FALLS PREMIER EYECARE

PATIENT INTAKE FORM

N86W16275 Appleton Ave | Menomonee Falls, WI 53051 | (262) 251-1570

PATIENT INFORMATION

Full name: Date of birth:

Phone: Email:

Address:

City / State / ZIP:

Preferred contact: ☐ Phone ☐ Email Occupation:

Parent / guardian name (if applicable):

EMERGENCY CONTACT & INSURANCE

Emergency contact / relationship: Phone:

Vision insurance: Medical insurance:

Subscriber name (if different): Subscriber DOB:

REASON FOR VISIT & OCULAR HISTORY

Main reason for today's visit:
☐ Routine exam ☐ Glasses ☐ Contacts ☐ Eye problem / symptoms

Last eye exam: Location of last eye exam:

☐ Wear glasses Age of current glasses: ☐ Prior eye surgery / injury
Current contact lens wearer? ☐ Yes ☐ No
Contact lens brand / type:
Contact lens comfort: ☐ Good ☐ Fair ☐ Poor Vision: ☐ Good ☐ Fair ☐ Poor

Eye conditions / concerns:

Family ocular history (glaucoma, diabetic retinopathy, macular degeneration, strabismus, keratoconus, blindness, retinal detachment, etc.):

MEDICAL HISTORY

Primary care provider: Last medical exam:

☐ Diabetes ☐ High blood pressure ☐ Thyroid disease ☐ Autoimmune disease

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PATIENT ACKNOWLEDGMENTS

Schiferl Eyecare Holdings LLC d/b/a Falls Premier Eyecare
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Please check and initial each statement below.

☐ I understand and agree that I am financially responsible for payment of all services, products, and charges not covered or paid by my insurance, including deductibles, copays, coinsurance, and denied claims, subject to applicable law, my plan terms, and the Practice's provider agreements.

Initials: _____

☐ I assign to Falls Premier Eyecare all insurance benefits otherwise payable to me for services and products provided, and I authorize my insurer to pay those benefits directly to Falls Premier Eyecare. I authorize Falls Premier Eyecare to release information necessary to process my claims. This assignment remains in effect until I revoke it in writing.

Initials: _____

☐ I understand that my eyeglass prescription, and my contact lens prescription if a contact lens fitting is completed, will be provided to me at the end of my visit, and that I will be asked to sign the Prescription Release Confirmation below at that time.

Initials: _____

☐ I understand that medical eye exams will be billed to medical insurance. If Falls Premier Eyecare is out of network with my medical insurance, I am responsible for any amount my plan does not cover. Examples include diabetic eye exams, dry eye, glaucoma, flashes, floaters, and other medical eye concerns. I understand that vision insurance/vision care plans generally do not cover a medical diagnosis. If I am uninsured or choose not to use my insurance, I have the right to receive a Good Faith Estimate of expected charges.

Initials: _____

☐ I understand that a contact lens fitting and/or evaluation is separate from my comprehensive eye exam and may result in an additional fee. Coverage varies by insurance plan; I agree to pay any applicable patient responsibility, subject to my insurance benefits and provider agreements.

Initials: _____

☐ I understand that Falls Premier Eyecare performs retinal imaging as part of each comprehensive eye exam. Retinal imaging is often not covered by vision plans, and I agree to pay the $39 retinal imaging fee to the extent not covered by my insurance, subject to my plan terms and the Practice's provider agreements.

Initials: _____

☐ I understand that if I miss a scheduled appointment or cancel with less than 24 hours' notice, I may be charged a $50.00 missed appointment fee. This fee is not billed to insurance and is my responsibility, except where prohibited by law or my insurance plan.

Initials: _____

☐ I acknowledge that Falls Premier Eyecare's HIPAA Notice of Privacy Practices is available to me.

Initials: _____

☐ I understand that if I request my medical records or prescriptions to be sent to me by unencrypted email, there is a risk that my personal health information may be intercepted or accessed by unauthorized individuals. I understand that more secure methods of receiving my information may be available. If I choose unencrypted email after being informed of these risks, I authorize Falls Premier Eyecare to send the requested information to my designated email address below.
Email address: _____

Initials: _____

☐ I understand that if I do not provide my current insurance information at the time of my examination, I am financially responsible for payment at the time services are rendered.

Initials: _____

Patient name (printed): _____

Patient / guardian signature: _____ Date: _____

If signed by guardian, printed name and relationship to patient:

_____

PRESCRIPTION RELEASE CONFIRMATION

To be completed at checkout, after the prescription has been provided. Check and initial each that applies.

☐ My eye care professional provided me with a copy of my eyeglass prescription at the completion of my eye exam. Initials: _____

☐ My eye care professional provided me with a copy of my contact lens prescription at the completion of my contact lens fitting. Initials: _____

☐ Instead of a paper copy, I consent to receive my prescription(s) electronically through the patient portal. Initials: _____

Patient / guardian signature: _____ Date: _____

Office use only: ☐ Patient declined to sign confirmation Staff initials: _____ Date: _____