Welcome to Family Vision Clinic

Dr. Martin B. Gresak, O.D. Dr. Laura Steiner Christy, O.D.

Patient Information

Date_______________

Patient Name____Birthdate________________Age____
Address____City__________________State_____Zip_______
Home Phone___________________________Cell Phone_______________________SSN___________________
Email Address ____________________________________Occupation/Grade______________________________
Employer/School_______________________________Work Phone_________________________X__________
Name of person responsible for this account____
Name of Spouse/Parent____Phone____________________________
Address____City___________________State____Zip_______
Method of Payment: ______Cash ______Check ______Credit Card ______Insurance
Insurance Company____
Insurance Address_____________________________________City___________________State____Zip_______
Policy Number______________________________________Group Number______________________________
Reason for today's visit____
Date of last eye exam_________________Name of doctor or location_________________________________
Do you currently wear: (circle one) **Glasses** Yes / No **Contacts** Yes / No
Are you interested in: **Trying contact lenses** Yes / No **Laser Vision Correction** Yes / No

When do you wear your glasses or contacts? (Check all that apply)

______All the time	______Sports	______Reading/ Hobbies
______Television	______Work Safety	______Night Driving
______Distance tasks only	______Sun Protection	______Computer work

Have you ever had any of the following conditions involving your eyes?

______Eye Surgery/LASIK/PRK	______Severe Pain	______Eye Infection/Disease
______Eye Injury	______Floaters/Spots/Flashes	______Double Vision
______Visual training	______Sensitivity to light	______Eye Strain
______Poor distance vision	______Poor near vision	______Eye burn/itch/water

Do any of the following conditions apply to you?

______Frequent headaches	______Drug allergies	______Pregnant
______Allergies/Dry eyes	______Sinus trouble	______Recently gave birth

Please list ALL medications you are currently taking, including birth control and eye drops_________________
____
____

Do you or anyone in your immediate family have a history of the following?
Please mark accordingly: ***S****=self* ***M****=mother* ***F****=father* ***SB****=sibling* ***G****=grandparent*

______Diabetes	______Blindness	______High Blood Pressure
______Cataracts	______Thyroid Disease	______Turned/Lazy Eye
______Glaucoma	______Heart Condition	______Other Eye Problems

Payment is expected at time of service

____ ______________________
Patient or Guardian Signature Date

The Following Policies Will Apply

I. Any patient not having insurance is responsible for the full balance of the eye exam or office visit. This must be paid in full on the service date. Materials must have a deposit made before the order can be placed, and the balance due is paid on the day of dispensing. If necessary, payments can be made and glasses dispensed when final payment is received.

II. All eye exams, office visits, and materials will be billed directly to **ACCEPTED** insurance providers; in some cases insurance can be submitted by patients. All patients with accepted insurance are responsible for paying their balances (including co-pays) that are not covered by their insurance plans on exam/visit dates. Patients are responsible for paying the full balance of their eye exam/office visits if their insurance providers are not accepted by this office; materials can carry a balance until the dispensing date.

III. All eyeglass prescriptions will be held until payments are made in full. All frames have a 1-year warranty against breakage. All lenses, with either scratch guard or anti-reflective coating, have a 1-year warranty against scratches. No-line bifocal/progressive lenses have a 60-day non-adapt manufacturer's warranty. If you cannot adapt to these lenses, they will be remade into traditional trifocal, bifocal or single vision lenses at no additional cost BUT you will not receive a refund.

IV. All contact lens records (including prescriptions) are part of the medical record. All contact lenses and replacement lenses must have a deposit made and balance paid in full on the dispensing date. Patients must return for a contact lens follow-up before this office will order their prescription lenses or release any prescriptions. Should someone want his/her contact lens prescription, it will be provided upon request **IF** the individual's exam and evaluation for contact lens fees have been paid.

V. This office accepts cash, check, Visa, MasterCard, American Express, and Discover.

HIPAA Acknowledgment and Consent

I acknowledge that I have been given an opportunity to review Family Vision Clinic's Notice of Privacy Practices. This acknowledgment is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

I have read and thoroughly understand the above policies.

________________________________ ____________________

Patient or Guardian Signature Date

For those with approved insurance, please read and sign the statement below.

Assignment of Benefits

I authorize Dr. Martin B. Gresak and staff to release any medical and/or other information necessary to process my insurance claim. I also request assignment of benefits be made to Dr. Martin B. Gresak or Family Vision Clinic on my behalf. I understand that I am responsible for any amount not covered by my insurance. This order shall remain in effect until revoked by me.

________________________________ ____________________

Patient or Guardian Signature Date

Thank you for allowing Family Vision Clinic to provide your vision care.