New Patient Information

ENDEAVOR EYE CENTER

Phone: (Cell)_____ (Hm)_____

Email: _____

Name : _____ Birthdate: _____
Last First MI

Address: _____Zip:_____

Patient Occupation/grade: _____ Patient Employer/school: _____

Patient SSN: _____ Emergency Contact Person (Name & Ph): _____

_____

Person Responsible For Account *(please circle)*: Patient (self) Parent Other *(explain)* _____

Responsible For Account (if not the patient):

Name: _____ Birthdate: _____ SSN: _____

Address: _____Zip:_____

Best Contact Phone: _____ Employer: _____

How did you find us?(circle) Insurance Co Internet/SocialMedia Family/Friend Neighborhood Doctor

Insurance Information:

Primary Insurance: _____ Subscriber Name: _____

Subscriber I.D. #: _____ Group #: _____

Secondary Insurance: _____ Subscriber Name: _____

Subscriber I.D. #: _____ Group #: _____

Authorizations

I, the undersigned, certify that I (or my dependent) have insurance with _____ and assign all insurance benefits (if any) to Endeavor Eye Center, PLLC, for services rendered that would otherwise be payable to me. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I herby authorize Endeavor Eye Center, PLLC, to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship to Patient Date

ENDEAVOR EYE
CENTER

Patient History Questionnaire

Patient Name: _____ Date: _____

Is vision difficult? **YES NO** If yes, how? **Distance Near Intermediate**

Do you currently wear EYEGLASSES? **YES NO** Contact Lenses? **YES NO**

Other vision or eye problems? _____

_____

When was your last EYE physician exam? _____

Do you have permanent eye/vision damage from injury or infection? *(please explain)*:

_____

Do you have/had had any of the following *(please circle)*:

Glaucoma **Cataracts** **Flashes/Floaters** **Headaches/ Eyestrain**

Retina disease **Crossed or Lazy Eye/Functional Eye Issue** **Autoimmune Disorder**

Have you had eye surgery? *(please explain)*: _____

Do you have an allergy to any medications? *(please explain)*: _____

Are you *being treated* for any of the following? *(please circle)*:

Diabetes **High Blood Pressure** **Neurologic Problems** *(numbness, migraine, etc.)*

Stroke **Heart/Lung Problems** **Cancers** **Mental Health Concerns**

Other Conditions *(please explain):* _____

Are you taking medications? *(please list)*: _____

_____

Patient Family History *(please circle):*

Diabetes **High Blood Pressure** **Heart Condition** **Other:**_____

Glaucoma **Retinal Detachment** **Macular Degeneration** **Blindness**

Our Financial Policies

We do our best at Endeavor Eye Center to give each patient our full attention when they are with us, and we are committed to serving their vision needs. We are also committed to providing affordable and comprehensive care to our patients, intending to be fair in how we charge for our services.

We routinely bill insurance companies on behalf of our patients, but payment for our services is ultimately the patient's responsibility. If you decide, part-way through a requested service, to discontinue participation, you remain the 'Responsible Party' for paying all costs for services and materials we have provided up to that point.

All payments, co-payments, and deductibles are due at the time of service.

For us to better serve you, the patient (or person signing on their behalf) must provide us with:

- *Current Insurance Cards* We need these in advance of visits where we are providing services to you, and if we are ordering materials through us.
- *Valid Government-issued Picture ID* We need a driver's license or other such card *in advance* of services provided or materials ordered.
- *Current Information* To bill a third-party on your behalf (e.g. insurance) we need current full legal name, address, phone number, and work contact information (if applicable) *in advance*. If you have seen us before, notify us immediately if any of these is not current.
- *Payment* We take credit card or cash. We need payment for amounts you owe us within 30 days.
- *Questions You Have* We need to know of any questions, concerns, or disputes concerning treatment or charges within 30 days of the completion of a procedure or the dispensing of hardware. All glasses prescription check and contact lens refit/request/follow ups after 90 days of the initial exam date is subject to an office visit fee.

Billing Insurance

We have agreements with many insurance companies, and we will submit claims to them on your behalf as a courtesy to you. As the Responsible Party, however, you remain financially responsible if your insurance company declines to pay for any reason. If you pay for the estimated balance quoted by your insurance carrier on the date of service, you will be held responsible for the amounts the insurance does not finally pay. You are solely responsible to know and confirm which treatments or procedures are covered, including exclusions, deductibles and maximums.

If you provide false or incomplete information, our office cannot be held responsible for an insurance company not paying. Some insurance companies require the use of Social Security numbers: though we respect those who decline to provide us with this, we will be unable to bill your insurance company, and you will incur the entire expense. If any procedures or treatments are not covered in full by your insurance, full payment for the estimated uncovered portion *in advance* is necessary.

Non-Payment On Account

When our office receives a statement from your insurance company of the amounts they will pay (called and Explanation of Benefits, or EOB), any amounts that remain will be billed to the patient or responsible party. Account balances that remain unpaid past 60 days will incur an interest charge at the maximum legal rate allowed. Our office will also charge the maximum service fee for any checks returned to us for insufficient funds, or similar electronic authorizations, or debt sent or provided to us for payment.

Should collection proceedings or other legal action become necessary to collect an overdue account, our office reserves the right to disclose all relevant personal and account information to an outside collection agency to collect payment for services we provided or materials you ordered through us. Our office also reports such accounts to credit rating bureaus.

The patient or responsible party is responsible for all costs of collection including, but not limited to; interest due at the maximum legal rate allowed; all court costs and reasonable attorney fees, and; a collection fee added to the outstanding balances.

Returned Check Policy

If a payment is made to us using a check, and this check is returned from the bank as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or responsible party will remain responsible for the original amount in addition to the maximum service charge allowed by law. Once notice is received of the returned check, our office will send a letter to the responsible party of the returned check. If a response is not made in 15 days from the date of the letter by the patient or responsible party, the account may be referred to an outside collection agency, and a collection fee will be added to the outstanding balance in addition to the check service charge.

Refunds and Exchanges

We want to inform you that once our professional services have been provided, we are unable to offer refunds. This policy extends to custom products, specifically prescription lenses, for which refunds are not applicable. However, our commitment to your satisfaction includes providing remakes or re-styling services (limit 2) at no additional cost to you. It is essential to note that, in the case of contact lenses, returns are not accepted; nevertheless, we do allow exchanges for store credit if the packaging remains unopened and in a pristine, saleable condition. We kindly request that any requests for remakes or alterations be made within a 30-day window from the date of purchase.

Financial Agreement

By signing below, you agree to accept full financial responsibility as a patient receiving our health care services, or as the responsible party for minor patients. You also authorize Endeavor Eye Center to release all information necessary to secure payments of insurance benefits, and to use the below signature to submit insurance claims. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

_____ _____

Signature of Patient (or authorized guardian) Date

_____ _____

Printed Name Relationship to Patient

Consent to Use or Disclose Health Information

For Treatment, Payment and Health Care Activity

When providing service to you, we document, receive and store your health information. When we conduct health care activities, we have to disclose this health information in order to treat you and to obtain payment for our services. Our comprehensive Notice of Privacy Practices describes these uses and disclosures in detail, and you are free to refer to it at any time prior to signing this consent document.

Our Notice of Privacy Practices describes how we use and disclosure your health information for treatment purposes in our office, but also how we use it in the event it is necessary or appropriate for you to receive further care from another health care professional. Similarly, we may use or disclose your health information in order to pay a billing agent or vendor for processing insurance claims or for obtaining payment. This includes, but is not limited to: submitting claims to third-party payers or insurers for claims review; determining benefits and payment, or; submitting your health information to auditors hired by third-party payers and insurers. Our Notices of Privacy Practices describes these uses in more detail, and we update this document whenever our privacy practices change. Updated copies of this Notice are available here at our office.

By signing this consent document, you attest that you grant permission to allow this office to use and disclose your health information to treat you, to obtain payment for our services, and to perform normal and customary health care activities. You may revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care activities in reliance upon our ability to use or disclose your health information in accordance with this consent. We reserve the right to decline serving you if you elect not to sign this consent form.

You also have the right to ask us to restrict the use or disclosures made for purposes of treatment, payment, and other health care activities. But, as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I have read this consent and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment and health care activities.

Patient Name: _____ Phone: _____

Patient Address: _____

Signature: _____ Date: _____

If you are signing as an authorized representative of the patient, please describe below.

Relationship: _____Your Printed Name: _____

Contact Lens Care Agreement

Informed consent agreement: contact lenses are medical devices worn on the eyes and do entail an increased risk for eye infection and injury. It is extremely important that you follow the instructions for the use and care of your contact lenses. Failure to do so may result in permanent injury to your eyes or even blindness.

To reduce contamination of lenses:

- Always wash, rinse, and dry hands before handling lenses
- DO NOT use saliva, tap water, or anything other than sterile solutions recommended for use with contact lenses
- Always clean, rub contact lenses with contact lenses solution before putting them in and storing them
- DO NOT swim, tan, or sit in sauna with lenses in
- Change solution in contact lens case daily and replace the case every 3 months

Remove your lenses if any of the following occur: Discomfort or pain, eye infections or discharge, stinging, burning, itching, redness, excessive tearing, sudden decrease in vision that doesn't clear up, blurred vision, halos around objects, and light sensitivity If you experience any of the above symptoms, you should contact our office immediately and discontinue wearing your contact lenses. Follow up care is an important part of your contact lenses prescription.

Extended wear agreement: with contact lenses that are approved to use as extended wear, our office strongly recommends proper use and care of them, including taking them out and cleaning them every night. Our doctors believes no patients should sleep in their contacts. Patients wearing contact lenses as extended wear are 10X more likely to get an eye infection. Lubrication drops may also be needed before and after sleep.

Service agreement: the contact lens fitting fee includes your first pair of contact lenses, 90 day follow up care, and instructions on lens insertion, removal, cleaning and care.

Refund policy: we cannot guarantee that you will be successful with contact lenses. Some people are unable to wear contact lenses comfortably or with clear vision. Should you be unable to continue with contact lenses, or if you simply change your mind and decide that they are not for you, the eye examination and contact lens fitting fee are not refundable. **Any prescription or contact lens brand changes must be done within 90 days.**

In accordance with 16 CFR Part 315.3, Patient also confirms receipt of contact lenses prescription when having a CL examination/evaluation.

I have read the above agreement. I understand that not complying with the recommended cleaning regime or wearing schedule could result in serious injury such as corneal ulcer or permanent loss of vision. Should non-compliance become a problem, this entity reserves the right to terminate doctor-patient relationship. I understand and agree to the terms outlined above. This form will be retained in your medical record.

Signature of patient or personal representative of patient Date

Signature of physician Date