Welcome to InVision EyeCare
Candace McBride, O.D. & Stephanie Davis, O.D.

Patient Information

Name of Patient_____ Date of Birth_____ Age: _____

Name of Parent or Legal Guardian (if a minor) _____

Home Phone_____ Cell Phone_____ Is it okay to text you? (yes) (no)

Address_____ City_____ State_____ Zip_____

Email Address_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

SS#_____ Employer_____ Occupation_____

Emergency Contact_____ Phone_____

Who is financially responsible for co-pay/balance of bill not covered by insurance? _____

Insurance Information (Please fill out as completely as possible.)

Vision Insurance *Plan Name:* _____ Vision Plan ID#_____

Medical Insurance *Plan Name*:_____ Phone_____

Member ID _____ Group _____ Policy _____

Name of Primary Policy Holder: _____ Policy Holder's SS#_____

Policy Holder's Date of Birth_____ Patient's Relationship to Primary_____

AUTHORIZATION FOR INVISION EYECARE TO FILE YOUR INSURANCE

I authorize the release of any medical information necessary to process my insurance claim. I authorize and request payment of government or medical benefits to InVision EyeCare, PLLC.

Patient (or Guardian) Signature _____ Date_____

Thank you for choosing our practice for your eye care needs. We will strive to make your visit as pleasant as possible. We hope that you will find our office enjoyable, our service professional, and our staff friendly. The success of our practice depends on keeping you and your family happy. If we can help you or your family or friends any time in the future, please don't hesitate to call us.

~Please sign back of page~

Financial Policy and Patient Responsibility

We (InVision EyeCare, PLLC) are committed to providing you with the best possible care. If you have medical insurance, we want to help you receive your maximum allowable benefits.

Payment: Payment for services is required at the time services are rendered. We accept cash, checks, and credit cards. Returned checks and outstanding balances may be subject to additional collection fees. We will be happy to discuss your proposed treatment and answer any questions related to your insurance. Any charges or fees quoted to you by employees or physicians of InVision EyeCare are based on information quoted to us by your insurance company. The insurance company, however, stresses that it is NOT a guarantee and that the correct amount due by the patient cannot be completely determined until after the claim is processed. Therefore, you may owe additional charges for non-covered services after we receive payment by the insurance company, for which you will receive a bill.

Insurance: Our office will file insurance benefits for you. The patient is responsible for 100% of services rendered if insurance deductibles have not been met at day of service. Any co-payment required by your insurance plan is required at the time of the visit. Insurance benefits MUST be verified and authorized by the insurance carrier before the exam.

Refraction for eyeglasses is not a covered Medicare service. According to Medicare regulations, non-covered services may be billed to the patient if the services are considered to be Medicare program exclusions. Determination of a refractive state, (HCPCS code 92015) is a program exclusion under Medicare; therefore, patients will be responsible to pay for that portion of the exam if a refraction is done for new glasses.

HIPAA Privacy Statement and Policy for Minors

All patients have the right to have confidential care provided. All information, medical or social, whether written, spoken, electronic, or computer generated, is held in strict confidence and will not be shared with any other organization, doctor's office, business office, or individual without the expressed written consent of the patient or the patient's legal representative (*please refer to the InVision EyeCare Compliance Privacy Rules Notice pamphlet*). This also applies to the release of information to a parent pertaining to a child 18 years of age or older who is still living at home. Patients under 18 years of age must have the written consent of their parent or legal guardian, and be accompanied by the parent, legal guardian or adult chosen by the parent or legal guardian, before care may be given.

Patient Consent for Examination and Treatment and CONTACT LENS FITTING POLICY

I hereby consent to a health examination, related diagnostic procedures and treatments provided by InVision EyeCare.

I understand that the doctor reserves the right to deny fitting for contact lenses if, during examination, it is determined that I am not a candidate.

I further understand that no warranty, guarantee or assurance has been made by InVision EyeCare, its doctors or its employees as to the results of any treatments, examinations or contact lens fittings, or other medical care and that exam fees are non-refundable.

I have read and understood the above disclosures on payment, insurance, health records, and services:

_____ _____

Patient (or Guardian) Signature **Date**

InVision EyeCare Medical History

Patient Name:_____ Age:_____ Sex: Male / Female Date:_____

Allergies:_____

History of the following diseases: ***(Please indicate with a check ✓ if present)***

	Self / Family
General/Constitutional	
Cancer	____ / ____
Significant weight loss/gain	____ / ____
Skin/Integumentary	
Rash	____ / ____
Melanoma	____ / ____
Eczema	____ / ____
Psoriasis	____ / ____
Rosacea	____ / ____
Shingles	____ / ____
Other_____	____ / ____
Neurological	
Chronic headache	____ / ____
Migraines	____ / ____
Epilepsy/seizures	____ / ____
Multiple Sclerosis	____ / ____
Tingling/numbness	____ / ____
Endocrine	
High thyroid	____ / ____
Low thyroid	____ / ____
Hormonal imbalance	____ / ____
Lymphatic/Blood Disorders	
Anemia	____ / ____
Bleeding tendency (hemophilia)	____ / ____
Increased blood clotting	____ / ____
Sickle Cell	____ / ____
Leukemia	____ / ____
Ears/Nose/Mouth/Throat	
Hearing Loss	____ / ____
Chronic allergies	____ / ____
Sinus congestion	____ / ____
Chronic cough	____ / ____
Recurrent cold sores	____ / ____
Gastrointestinal	
Ulcers	____ / ____
Colitis	____ / ____
Irritable bowel syndrome	____ / ____
Crohn's Disease	____ / ____

	Self / Family
Respiratory	
Asthma	____ / ____
COPD	____ / ____
Emphysema	____ / ____
Sleep Apnea	____ / ____
Other_____	____ / ____
Cardiovascular/Vascular	
Diabetes	____ / ____
High blood pressure	____ / ____
High cholesterol	____ / ____
Stroke	____ / ____
TIA	____ / ____
Heart disease	____ / ____
Irregular heart beat	____ / ____
Chest pain	____ / ____
Dizziness	____ / ____
Immunologic	
Lupus	____ / ____
Tuberculosis	____ / ____
HIV/AIDS	____ / ____
Hepatitis	____ / ____
Liver disease	____ / ____
Sarcoidosis	____ / ____
Genitourinary	
Kidney disease	____ / ____
Prostate disease	____ / ____
Ovarian disease	____ / ____
Sexually transmitted disease	____ / ____
Bones/Joints/Muscles	
Rheumatoid Arthritis	____ / ____
Chronic joint/muscle pain	____ / ____
Fibromyalgia	____ / ____
Osteoporosis	____ / ____
Psychiatric	
Depression	____ / ____
Anxiety	____ / ____
Attention deficit disorder	____ / ____
Bipolar disorder	____ / ____
Schizophrenia	____ / ____

Previous surgeries:_____

Other pertinent information:_____

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Current Medications:_____

_____

_____

Cigarette use: Yes/No Alcohol use: Yes/No

If you are female, possibility of pregnancy? Yes / No

Ocular History

History of eye diseases: ***(Please indicate with a check ✓ if present)***

	Self / Family
Glaucoma	____ / ____
Cataracts	____ / ____
Macular Degeneration	____ / ____
Retinal Detachment	____ / ____
Blindness	____ / ____
Retinal Disease	____ / ____
Color Blindness	____ / ____
Strabismus (eye turn)	____ / ____
Amblyopia ("Lazy" eye)	____ / ____
Other_____	____ / ____

Do you suffer from any of the following:

Blurry Vision	_____	Sinus Problems	_____	Flashes of Light	_____
Dry Eyes	_____	Headaches	_____	Halos	_____
Watery Eyes	_____	Pain in your eyes	_____	Floaters	_____
Seasonal allergy	_____	Dizziness	_____	Other	_____

Have you ever had any serious trauma to your eyes? Yes / No _____

Have you ever had any serious eye infections? Yes / No _____

Do you use any prescription or non-prescription eye drops? Yes / No _____

Contact Lens History

Contact Lens use? Yes / No What kind? Soft / Hard Brand:_____

Current replacement schedule? _____ Brand of cleaning solution: _____

Do you ever sleep in your contact lenses? Yes / No (If Yes, how often?_____)

Approximate date of last eye exam:_____ Present eye doctor:_____

Approximate date of last physical exam:_____ Present medical doctor:_____

Purpose of today's visit:_____