Griffeth Vision Group

Welcome to Griffeth Vision Group. Please complete the following information. You will be responsible for payment if incorrect or incomplete information is given. CO-PAYS ARE DUE AT TIME OF SERVICE. Patients without insurance are required to pay at time of service. *There will be a $25 fee for all missed appointments.*

Mr.____ Mrs._____ Miss _____ Ms._____ Marital Status_____ Male ____ Female ____

_____

First Name, MI, Last Name Preferred Name

_____

Street Address City State Zip Code

_____

Social Security Number Date of Birth Home Phone Other Phone

_____

Email Address **Person Responsible for Bill- Name & Date of Birth**

RACE American Indian or Alaskan Native _____ Asian _____ Black or African American_____ White_____

Native Hawaiian or other Pacific Islander_____ Other_____ Decline to Specify _____

ETHNICITY Hispanic or Latino ____ Not Hispanic or Latino____ Unknown____ Decline to Specify _____

PREFERRED LANGUAGE _____

VISION INSURANCE INFORMATION Patient's Relationship to Insured_____

_____

Name and Address of Ins. Company

_____ M_____ F_____

Policy Holder's Full Name

_____

Policy Holder's Identification Number Social Security Number Date of Birth

PRIMARY MEDICAL INSURANCE INFORMATION Patient's Relationship to Insured_____

_____

Name and Address of Ins. Company

_____ M_____ F_____

Policy Holder's Full Name

_____

Policy Holder's Identification Number Social Security Number Date of Birth

SECONDARY MEDICAL INSURANCE INFORMATION Patient's Relationship to Insured_____

_____

Name and Address of Ins. Company

_____ M_____ F_____

Policy Holder's Full Name

_____

Policy Holder's Identification Number Social Security Number Date of Birth

I understand that the insurance provided at the time of service will be billed on my behalf. I acknowledge that it is my responsibility to provide current medical and vision insurance information. I also understand that it is my responsibility to know my insurance benefits (deductible, co-pay, etc). All benefits quoted to me are not a guarantee of payment and ultimately determined by your insurance company upon claim processing. _____Initial here

HIPAA INFORMATION AND CONSENT

As of April 2003, it is required by law to have a privacy policy in place and accessible to you. At your request, you may obtain a complete HIPAA disclosure form.
Your personal health information is protected from anyone but yourself unless you specifically list those whom you feel it is appropriate to give information to on your behalf. Your personal health information may be given without consent if it is requested by a court order or the military. It may also be shared with another doctor's office that you may be referred to by our office. Your protected health information will be used and disclosed to provide, coordinate, or manage your health care and any related services.
I understand my rights regarding my medical records. A copy of the Griffeth Vision Group Notice of Privacy Practices has been made available to me.

In the event you are unable to communicate with us yourself and you feel it is appropriate to give information to someone else, please list them below. *This applies to both medical and billing information.*

_____ _____

Signature of Patient or Guardian (if minor) _____

AGREEMENT TO COVER COLLECTION CHARGES

Any Patient portion is due at the time services are rendered (co-pay, deductible, coinsurance, non-covered services) and Payment in full for a "Self Pay" Patients. You are expected to pay your balance in full on the date of service. Should special circumstances arise, we ask that you please contact our billing department to set up payment arrangements.
Accounts 90 days old are subject to collection fees up to 40%. There will be a $25.00 service charge on all returned checks. I agree to pay court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee equal to 40% of the outstanding balance as compensation to this office for any commission it must pay to a collection agency in collecting any outstanding balance. Furthermore, I agree that this fee is proportionate to the actual damage caused by my nonpayment and is not an excessive estimate of the costs of collection.

_____ Printed Name:_____
Signature
Printed Name, DOB & Address:_____

CANCELLATION/NO SHOW POLICY

If your appointment is not cancelled at least 24 hours in advance you will be charged a $25.00 fee; this will not be covered by your insurance company.

In order to keep our office on schedule, and in consideration of all patients, if a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

_____ _____ ____/____/____
Print Name Patient Signature Patient/Guardian Date

ROUTINE EXAMS -VS- MEDICAL EYE EXAMS

Some medical insurance plans provide a benefit for one routine, preventative eye exam per year. If this is the case, they will first be billed then we will forward any remaining charges to your vision plan for coverage. This helps reduce out-of-pocket costs for you, our patient. Please be aware that a Preventative benefit may not be payable through your medical insurance but outsourced to a Vision insurance that we may not be contracted with. **It is important you clarify with your medical insurance that the preventative benefit is processed by them.** ***It is your responsibility to tell us what insurance benefit you intend to use.***

Routine Eye Examination Your "vision" insurance is intended to provide you with a baseline eye evaluation and update your eyeglass prescription only.

Medical Eye Examination If you have an eye condition or certain health condition or new symptoms that need to be evaluated, this examination will be billed to your medical insurance. If the doctor discovers a medical eye problem during a routine eye exam, you will be given the choice to continue with the exam and have you return to address the medical condition or address the medical condition and bill your medical insurance.

***Medicare or Medicare Advantage plans will *never* pay for a routine eye exam (prescription update). Your exam will need to be filed medical and the refraction, which is used in obtaining your eyeglass prescription, will be your responsibility ($25.00 after courtesy discount, due at the time of service).**

_____ _____

Signature **Date**

EMERGENCY CONTACT

In case of emergency please contact: (Person NOT living with patient)

Name:_____ Phone #:_____

Relationship to Patient:_____

CONTACT LENS AGREEMENT

Dr. Griffeth is dedicated to providing the highest level of contact lens products and services for our patients. Contact lenses are a medical device. If used improperly, they can compromise the health of your eyes. We feel that to assure good eye health in contact lens wearers, yearly eye examinations are essential.

Because of the extra time involved in evaluating, testing and discussing contact lenses, we charge a contact lens evaluation fee in addition to the medical eye examination fee.

Your contact lens evaluation fee includes follow-up visits for 60 days from your initial examination. This means that you will not be charged for follow-up visits during this time. However, these visits are for contact lens fitting and wearing concerns only and not for other eye problems. Any medical eye conditions, even if they are related to wearing contact lenses, will not be covered and will be your responsibility or the responsibility of your insurance company. Additionally, any contact lens related visits after 60 days will not be included in the original fee. So, additional charges will apply.

For patients who purchase their contact lenses at InFocus Optical in our office, we offer the following complimentary benefits:

Free trial lenses in emergencies when possible (except custom lenses)
Free exchanges for 60 days on specialty lenses and on any unopened and unmarred boxes of disposable lenses.
(Note: Most specialty lenses are not fully refundable)

A comfortable contact lens does not necessarily imply that the lens fits correctly. Because an improperly fitting lens can cause eye health problems, including severe infection and temporary or permanent vision loss. We will not release the contact lens prescription until you have attended your follow-up visits for the doctor to determine if the lenses fit appropriately.

Fees for contact lens professional services will be due in full at the time of the initial contact lens evaluation. We will order or dispense contact lenses when we have received full payment. If during the 6o days fitting period it is determined that your eyes required more complex lenses, additional fees for lenses and services may be charged.

Refund Policy: Contact lens professional fees are non-refundable. If it is necessary to discontinue contact lens wear, you may receive a credit for the cost of the contact lenses if they are returned in unopened and unmarred boxes or in acceptable condition (depending on the type of lens) within 60 days of the day they were ordered. A restocking fee of $5 per cox of lenses will apply to lenses that are ordered and not picked up within 30 days. Toric and multifocal lenses are not fully refundable. Refunds may not be available if lenses are returned more than 60 days after the initial order.

General guideline for contact lens evaluation fees*

Contact lens insertion/removal training	$40.00
Contact lens evaluation (spherical)	$20.00

*Fees described above are guidelines only. Dr. Griffeth reserves the right to vary changes according to the difficulty of the contact lens fit.

With my signature below, I acknowledge and accept this agreement as written. A complete medical eye examination does not include evaluation of contact lenses. If I choose not to have my contacts evaluated today, I understand that a contact lens prescription cannot be written nor may contacts be ordered.

_____

Patient Name (please print)

_____ _____

Signature of patient (Or parent/guardian) Date

Griffeth Vision Group

PATIENT HISTORY AND INFORMATION

NAME_____ DOB:_____ REFERRED BY: _____

Primary Care Physician:_____ Pharmacy:_____

HEALTH HISTORY **Height_____** **Weight_____**

What is the main reason for today's exam? _____

Past Illnesses or injuries _____ None _____

Past Surgeries:_____None _____

Current Medications_____

_____ None _____

Current Eye Drops: _____None _____

Allergies to Medications: _____ None _____

CURRENT EYE SYMPTOMS

	YES	NO		YES	NO		YES	NO
Glaucoma			Dryness			Strabismus (Crossed Eyes)		
Cataract			Excess Tearing/Watering			Blurred Vision Distance		
Macular Degeneration			Eye Pain or Soreness			Blurred Vision Near		
Retinal Detachment			Foreign Body Sensation			Distorted Vision (Halos)		
Color Blindness			Infection of Eye or Lid			Double Vision		
Headaches			Itching			Floaters or Spots		
Glare/Light Sensitivity			Mucous Discharge			Fluctuating Vision		
Tired Eyes			Drooping Eyelid			Loss of Vision		
Amblyopia (Lazy Eye)			Redness			Loss of Side Vision		
Burning			Sandy or Gritty Feeling					

GENERAL HEALTH CONDITION

	YES	NO		YES	NO		YES	NO
Heart Disease			Kidney			Diabetes- Type 2		
Ears, Nose, Throat			Muscles, Bones, Joints			Thyroid		
High Blood Pressure			Skin			Blood/Lymph		
Respiratory (Asthma)			Neurological			Are You Pregnant?		
Anxiety			Diabetes- Type 1			Are You Nursing?		

NAME: _____

FAMILY HISTORY AND RELATIONSHIP

	YES	NO	RELATIONSHIP		YES	NO	RELATIONSHIP
Amblyopia (Lazy Eye)				Retinal Detachment			
Blindness				Strabismus (Eye Turn)			
Cataracts				Rheumatoid Arthritis			
Color Blindness				Cancer			
Glaucoma				Diabetes			
Macular Degeneration				Heart Disease			

FAMILY HISTORY AND RELATIONSHIP

	YES	NO	RELATIONSHIP
High Blood Pressure			
Kidney Disease			
Lupus			
Stroke			
Thyroid Disease			
Other			

SOCIAL HISTORY

Do you drink alcohol? If yes, how much/often: No ____Occasional____ 1 Per Day ____ 2-3 Per Day____ 4+/Day____

Do you smoke? If yes, how much/often: No____ Occasional____ Everyday____ ½ Pack /Day ____ 1Pack/Day ____ 1+Pack/Day_____ Former Smoker_____ Never Smoked____

Method of Tobacco Intake: Smoking____ Chewing____ E-Cigarettes_____

Do you use Illegal Drugs? Yes____ No ____

DILATING DROPS

I hereby authorize Dr. Griffeth and/or such assistants as may be designated by him to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

Yes	No	Refused	Deferred after Education

Signature_____

Name: _____

Please put an X in the box for all that currently apply

	YES		YES		YES
CARDIOVASCULAR		**HEENT**		**MUSCULOSKELETAL**	
chest pain		dizziness		back pain	
irregular heart beat		hearing loss		joint pain	
shortness of breath		hoarseness		muscle aches	
		ringing in ears		stiffness	
		sore throat		swelling	
RESPIRATORY		**BLOOD PRESSURE CONTROL**		**CONSTITUTIONAL**	
cough		good BP control		fatigue	
trouble breathing		borderline BP control		fever	
wheezing		poor BP control		night sweats	
		unknown BP control		weakness	
				weight loss	
HEMATOLOGIC		**NEUROLOGICAL**		**SKIN**	
bleeding		balance problems		hair loss	
bruising		headache		rash	
tender nodes		numbness		skin lesions	
		tingling			

DIABETES CONTROL		**GENITOURINARY**		**METABOLIC**	
good DM control		genital discharge		cold intolerance	
borderline DM control		genital lesions		excess hunger	
poor DM control		painful urination		excessive thirst	
unknown DM control		urgency		frequent urination	
				heat intolerance	

PSYCHIATRIC		**ALLERGY**		**PREGNANCY**	
anxiety		itching		first pregnancy trimester	
depression		hives		second pregnancy trimester	
insomnia		chronic runny nose		third pregnancy trimester	
irritability		seasonal allergies		not pregnant	
nervousness					

Please Initial _____