PATIENT REGISTRATION FORM

Patient Information

Last Name: ________________________ First Name: ___________________ MI___ SS#:___________

Address:______________________________ City:___________________ State:______ Zip:_________
(please include Apt #)
Birth Date:__________________ Home or Cell#__________________ Work #____________________

Employer:____Occupation:__________________________

Gender: ____MALE ____FEMALE Marital Status:____

Email Address:____

How did you learn about our office?____

Emergency Contact:________________________ Phone #_________________Relationship:_________

If patient is under 18 years of age:

Name of parent / Legal guardian:_____________________________ Phone #____________________

Insurance Information

Primary Insurance Name___________________________________ Policy #_____________________

Policy Holder Name:______________________________ Birth Date:_____________ SS#___________

Relationship to Patient____

PAYMENT FOR THE DOCTOR IS REQUIRED AT THE TIME OF SERVICE.

If you are paying by check, we do require a valid driver's license. Returned checks and withdrawn credit card transactions will be assessed a $35.00 service charge.

I certify that the above information is true and accurate. I hereby assign or transfer payments benefits made to me and my behalf to St Cloud Eye Care for any services furnished to me by this physician/supplier. I further agree that I am responsible for payment or charges incurred by me that are not covered by my insurance or for which my insurance has paid me. I understand that professional services are not refundable.

Patient/Legal Representative (Print): ____
Patient/Legal Representative Signature: ____
Relationship to patient (If Minor): ________________________ Date: ____________________________

MEDICAL QUESTIONAIRE / EYE HISTORY

Reason for this visit: ☐Routine exam for glasses ☐Routine exam for glasses and contact lens

☐Eye infection ☐Eye injury

Other:____

Last eye exam:_________________________________ Doctor's Name:______________________

Have you ever had any injury or surgery to or around your eyes?_________ If yes, please__________ describe____

____

Last physical exam:______________________________ Doctor's Name:____________________

Please list any and all medications you may be taking including eye drops, hormones and birth control (If you don't know the name of the medication, please list the reason for the medication): _______________

____

____

Please list any medication allergies:____

Have you ever suffered from the following (please check yes or no):

	Yes	No		Yes	No		Yes	No
Glaucoma	____	____	Kidney/Liver Disorder	____	____	High Cholesterol	____	____
Cataracts	____	____	Arthritis	____	____	Thyroid Disorder	____	____
Lazy Eye	____	____	Fainting/Dizziness	____	____	Asthma/Bronchitis	____	____
Blindness	____	____	Cancer (type)	____	____	Diabetes, how long?	____	____
Allergies	____	____	High Blood Pressure	____	____	Do you smoke?	____	____
Retinal Disorder	____	____	Heart/Vascular Disorder	____	____	Do you drink?	____	____
Color Blindness	____	____	Neurological Disorder	____	____	Other	____	____

Is there any family history of any conditions listed above? Please list relative for the condition. ________

____

____

Dilation: It is our goal to provide you a complete and thorough comprehensive eye examination. This will require placing drops in your eyes, which will open the pupil (black spot) and allow a better view of the inside of your eye.

As with many medications, there are some side effects of the drops used to dilate the pupil. These include sensitivity to light and blurred reading vision (in most cases the distance vision will not be affected). Please use caution when driving. The side effects last several hours and in some cases may last as long as 24 hours.

While we believe dilation is an important part of the eye examination process, we understand that you may want to defer or omit this procedure.

I certify that the above information is true and accurate.

Patient/Legal Representative Signature: _______________________________ Date:______________

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a means by which a third-party payer can verify that services billed were actually provided
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been offered a copy of the *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing except to the extent that the organization has already taken action in reliance thereon.

Patient/Legal Representative Signature:_____________________________ Date:___________

Thank you for your confidence in our professional services and practice.
We look forward to serving you.

St. Cloud Eye Care

Office Policies

1. **Professional Services Are Non-Refundable**
2. All completed orders should be picked up within 3 months following notification, If not picked up; the material(s) will be disposed of.
3. We are not responsible for glasses or contacts that are not picked up within 90 days. **Payments or deposits will not be refunded.**
4. Contact lens fitting/evaluation has to be done within **60 days** of the routine examination. Otherwise additional fees will apply. Any evaluation over 6 months from routine examination will require whole new exam in addition to the contact lens fitting/evaluation.
5. Once contact lenses are finalized by the doctor, **no changes can be made** to the powers or brand of the contacts.
6. All contact lens follow-ups within 2 months of a contact lens exam will be at no charge. However, **any follow-up visits after 2 months from the date of the contact lens exam will be charged the regular fitting fee.** Anything over 6 months will require a new exam fee in addition to the fit.
7. Only boxes that are unopened in resalable condition-free of markings, dents, or damages will be exchanged or refunded. **NO EXCEPTIONS**
8. Prescription re-checks within 45 days of exam date will be at no charge. **All re-checks more than 45 days after the date of exam, but not more than 6 months, will be charged a refraction fee.** Thereafter, a new exam is required.
9. We do require a deposit of 50% for all orders and all balances must be paid in full when picking up material(s).
10. Patients may use own frames for orders, however for all orders of patients own frames, **we are NOT** responsible financially if the glasses break going through the lab, are stolen, or are lost during the process of completing the order.
11. Often we have little to no control over the amount of time it will take to manufacture the eyewear order. The average turnaround time is 14 business days but rest assured we will call you as soon as your order is received.
12. **Prescription glasses are made to fit your needs only, they are a custom-made medical device. NO returns will be permitted.**

By signing below, you are acknowledging and accepting our office policies. If you have any questions regarding this form, please speak with one of our associates before signing.

Thank You

Signature____ **Date**________________

OFFICE CANCELLATION POLICY

This policy has been established to better serve our patients needs.
It is necessary for us to make appointments in order to see our patients as efficiently as possible. When an appointment is made it takes that time slot away from another patient. No shows and late cancellations delay the delivery of our services to our other patients.

A “no show” is missing a scheduled appointment. A “late cancellation” is cancelling an appointment without calling 24 hours in advance.

We do understand that there are times when you must miss an appointment due to emergencies, obligations from work or family. However, when you do not call to cancel an appointment in advance, you are preventing another patient from being seen.

IF AN APPOINTMENT IS NOT CANCELLED 24 HOURS IN ADVANCE YOU WILL BE CHARGED A TWENTY-FIVE DOLLARS ($25.00) FEE; THIS WILL NOT BE COVERED UNDER YOUR INSURANCE.

____
PRINT PATIENT NAME

_______________________________________ ____________________
SIGNATURE PATIENT/GUARDIAN DATE

St. Cloud Eye Care

Child Medical Consent

Patient name: ____ Date of Birth: ________________

We understand there are times when the parent or legal guardian cannot be present to bring the child to his/her appointment. Unfortunately, without parental consent your child will not be seen at our facility. In the event of an emergency, where for one reason or another you the parent cannot be present, who do you authorize and give consent to bring your child into our facility?

Name: ____________________________________ Phone number: __________________________

Address:____

____

Date of Birth: ___________________ Relationship to patient: ________________________________

Name: ______________________________________ Phone number: ___________________________

Address:____

____

Date of Birth: ____________________ Relationship to patient: _______________________________

Name: ______________________________________ Phone number: ___________________________

Address:____

____

Date of Birth: __________________ Relationship to patient: _________________________________

BY SIGNING BELOW, YOU ARE GIVING CONSENT FOR THE INDIVIDUALS LISTED ABOVE TO BRING YOUR CHILD AND MAKE ANY MEDICAL DECISIONS ON YOUR BEHALF AND THAT OF YOUR CHILD. PLEASE UNDERSTAND IF ANYONE NOT LISTED BRINGS YOUR CHILD TO OUR FACILITY, YOUR CHILD WILL NOT BE SEEN. YOU HAVE THE RIGHT TO REVOKE ANY INDIVIDUAL AT ANY TIME. WE WILL NEED A LETTER STATING THAT IF IT OCCURS. LEGAL FORM OF IDENTIFICATION IS REQUIRED BY ALL INDIVIDUALS AT THE TIME OF VISIT.

Patient/Legal Representative (Print): ____

Patient/Legal Representative Signature: ____

Relationship to patient: _______________________________ Date: ___________________________

St. Cloud Eye Care

Release Form

In order to help us stay within the guidelines of HIPPA, please list below any person/persons that you authorize us to disclose your Protected Health Information with, including billing information and dispensing of prescriptions. Please provide all information requested.

Name: ________________________________ Phone number:___________________________________

Date of Birth: _______________________________ Relationship to patient:________________________

Name: ________________________________ Phone number:___________________________________

Date of Birth: _______________________________ Relationship to patient:________________________

Name: ________________________________ Phone number:____________________________________

Date of Birth: _______________________________ Relationship to patient:________________________

(Patient Information)

Patient Name: _________________________________ Date of birth: ______________________________

SSN: ____________________________ Phone number: ____

This authorization will continue until it is withdrawn, by me (the patient), in writing.

Patient Signature: _________________________________ Date: __________________________

(Office use only)

Use this space for consent withdraws only: Need written letter from patient.

____ ____

Date consent revoked Staff Signature