Welcome to
Eberhardt Vision Center

Patient Profile

Last Name	**First Name**	**Title** ☐ Ms ☐ Mrs ☐ Mr ☐ Dr ☐ Other _____	
Address	**City**	**State**	**Zip Code**
Home Phone	**Cell Phone**	**Work Phone**	**Name of Employer**
Date of Birth	**Last 4 of Social Security**	**Occupation**	**Referred by ☐ Friend ☐ Relative ☐ Other _____**
Date of Last Exam	**Location of Last Exam**	**Name of Primary Care Doctor**	
Name of Vision Insurances (If Any)	**Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other**	**Name of Insured (If not Self)**	

What type of exam are you here for? ☐ Routine Vision Exam ☐ Contact Lens Exam ☐ Eye Health Condition

Do you currently wear contact lenses? ☐ Yes ☐ No

Have you ever worn contact lenses? ☐ Yes ☐ No

If not, are you interested in trying contact lenses? ☐ Yes ☐ No

List any sports, hobbies, or any recreational activities that you are involved in:_____

Are you currently having any specific vision or eye health problems? ☐ Yes ☐ No

If yes, please explain in detail:_____

Are you sensitive to light? ☐ Yes ☐ No Do you ever see double? ☐ Yes ☐ No

Do you have frequent headaches or eye strain? ☐ Yes ☐ No

Do you ever see flashes of light, spots, or floaters? ☐ Yes ☐ No

Do you work at a computer terminal? ☐ Yes ☐ No How many hours/day? _____

Do you have any medical conditions such as: Diabetes ☐ Yes ☐ No High blood pressure ☐ Yes ☐ No
Thyroid disorder ☐ Yes ☐ No Respiratory problem ☐ Yes ☐ No Other: _____

Are you taking any medications? ☐ Yes ☐ No Please list:_____

_____

Are you allergic to any medications? ☐ Yes ☐ No Please list:_____

_____

Have you ever been involved in an accident involving head trauma? ☐ Yes ☐ No

Have you or any family member been diagnosed with glaucoma, cataracts, or a retinal disorder? ☐ Yes ☐ No
Who?_____ What condition?_____

Have you ever had an eye injury, infection, or surgery? ☐ Yes ☐ No Describe:_____

Are you or any family member color blind ? ☐ Yes ☐ No Who? _____

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PATIENT ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Eberhardt Vision Center. These Privacy Practices can also be found on our website at www.eberhardtvision.com. A copy of this signed, dated document shall be as effective as the original.

My signature will also serve as a protected health information document release should I request treatment or imaging be sent to other attending doctor/facility in the future.

_____ _____
Patient Name Name of Legal Representative and Relationship to Patient:

□ Self □ Spouse □ Parent □ Other_____

_____
Signature of Patient/Legal Representative

Please list any other people who can have access to your health information

Name: _____ Relationship: _____

Name: _____ Relationship: _____

How do you want to be summoned from the reception area?

First name only? _____ Last name with Mr./Mrs./Ms./Dr.? _____ Other? _____

I authorize contact from this clinic to confirm my appointments, treatment, and billing information by:

□ Cell Phone □ Home Phone □ Work Phone □ Fax □ Any Listed

I authorize INFORMATION ABOUT MY HEALTH be conveyed via:

□ Cell Phone □ Home Phone □ Work Phone □ Fax □ Any Listed

Guarantor Acknowledgment and Agreement on:
Consent to Bill my Vision and/or Medical Insurance, Full Disclosure of All Insurance Coverage Information and Patient Balances Not Covered by Insurance

I authorize Eberhardt Vision Center to bill my vision and/or medical insurance company, for myself and covered dependents (spouse, domestic partner, and/or children) for professional services rendered and any hardware product (ie. frames, eyeglass lenses, sunglasses, contact lenses, etc.) ordered through the optical department. I understand and agree that information given to the insurance coordinator at Eberhardt Vision Center from my vision and/or medical insurance company is NOT a guarantee of payment and is only an estimate. Final determination of all benefits is decided by my vision and/or medical insurance company at time of claim processing as is subject to factors such as unmet deductibles, copays, insurance coverage cancellation without patient acknowledgment or due to late or unpaid insurance premiums. The exact dollar amount is determined at the time of insurance claim processing by my vision and/or medical insurance company.

I understand that Eberhardt Vision Center is not liable nor financially responsible for erroneous, incomplete information given to the Eberhardt Vision Center by phone call or insurance website information from my vision and/or medical insurance company. I agree to pay Eberhardt Vision Center for all professional services and optical product if my vision and/or medical insurance company deny payment for whatever reason.

I agree to disclose insurance coverage information from ALL of my vision and/or medical insurance company including primary, secondary, and supplemental policies at time of service and/or ordering optical product for myself and all of my dependents (whoever is utilizing the benefit). If I am a dependent of the insured subscriber, I agree to disclose ALL my vision and/or medical insurance company (including myself, spouse, parents, and step parents) at time of service and/or ordering optical product. I understand that failure to disclose this information will result in all professional fees and optical product fees being my own (or guarantor) financial responsibility. I understand that insurance companies can go back and review claims up to three years and my financial responsibility will extend up to three years for failure to disclose this required information.

FOR CONTACT LENS PATIENTS: Contact lenses are classified as medical devices by the F.D.A. because they affect the health and metabolism of the cornea and can cause infections and corneal ulcers if a patient is non-compliant with use, care, or following the manufacturer replacement schedule. A contact lens examination includes the measurement of the corneal curvature and diameter, recommendation of lens material depending on patient wearing schedule, corneal health status, and eye dryness or wettability, as well as a physical check of the contact lens centration and alignment with a biomicroscope by the eye doctor. Contact lens evaluation/exam fees are NOT a part of the routine eye exam and the separate fees will vary depending on factors such as the patient being a first time wearer or not, needing a specialty lens such as a multifocal, rigid gas permeable, or keratoconic lens. Most All contact lens evaluation fees include 60 days of follow up care. If the patient is non-compliant with the mandatory follow up visits (when required by the eye doctor) during this 60 day period, the patient will have to restart this process after 60 days, including paying for the contact lens evaluation again.

I have read, understand, and agree to all the items discussed in this financial agreement.

Patient or Guarantor Signature: _____ Date: _____

Eberhardt Vision Center, Inc.
No Show or Late Cancellation Policy

When you schedule an appointment, a reserved time period is set aside between you, our physician assistant, and our eye doctor. When patients do not show up to their scheduled appointments or do not call and give the clinic sufficient cancellation notice, other patients are prevented from receiving eye medical care who are on our cancellation list. Broken appointments also create a financial loss to the clinic as various employees are scheduled to be here so that they can provide you with professional eye care services during your reserved appointment time. Also, if you have insurance that we are billing, our insurance coordinator has dedicated time in advance to contact your insurance company to get your benefits verified before your scheduled appointment.

Our clinic policy is as follows:

For morning and early afternoon appointments scheduled before 1:00 pm, patients are required to cancel or reschedule their appointment by 12:00pm the DAY BEFORE THEIR APPOINTMENT.

For appointments scheduled in the afternoon or evening (2:00 pm or later), patients are required to cancel or reschedule their appointment by 5:00pm the DAY BEFORE.

A patient will have a broken appointment on their record if this notice is not given by the specified time by phone, voice mail, or in person. In cases of inclement weather or same day medical emergencies, this policy will not apply but please call the clinic before your scheduled appointment time.

As a courtesy to our patients, we do NOT charge "Broken Appointment Fees" or overbook our patient schedule anticipating some patients not to show up. **However, if you break an appointment without giving us the required notice as specified above, a refundable deposit of $60 must be put down to reschedule your next appointment.**

Your full deposit will be refunded back to you within 4 business days or this amount can be applied toward your patient balance, if any. If you break your appointment after putting down your deposit, then your full deposit will be forfeited (not refunded as a penalty due to financial losses to the clinic and from preventing other patients from being seen).

I have read, understand, and agree to the above.

Patient Name: _____

Patient or Parent/Guardian Signature: _____

Date: _____