Luxe Eye Care

Welcome to our office! We're happy you are here.

Patient Information

Title_____ First Name_____ MI_____ Last Name_____

Address_____ Apt#_____ City_____ State_____ Zip_____

Home: ( )_____ Mobile: ( )_____ Birth Date:_____ Sex: (Circle one) M F

Email:_____ Occupation:_____

In case of emergency, contact:_____ Relationship:_____ Phone: ( )_____

☐ Married ☐ Single ☐ Minor ☐ Employed ☐ FT Student ☐ PT Student ☐ Other

How did you hear about us?_____

Insurance Information

Vision Insurance:_____ Group#:_____ Subscriber Name:_____

DOB:_____ ID#:_____ Subscriber LAST 4 SSN:_____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Primary Medical Insurance:_____ Group#:_____ Subscriber Name:_____

DOB_____ ID#_____ Subscriber LAST 4 SSN:_____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with_____
(name of insurance company (ies))

And assign **Luxe Eye Care** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named practice may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

X_____ _____ _____

Signature of Patient, Parent, Guardian, or Personal Representative | Print Name | Date

Notice of Privacy Practices

I acknowledge that I have reviewed Luxe Eye Care's Notice of Privacy Practices and received a copy.

X_____ _____

Signature | Date

Additional Examination

Visual Fields Screening:

Our doctors have incorporated a computerized visual field analyzer into the practice that tests for loss of eyesight in your central and peripheral vision. This painless quick screening test can help the doctor in the detection of numerous health problems including**: Glaucoma, Diabetes, Stroke, Optic Nerve Disease, Retinal Detachment, Macular Degeneration, and some brain tumors.** Your doctor recommends that all patient take this evaluation once per year, especially if there is family history of these conditions or if you are having headaches or any visual problems. The visual field analysis takes only a few minutes and there is an additional fee of **$30.00** for this testing.

Do you want the VF screening? ☐ Yes ☐ No

If you checked NO for the Visual Field Screening, please read and sign below:

I understand that the importance of this procedure and assume all risk associated with the failure to detect any eye condition or health due to lack of diagnostic information which could have been provided by this procedure.

X_____ _____

Signature | Date

Chief Complaint

What is the reason for your visit today? Please list any signs and/or symptoms you are experiencing.

Health History

Date of Last Eye Exam:_____ Date of Last Primary Care Physician:_____ Are you Pregnant/Nursing?_____

Current Illnesses or Injuries:_____

Past Surgeries:_____

Current Medications:_____

Current Eye Drops:_____

Drug/Food/Environmental Allergies:_____

Personal and Family History: Do you or your family have any of the following? (Please check the following that applies)

Disease/Condition	Self	Family		Self	Family
Thyroid Disease	☐	☐	Kidney Disease	☐	☐
High Blood Pressure	☐	☐	Arthritis	☐	☐
Heart Disease	☐	☐	Cancer	☐	☐
Diabetes	☐	☐	Macular Degeneration	☐	☐
Glaucoma	☐	☐	Cataract	☐	☐
Blindness	☐	☐	Retinal Detachment	☐	☐
High Cholesterol	☐	☐			

Ocular History: (Please check the following that applies to the patient)

☐ Glaucoma	☐ Burning	☐ Amblyopia (Lazy Eye)
☐ Cataract	☐ Dryness	☐ Blurred Vision
☐ Macular Degeneration	☐ Excess Tearing	☐ Distorted Vision
☐ Retinal Detachment	☐ Eye Pain/Soreness	☐ Double Vision
☐ Headaches	☐ Infection of Eye/Lid	☐ Floaters or Spots
☐ Color Blindness	☐ Itching	☐ Fluctuating Vision
☐ Light Sensitivity	☐ Mucous Discharge	☐ Loss of Vision
☐ Tired Eyes	☐ Redness	☐ Sandy or Gritty Feeling
☐ Drooping Eyelid	☐ Strabismus (Cross Eyed)	

Contact Lens History

If you are not a contact lens wearer, are you interested in trying contact lenses at this time? ☐ Yes ☐ No

Have you ever tried to wear contact lenses? ☐ Yes ☐ No Reason for stopping:_____

Do you currently wear contact lenses? ☐ Yes ☐ No Since:_____ Brand of Contact Lenses_____

Prescription of current Contact Lenses (If known): R:_____ L:_____

How many hours/day do you wear contacts?_____ How many days? _____ How often do you replace your contacts?_____

Social History

Do you drink alcohol? ☐ Yes ☐ No If yes, how often?_____

Do you smoke? ☐ Yes ☐ No If yes, how often?_____

Cosmetic Concerns

Are there any areas around your eyes that you wish could be changed?

Wrinkles ☐ Yes ☐ No Crow's feet ☐ Yes ☐ No Dark Spots ☐ Yes ☐ No Texture ☐ Yes ☐ No

Would you like your eyes to appear more open and brighter? ☐ Yes ☐ No

Luxe Eye Care

Office Policies:

Refraction:

During the refraction portion of the exam, the doctor works with you to determine the best prescription for you. When first receiving a pair of glasses or contacts with a new prescription, it is very common to experience headaches, dizziness, and blurry vision. In the event these symptoms occur, we recommend wearing the new prescription consistently for two weeks to allow your brain to fully adapt to the changes. If you are still having any difficulty after this adaptation period, we are happy to recheck the prescription for glasses or contacts at no charge within sixty (60) days from your original exam date. After this time frame, there will be an additional fee for any prescription rechecks or adjustments.

Contact Lens Prescriptions & Sales:

A contact lens evaluation is always a separate fee from your comprehensive eye examination. Contact lens evaluations include separate testing to measure the curvature of your cornea and make sure your eyes are healthy to proceed with contact lens wear. Contact lens fees vary according to the complexity of the contact lens fit and the type of lens used. Contact lens prescriptions are valid for one year; No contact lenses can be ordered or released once this prescription expires.

With regard to the sale of soft contact lenses, any unopened, unmarked, and non-expired boxes may be exchanged within 1 month of the date of purchase, minus a 10% restocking fee. All sales of contacts are final as we do not offer refunds on contact lens sales. For your convenience, we offer FREE shipping for semi-annual or annual contact lens orders. Contact lens orders shipped to the office will be held for a max of 6 months (180 days) before being considered abandoned orders. Abandoned orders are not eligible for return.

Vision Insurance vs. Medical Insurance:

Vision insurance is designed to cover the following: glasses and contact lens prescriptions and basic health screening (Dilation). It does not cover any other issues with the eye, such as allergies, dryness or infections nor any treatment for headaches, cataracts, macular degeneration or glaucoma. In addition, it does not cover any monitoring for patients on high risk medications (such as plaquenil) or diabetic eye exams. Health insurance may provide additional coverage for these conditions and many more. Unfortunately, due to the rules of insurance companies, we may have to bring patients back for a separate visit from their annual wellness exam to treat their medical concerns.

Please let us know what your primary concern is for your visit so we can help you maximize your benefits and obtain the correct insurance information.

No Show Fee:

For patients that miss their scheduled appointments without notifying staff prior to the time of visit, a $25 fee is automatically assigned to your account for each missed appointment. Please give us a 24 hour notice for any appointments that need to be rescheduled when possible. Excessive rescheduling and cancellations of appointments may result in loss of preferred appointment times for future bookings.

All examination fees are non-refundable.

I have read and understood all aspects of the above policies.

Name: _____

Signature: _____

Date: _____

Informed Consent or Refusal for Optomap Exam

Luxe Eye Care offers a state-of-the-art digital scanning technology that allows us to view the inside of your eye without the use of dilation drops. The OPTOMAP allows us to evaluate your retina for problems such as macular degeneration, retinal holes, retinal detachments, hypertension and diabetic retinopathy. The scanning system is completely safe for kids and adults and allows you the opportunity to see the inside of your eye just as the doctor sees it.

Dilated Exam	**vs.**	**Optomap Exam**
1. Blurred near vision for 4-6 hours		1. NO blurred vision
2. Light sensitivity for 4-6 hours		2. NO light sensitivity
3. Extra wait time of 30 minutes for eye drops to take effect		3. Photos take less than 2 minutes with no side effects
4. No permanent record of retina		4. Permanent digital image that can be compared each year
5. Only the doctor can see the retina		5. You can see your retina

Early Detection is Crucial! Our doctors recommend that ALL patients have a thorough examination of their retina every year. **Without the Optomap or a dilated examination, the doctor cannot fully assess the health of your eye.** Without a retinal health check you accept all risk for the possibility of undetected diseases without dilation that could lead to partial or total vision loss, or even death.

There is an additional fee of $40.00 for the Optomap. In most cases, this procedure is not covered by insurance. Dilation may still be required in rare instance.

_____ I elect to have a digital photo of my retina today ($40.00)

_____ I prefer a dilated exam of my retina ($40.00 if no insurance; covered by most insurances)

_____ _____

Patient Signature Date