Apple Valley Vision

539 South 100 West | Payson, UT 84651

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY LAW

While providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information to treat you, to obtain payment for services, and to conduct healthcare operations involving our office. Our Privacy Policy describes the uses and disclosures in detail. Apple Valley vision must make its notice available in hard copy format to any person who asks for it.

OPTOMAP RETINAL IMAGING

As part of *every eye exam,* we take a picture of the back part of your eye, called the retina. This *often replaces dilating drops* and provides an annual, permanent record which gives your doctor comparisons for tracking and diagnosing potential issues. If your insurance covers this charge, we will let you know.

The copay for this test is $15 per individual

REFRACTION FEE

The part of your evaluation that determines your prescription is called a "refraction." Routine vision benefits such as VSP, Eye Med, or Medical Eye Services, typically include this with your exam benefits. Some medical insurances, namely Medicare, may or may not cover this fee.

The fee for refraction is $35

SPECTACLE CANCELLATION and/or REMAKE POLICY

Due to the custom nature of each pair of glasses, we require a deposit of 50% on all eyeglass orders before they will be submitted. The remaining balance will be due at the time of delivery. Any cancellations after lenses have been ordered will be billed at 50% of retail. At the doctors' discretion, patients who are not seeing well with their glasses may have their prescription adjusted at no cost, within 45 days of the original purchase date. Any patient who fails to adapt to their new lenses will have their prescription remade one time into a lens of their choice at no additional charge. Refunds are not available after 30 days on all lenses. However, there is an option for in office credit or a refund to the same card previously used.

THE CONTACT LENS PROCESS

***Contact lens fitting and evaluation services ARE NOT included as part of a normal ROUTINE EXAM*. These are considered distinct procedural services and additional fees apply.** Fees are customized according to the complexity of the case and the predicted time necessary to care for the individual patient. *Evaluation fees cover the following: fitting, training, sample cleaning solutions, two months of follow up care as well as disposable trial lenses, until the prescription is finalized.* Specialty lenses (soft and rigid) and office visits outside the initial two-month period are not included and will be billed accordingly. Much like glasses, contact lens materials require additional fees.

- Our contact lens warranty includes exchange of unopened, clean boxes of contact lenses if your prescription changes during 1 year after purchase. All gas permeable contact lenses have a 60-day warranty.
- By Signing below, I am giving consent to receive my contact lens prescription electronically. Hard copies granted on request.

Most soft contact lens fees range from $40 to $150+, specialty lenses up to $1500

FINANCIAL DISCLAIMERS

We will attempt to verify your insurance eligibility for services and or materials before your appointment. Verification of eligibility is done as a courtesy only and is not a guarantee of payment. If I have medical insurance or routine vision benefits, I authorize my plan carrier to directly pay Apple Valley Vision. I also authorize Apple Valley Vision to release any information required for payment. **It is the patient's responsibility to know their insurance coverage, and relay that information to the office staff**. Any fees not covered by insurance will be billed to the patient. **Please remember that insurance is considered a method of reimbursing the patient for fee paid to the doctor** and is not a substitute for payment. Some companies pay fixed allowance for certain procedures, and others pay a percentage of the charge.

It is your responsibly to pay any deductible amount, co-insurance, or any other balance not paid by your insurance

If my insurance does not pay, or partially pays, I understand I am responsible for the payment in full or the remaining balance. This includes any collection fees, court costs and attorney fees incurred in collecting the balance. There is up to a $30 fee for returned checks. A 1.5% monthly (18% annual) fee will be added to all accounts not current, i.e. After 30 days there may be a $5.00 late fee added each month if payment is not made. Balance must be paid in full by the end of the 120-day period or your account will be turned over to our collection agency. The undersigned specifically agrees to pay all reasonable attorney fees and court costs in the event legal action is taken to collect on an account. The undersigned further agrees to pay an additional amount representing up to 40% of the principal balance if the account is referred to a collection agency or attorney for collections. This additional amount is in recognition of the cost associated with said collection action processing.

I acknowledge that I have received or have access to Apple Valley Vision's Notice of Privacy Practices and agree to all office and financial policies written on this form:

_____ _____ **Date:** ____/____/_____

Print Patient Name **Patient Signature (or parent/guardian if under 18):**

Patient Information

Today's Date: ____/____/_____

(All information is kept secure and confidential at all times)

PATIENT INFORMATION

Patient's Name: (Last, First, Middle) _____ Social Security#: _____

Birthdate: ____/____/____ Age: _____ Sex: M F (⬆ SS for insurance verification)

Address: _____ City, State, Zip: _____

Home Phone: ( ) _____ _____ Cell Phone: ( ) _____ Text okay? Yes No

INSURANCE INFORMATION

Medical Insurance Name: _____

Policy Holder Name, Date of Birth (If different than patient): _____

Vision Insurance Name: _____

Policy Holder Name, Date of Birth (If different than patient): _____

Policy Holder SS# (for insurance verification): _____

Email: _____ (Required for Contact Lens Prescriptions)

☐ (check box) The government mandates that all final contact lens prescriptions are to be given when finalized and exam fees are paid. If I am to wear contact lenses, I consent to receive a copy of my prescription electronically.

Patient Signature (or parent/guardian if under 18): _____ Date: ____/____/_____

Person responsible for payment **(If different from above):** Name:_____ Social Security#: _____

Address: _____ City, State, Zip:_____ Phone: ( ) _____

Emergency Contact Name: _____ Relation: _____ Phone: ( )_____

REASON FOR VISIT:_____

PERSONAL EYE HISTORY

List any personal current or past history of: crossed eyes, keratoconus, drooping eyelids, glaucoma, retinal disease, cataracts, eye infections, or eye injuries: _____

_____

List any eyedrops you use (including artificial tears, prescription eye drops, ointments, allergy drops, etc.): _____

_____

PERSONAL MEDICAL HISTORY

List all MEDICATIONS you currently take (including oral contraceptives, aspirin, over the counter and home remedies): _____

_____

List MEDICATION ALLERGIES you have, if any: _____

If Female, Are you pregnant or nursing? ☐Yes ☐No

Notes – you may tell us any pertinent information about your health history here:

FAMILY OCULAR / MEDICAL HISTORY Please check any ***family*** history (living or deceased) of the following conditions: (Check All That Apply)

☐ Unknown / Adopted

☐ Crossed / Lazy Eye
☐ Glaucoma
☐ Macular Degeneration
☐ Retinal Holes, Tears, or Detachment(s)
☐ Cancer
☐ Diabetes
☐ Heart Attack / Stroke
☐ High Blood Pressure
☐ Thyroid Disease

REVIEW OF SYSTEMS *Do you currently, or have you ever had any chronic problems in the following areas:*

	NO	YES	IF YES, EXPLAIN:
EYES (Loss of side vision, double vision, dryness, irritation, flashes/floaters, chronic infections, etc.)	☐	☐	_____
EAR, NOSE, MOUTH, THROAT (Allergies, sinus issues)	☐	☐	_____
RESPIRATORY (Asthma, Chronic Bronchitis, COPD, etc.)	☐	☐	_____
ENDOCRINE (Thyroid)	☐	☐	_____
ALLERGIC/IMMUNE DISORDERS	☐	☐	_____
CARDIOVASCULAR (Diabetes, heart pain, heart attack/stroke, high cholesterol, blood clotting disorders, anemia)	☐	☐	_____
SKIN	☐	☐	_____
BONES, JOINTS, MUSCLES (Arthritis, muscle/joint pain)	☐	☐	_____
NEUROLOGICAL (Headaches, Migraines, Seizures)	☐	☐	_____
PSYCHIATRIC (Anxiety, depression, ADD/ADHD)	☐	☐	_____

Lifestyle Index

PT INITIALS / ID _____

DATE _____

This questionnaire is meant to help your doctor understand what you're experiencing on a regular basis — whether it's caused by your eyes, posture, stress, etc. Your responses will help make sure you receive the best care possible.

How often do you experience any of these symptoms? Fill in applicable circle. For example: 1 2 3 4 5

Headaches
of any severity each week, usually getting worse later in the day

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Stiffness / pain in neck / shoulders
when you work at a computer or read

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Discomfort with Computer Use
in your eyes (redness, burning) after long hours looking at the screen

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Tired Eyes
with increasing feeling of eye fatigue throughout the day

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Dry Eye Sensation
feeling progressively more gritty/sandy while working at computer or reading

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Light Sensitivity
especially with brighter, stronger lights like fluorescents or headlights

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Dizziness
or an experience like motion sickness or vertigo

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always
○	○	○	○	○

Age-Related Macular Degeneration (AMD) Risk and Symptom Assessment

AMD is the leading cause of vision loss among older Americans. It is a progressive condition that causes a part of your retina called the macula to deteriorate with age. The macula is responsible for your central vision, which allows you to do things like read, watch TV, recognize faces and drive.

Fill this form out if you are Over 50 Years of Age

Risk factors for AMD

There are several factors that may increase your risk of developing AMD, including the ones listed below. Check all that apply:

- ☐ 50 years of age or older
- ☐ Current or past smoker
- ☐ Family history of AMD
- ☐ Overweight
- ☐ Caucasian (white)
- ☐ Heart disease, high blood pressure and/or high cholesterol

Since poor night vision is a common symptom of AMD, we use the AdaptDx device to measure the number of minutes it takes you to adjust from bright light to darkness. This number is your Rod Intercept™ (RI) and it can help us detect AMD at its earliest stages. The test is non-invasive and takes 5-10 minutes to complete.

Early symptoms of AMD

Before any structural changes can be seen in the back of your eye, you may experience the following early symptoms. Check all that apply:

- ☐ Difficulty seeing in the dark
- ☐ Difficulty navigating at night
- ☐ Difficulty reading in dim light
- ☐ Other night vision problems (please specify) _____