

PLEASE PROVIDE US WITH COPIES OF YOUR INSURANCE CARDS & PHOTO ID

Patient Last Name: _____ **Patient First Name:** _____

Patient Address: _____

Street City State Zip Code
Date Of Birth: _____ **Age:** _____ **Sex:** ☐ M / ☐ F / ☐ Other _____

Social Security Number: _____ **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Phone: (HOME): _____ **(CELL):** _____ **(WORK):** _____

Primary Language: _____ **Email Address:** _____

Family Doctor: _____ **Address:** _____ **Phone:** _____

Primary Medical Insurance Carrier: _____ **Insurance ID Number:** _____

Subscriber Name: _____ **Date of birth:** _____ **SSN:** _____

Secondary Medical Insurance Carrier: _____ **Insurance ID Number:** _____

Primary Vision Insurance Carrier: _____ **Insurance ID Number:** _____

Subscriber Name: _____ **Date of birth:** _____ **SSN:** _____

Employer: _____ **Contact Person:** _____ **Phone Number:** _____

Employer Address: _____

Street City State Zip Code
Who referred you? _____ **Phone:** _____
(O.D., M.D., Friend, Other)

Who should we notify in case of an Emergency (nearest relative or friend)?

Name: _____ **Relationship:** _____ **Phone:** _____

May we confirm your appointments by:
 text ☐ Yes ☐ No
 email ☐ Yes ☐ No
 phone ☐ Yes ☐ No

May we leave a message on your answering machine at home phone? ☐ Yes ☐ No

May we discuss your medical condition with any member of your family or someone involved in your care? ☐ Yes ☐ No

If yes, that person or persons must be listed below, along with one identifying piece of information to verify the person's identity if they contact us (such as date of birth):

Name: _____ **Relation:** _____ **DOB:** _____ **Phone:** _____

Name: _____ **Relation:** _____ **DOB:** _____ **Phone:** _____

Patient or Legal Representative Signature **Date of Signature** **Relationship of Legal Representative to Patient**



Patient Name: _____ DOB: _____

CONSENT TO OBTAIN PATIENT MEDICATION HISTORY

I authorize Natural Vision to download my electronic prescription history

Pharmacy Name: _____ Pharmacy Phone Number: _____

Pharmacy Address: _____/Cross Streets: _____

CONSENT TO MEDICAL CARE AND TREATMENT

I consent to outpatient ophthalmic and optometric examinations, medical and surgical care, and diagnostic testing that my Physician determines to be necessary for my treatment at Natural Vision. I understand that medical care cannot guarantee specific results.

I agree to follow my Physician's instructions and recommendations regarding my care. I understand that Natural Vision and my Physician are not responsible for any problems, complications, or injuries that may result from my failure to follow such instructions or recommendations.

ASSIGNMENT OF BENEFITS

I hereby assign and authorize payment of all insurance and health care benefits available to me directly to the Natural Vision for services provided to me. I understand that benefits may be payable to me directly if I do not provide this authorization.

FINANCIAL RESPONSIBILITY

I understand and agree that I am financially responsible for payment of all charges incurred (co-payments, deductibles, co-insurances, etc.) which are not paid by insurance or health care benefits, including any and all products provided or services rendered to me which are not eligible for payment (non-covered) under health care plans, Medicare, Medicaid or other insurance or payers (e.g., services rendered by health care providers who do not participate with my insurance plan). Non-covered services also may include those services my physician determines to be medically necessary, but are later determined unnecessary by the payer. Co-payment is due at the time of services.

RETURNED CHECK POLICY

If a check is returned by your financial institution for any reason, a \$45 returned check fee will be charged to your Natural Vision account.

Natural Vision reserves the right to decline payment by check from any individual who has previously submitted a check that was returned for any reason.

CANCELLATION AND NO-SHOW POLICY

I agree to schedule and attend appointments for my treatment. If I need to cancel or reschedule an appointment, I understand that I must notify the practice at least 24 hours before the scheduled appointment time. I understand that missing three appointments within a 12-month period without providing notice (no call/no show) may result in discharge from the practice.

Patient or Legal Representative Signature

Date of Signature

Relationship of Legal Representative to Patient



ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you a copy of our HIPAA Notice of Privacy Practices (Notice), which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have been offered and/or received a copy of this organization's HIPAA Notice of Privacy Practices.

Please print patient name here

Signature of patient or guardian and printed relationship if not patient

Date

For Office use only

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

Employee signature

Date



EYE HISTORY

(Please Print & Use Black Ink)

Name: _____ Date: _____

Thank you for choosing Natural Vision for your eye care. To better serve you, please answer the following questions:

1. Do you wear glasses? ☐ Yes ☐ No
2. Do you wear contact lenses? ☐ Yes ☐ No
3. Do you have problems reading? ☐ Yes ☐ No
4. Are you currently experiencing any eye symptoms? Please check all that apply:
☐ Eye pain ☐ Blurred Vision ☐ Eyelid Crusting ☐ Flashes of Light ☐ Halos
☐ Discharge ☐ Light Sensitivity ☐ Double Vision ☐ Decreased Vision ☐ Floaters
5. Have you ever had an eye injury? Please describe:

6. Have you ever had eye surgery? Please list type, which eye and approximate dates:

_____ R/L _____
_____ R/L _____

7. Are you currently using any eye medication? Please list name and how often used:

8. Are you being treated for any medical conditions? Please check all that apply:

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Cholesterol
☐ Stroke ☐ Arthritis ☐ Other: _____

9. Are you positive for HIV or any form of Hepatitis? ☐ Yes ☐ No

10. What medications other than above are you taking? Please list:

11. Are you allergic to any medications? Please list:

12. Do you have any family history of eye problems? Please check and list family relationship:

☐ Glaucoma _____ ☐ Cataract _____ ☐ Retinal Disease _____ ☐ Macular Degeneration _____

13. Do you smoke? ☐ Yes ☐ No. If so, for how long: _____ How much: _____