DIGITAL RETINAL IMAGING

Optomap retinal imaging allows a much broader detailed view of the retina. Brier Creek Vision Care's recommendation is to have an Optomap every time you have an eye exam. This will ensure you have a digital record of your retinal health on file which can be compared for changes over time. These images will be captured during your pre-test work up, and reviewed during your examination. The $39 fee for this procedure is generally a non-covered service, unless billed to your major medical insurance when associated with a medical diagnosis.

☐ Yes, I consent to retinal imaging Initials: ________
☐ No, I do not consent to retinal imaging

CANCELLATION/NO SHOW POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. If an appointment is not cancelled at least 24 hours in advance or if you fail to cancel an appointment and do not show up, you will be charged a seventy-five dollar ($75) fee; this will not be covered by your insurance company.

☐ Yes, I understand Initials: _________

HIPAA PRIVACY POLICY

A copy of our HIPAA privacy policy is located on the online forms section of our website and on the front desk counter of the office. Please review this policy carefully. If you have any questions regarding this policy, please feel free to ask one of our staff members. If you would like a copy of this policy for your own records, please ask a staff member and we will provide one for you.

☐ A HIPAA privacy policy was made available to me; I have read and understand the policy

Initials: ________

All information above is correct and I agree to the statements as indicated. I consent that typing my name below will act as my signature.

Name: ____ Date: ___________