Welcome to Simpli Eye Care PLLC! (Please Print Legibly)

Patient Information

Patient's Full Legal Name:_____ Email:_____@_____

Patient's Date of Birth:____/____/_____ Biological Sex Assigned at Birth: F / M Occupation_____

Phone: (____)_____ Address:_____ City/State/Zip_____

How did you hear about us? _____ Last Eye Exam_____

For office use: Insurance / Cash Pay

CL Fit: Sphere / Prem / RGP OPTOS

Vision Insurance information ***skip this section if not using vision insurance***

Vision Insurance Provider: (circle) Spectera / VSP / Costco Vision Insurance

ID#: _____ Employer: _____ Relationship to primary insured: ☐self ☐spouse ☐dependent

If not self, name of primary insured_____ → **Primary insured DOB and Last 4 SSN:**_____

Medical and Ocular history

What is the reason for your visit today? ☐ Routine vision exam ☐ Contact lens exam other:_____

Please list any allergies to medications or eyedrops:_____

Please list all medications, including any eyedrops you are currently taking: _____

_____

_____

Please list any major eye problems, injuries, or eye surgeries you have/ have had: _____

_____

Do you wear/ have you worn glasses? Yes / No Contacts? Yes / No Are you pregnant or nursing? Yes / No

Please check any of the following symptoms you recently experienced or are currently experiencing:

☐ blurry vision ☐ double vision ☐ itching ☐ dryness ☐ excessive light sensitivity

☐ burning ☐ eye pain ☐ headaches ☐ floaters ☐ flashes of light, if yes, when did it start?_____

☐ other ocular problems: _____

Have you or your blood-related family member ever been diagnosed with any of the following:

Ocular	***Self***	***Family Member***	***Systemic***	***Self***	***Family Member***
Blindness	☐	☐	diabetes	☐	☐
Glaucoma	☐	☐	high blood pressure	☐	☐
Macular Degeneration	☐	☐	cancer	☐	☐
Retinal detachment	☐	☐	thyroid disease	☐	☐
Lazy eye/amblyopia	☐	☐	heart disease	☐	☐
others: _____			others:_____		

I certify that I have answered the above to the best of my knowledge.

Notes

Patient/guardian **signature**: _____ Date: _____

Disclosures and office policies

Appointment cancellation: 24-hour notice is required for appointment cancellation. Confirmation of appointment is required to guarantee the appointment slot. Failing to show for appointment or cancelling with less than 24 hours notice will result in $40 no show fee and/or no further appointments will be honored. Exceptions are made at the discretion of office staff and optometrist.

Methods of payment: Simpli Eye Care PLLC accepts all major credit cards, HSA (with Visa/MasterCard logo), cash, and checks. All payments are due at the time of service.

Authorization for disclosure of information to 3rd party vision insurance requests and to health practitioners

In signing below, the patient/guardian authorizes Simpli Eye Care PLLC and its affiliated optometrists to release any information including the diagnosis, records of treatment, and examination rendered the patient to third party payers (insurance) upon request and to health practitioners who are participating in the patient's care. Patient/guardian authorizes insurance company to pay all appropriately billed services and fees to Simpli Eye Care PLLC and its affiliated optometrists. Patient is responsible for any fees, including copay and deductible, not covered by insurance.

Contact lens evaluation and prescription renewal fees: Please, be aware that a contact lens exam and renewal is generally **not** covered by vision insurance and is a separate billable service. This applies to new wearers and those renewing their prescriptions. Please, contact Simpli Eye Care PLLC or your vision insurance company with any questions regarding contact lens evaluation fees.

Ocular disease exam and treatment policy

Vision insurance covers a routine examination with refraction and ocular health check. It does not cover the treatment of eye diseases and prohibits the use of vision insurance benefits for any treatment of ocular or systemic diseases. Patients who need a medical eye exam, or if the optometrist finds it necessary to treat the patient for a medically related eye problem, will be charged a medical eye exam fee and any appropriate follow up charges. This will be discussed with the patient before the doctor proceeds with treatment.

Re-check and follow up policy: Patients have **60 days from examination date** for follow up visits. This includes 2 contact lens follow ups at the doctor's discretion and 1 eyeglass prescription re-check. After this time, there will be a minimum $45 office visit fee. This does not include medical related visual changes, such as pregnancy, diabetic related visual changes, surgeries, or eye infections that may occur during this time. Simpli Eye Care PLLC and its affiliated optometrists will ensure the accuracy of their prescriptions but is not responsible for any refunds should the patient have problems with materials such as frames and lenses. **No refunds will be given for services.**

Patient acknowledges and understands the above policies

Patient/guardian signature → _____ **Date:** _____

HIPAA notice of privacy policies: Simpli Eye Care PLLC respects patient privacy and will not share patient information without written permission from patient or guardian. Complete HIPAA policies are available upon request.

Patient acknowledges and understands the above office and HIPAA policies

Patient/guardian signature → _____ **Date:** _____

The following applies only to contact lens patients: The Federal Trade Commission enforces the Contact Lens Rule (amended in 2020), which requires that the patient acknowledge receipt of the contact lens prescription by signing a separate confirmation the below statement.

I have been informed of the need to schedule and attend follow-up appointments with my optometrists and to comply with the wearing schedule and cleaning method that my optometrist has prescribed for me. I also understand that I should notify my optometrist immediately if I experience any symptoms such as unusual redness, irritation, or blurred vision while wearing my contacts. I realize that my failure to do so may result in injury to my eyes and vision. I, the patient, or their guardian, confirm with my signature that I will/have receive a copy of my contact lens prescription at the conclusion for my contact lens fitting service.

Patient/guardian signature, → _____ **Date:** _____