Premier Vision

Kent A. Wilson, O.D.

WELCOME BACK TO OUR OFFICE

We are happy to "SEE" you again!

First Name _____ MI _____ Last Name _____Today's Date _____
Date of Birth ___/___/_____ Address _____ City _____
State_____ Zip _____Home Phone _____Cell Phone _____
E-mail _____

REASON FOR "TODAY'S" VISIT

☐Loss of Vision	☐Blurred Vision	☐Distorted Vision/Halos	☐Loss of Side Vision
☐Double Vision	☐Glare/Light Sensitivity	☐Eye Pain/Soreness	☐Stys/Chalazion
☐Eye Injury	☐Flashes/Floaters in vision	☐Retinal Disease	☐ Cataract
☐Dryness	☐Mucous Discharge	☐Redness	☐Sandy/Gritty Feeling
☐Itching	☐Burning	☐Glaucoma	☐Excess Tears/Watering
☐Foreign Body Sensation	☐ Chronic Infection of eye or lid		☐Other _____

PERSON RESPONSIBLE FOR PAYMENT

Patient/Guardian/Parent: _____ Relationship: _____

Address _____ City _____ State _____ Zip _____

Date of Birth ____/_____/_____ Home Number _____Cell Number _____ Email_____

GLASSES/CONTACTS HISTORY:

Do you wear glasses? ☐Yes ☐No Are they for… ☐Full Time ☐Reading ☐Computer ☐Driving
Computer/Screen Time: ☐1-2 hours ☐3-4 hours ☐6-8 hours ☐8+ hours
Do any of the following bother you?☐Computer Screen ☐Sun ☐Oncoming Traffic ☐Glare Problems
Do you wear contacts? ☐Yes ☐No … If yes, are they comfortable? ☐Yes ☐No
Type: ☐Daily ☐Overnight Wear ☐Rigid ☐Soft How often do you dispose of them? _____
Brand of Lenses: _____

Have you had any changes in your health since your last visit? ☐ Yes ☐ No If yes, explain:

_____

Have you had any recent surgeries? ☐ Yes ☐ No If yes, explain: _____

_____

Have you had any changes in your medications since your last visit? ☐ Yes ☐ No If yes, explain:

_____

_____

PREMIER VISION FINANCIAL POLICIES AGREEMENT

FINANCIAL RESPONSIBILITY

As a member of a vision care plan and/or medical insurance, I acknowledge that I will assume full financial responsibility for services rendered to me if my vision or medical insurance carrier denies or does not cover my claim for these services. I understand that my personal insurance coverage is a contract between me and my insurance company not Premier Vision. **All co-pays, deductibles, and/or co-insurance, and any non-covered services are due at the time of the appointment**, as outlined by my chosen plan contract with my insurance provider. All benefits quoted are not a guarantee of payment by my insurance company and final determination can only be made when the claim is processed. If my insurance company has not reimbursed Premier Vision in full, **I am responsible for payment of any remaining fees owed.**

NO SHOW/CANCELLATION POLICY

It is important to be present for your appointment. Please call at least 24 hours in advance if you need to move your appointment time or date in order to avoid a **$15 cancellation fee**. We understand emergencies happen. However, if a patient does not show up for their appointment for 3 consecutive visits or cancels up to 3 times in a row, cancellation fees will accrue and must be paid before given a new appointment time.

CONTACT LENS POLICY

Contact lens and/or service fees not covered by insurance must be paid in full at the time of service and are not refundable. For your benefit, please make a final decision on the success of your contact lenses within **30 days**. Contact lens prescriptions will only be released after the initial fitting period is successfully completed and after all fees are paid. Contact lenses are to be paid in full before being ordered. Open and/or damaged boxes of contact lenses are not returnable.
Trial lenses will only be dispensed during the fitting process, as needed, to reach a final prescription.

LAB REFUND, PRESCRIPTION CHANGE POLICY

New frames normally have a 1–2-year warranty from the original date for manufacturer defects only. This warranty does not cover loss. If a patient is unable to adapt to his/her new prescription, please let us know within **30 days**. We will make adjustments, but this does not entitle the patient to a refund. First time recheck within **30 days** will be at no charge. After that, patient will be responsible for the cost of an office visit.

REFRACTION POLICY and ACKNOWLEDGEMENT

Refraction is the process of determining the eye's refractive error, or need for corrective lenses (glasses). Refraction is part of an eye exam but is NOT a covered service by Medicare or most managed care plans. Our office fee for the refraction (glasses prescription) is **$40.00**. This refraction fee is in addition to the patient's co-pay. (Please check box.)

☐ I have read the above statement and understand the refraction is a non-covered service. I accept full financial responsibility for the cost of the service. The co-pay is separate from and not included in the refraction fee.

CONSENT FOR USE OF INSURANCE INFORMATION AND FINANCIAL RESPONSIBILITY

I authorize Dr. Wilson to release any information required to process my insurance claim, or insurance claim for my child. I also authorize my insurance benefits to be paid directly to Dr. Wilson and understand that I am responsible for any non-covered or denied services.

I have read and understand my financial responsibilities and the above policies and have accurately answered all medical questions on the previous pages to the best of my knowledge. Any copy of this authorization shall be as valid as the original.

Signed _____ Date _____