Welcome to Highland Eye Boutique!

Legal Name: First ___________________________M.I. ______ Last
__________________________________ Date of Birth _____/_____/_______ Sex: M ___ F ___ Marital Status ________________
SSN# ______-______-_______ (At least last 4 for insurance verification)
Address ____ City ______________ State ______ Zip ______
Home # __________________ Cell # __________________ Email _________________________________
Employer ____________________________ Occupation ___________________________
Preferred contact method (select all that apply): ○ Home # ○ Cell # ○ Text ○ Email

How did you hear about Highland Eye Boutique? ____

Medical Insurance Information

Please complete if the policy holder is NOT the above patient.
Policy Holder Name: First _____________________ Last _________________________
Date of Birth _____/_____/_______ SSN# ______-______-_______ (At least last 4 for insurance verification)
Relationship to Patient __________________
Address (if not the same) ____

Consent for Treatment of a Minor

I, _______________________________, the parent/guardian of the above stated minor patient, gives consent to authorize any treatment deemed necessary by Dr. Kristie Bennett.

_______________________________ _________________________________ ________________
Print name of Parent/Guardian Signature of Parent/Guardian Date

Notice of Privacy Practices

I acknowledge that a copy of the Highland Eye Boutique's Notice of Privacy Practices has been presented to me and a copy is available upon request.

As stated in the Notice of Privacy Practices, we will use and disclose your health information for treatment and payment, as well as other purposes stated in the Notice. By consenting to treatment and accepting financial responsibility for your treatment, you agree and acknowledge that from time to time we will communicate with you about your treatment, payment and related issues using means of communication including your email and cell phone number. We may call and/or text your cell number or email you with treatment or related information, such as appointment confirmations and reminders, recalls, prescription notifications, payment reminders or follow-up services. It is the policy of Highland Eye Boutique that you may opt-out of email or cell/text communications at any time.

____ ________________
Signature of Patient (Parent/Guardian if minor) Date

Authorized Release of Medical Information

I allow the following names below to discuss and participate in my medical care. (Names of family members/friends who may be calling on your behalf, it is not necessary to list doctors' names.) I understand that if the names are not listed below, the office of Highland Eye Boutique cannot release my information.

Name ______________________________________ Relationship _________________________

Name ______________________________________ Relationship _________________________

Financial Responsibility Agreement

In exchange for services rendered, patient agrees to: (PLEASE INITIAL IN BOX FOR THE FOLLOWING)

☐ 1) Has been notified that Highland Eye Boutique is an out-of-network provider for vision insurance plans including EyeMed, Vision Services Plan (VSP), Davis, Spectera, and others. **We are still providers for most medical insurance plans** including Medicare, Aetna, Cigna, Anthem BC/BS and United Healthcare, and more. For your out-of-network benefits, we will provide you with an invoice and reimbursement form that you will need to file for reimbursement with your vision plan.

☐ 2) Authorize payment of medical benefits to Highland Eye Boutique, which would otherwise be payable to you. The filing of medical insurance claims is a courtesy that we are happy to extend to our patients to help you receive your maximum benefits. Your insurance is a contract between you, your employer, and the insurance company. We are contractually obligated to accept the insurance provider's terms and co-pays for your services.

☐ 3) Pay all non-covered charges (including refraction and contact lens evaluations), co-pays, co-insurance, deductible, and out-of-network charges at the time of services.

☐ 4) It is your responsibility to confirm what your out-of-network reimbursements will be with your vision plan. Since we are an out-of-network provider, we are unable to determine what your reimbursement will be.

☐ 5) Accounts 90 days old are subject to collection fees and there will be a $25 service charge on all returned checks.

☐ 6) Appointments not cancelled within 24 hours of the appointment time will be subject to a $50 cancellation fee.

I acknowledge and agree to this financial policy as detailed above.

_____________________________________ _______________

Signature of Patient (Parent/Guardian if minor) Date

Medical History Form

Primary Care Physician ____

List any medications you currently take: ____

____

List any eye drops you currently use: ____

Are you allergic to any medications? o No o Yes, please list _____________________________________

List all previous surgeries: ____

Eye History

When was your last eye exam? __________________

If you wear contact lenses: How many hours/day? _____ Today's wearing time? _____

How often do you put in a new pair? _____________ Brand of solution used? ________________

Blurred Vision Distance	o Yes	o No	Glare at night	o Yes	o No
Blurred Vision Near	o Yes	o No	Eyestrain	o Yes	o No
Dryness	o Yes	o No	Double Vision	o Yes	o No
Watering	o Yes	o No	Floaters/Flashes of Light	o Yes	o No
Itching	o Yes	o No	Redness	o Yes	o No
Glaucoma	o Yes	o No	History of Cataract Surgery	o Yes	o No
Cataracts	o Yes	o No	History of LASIK/Refractive Surgery	o Yes	o No
Macular Degeneration	o Yes	o No	History of Strabismus Surgery	o Yes	o No

General Health Are you currently experiencing any problems? Circle or write in the problem:

Constitution (fever, weight gain, other)	o No	o Yes ______________________
Cardiovascular (high blood pressure, cholesterol, other)	o No	o Yes ______________________
Ear, Nose, Mouth (sinusitis, hearing loss, other)	o No	o Yes ______________________
Respiratory (asthma, bronchitis, other)	o No	o Yes ______________________
Gastrointestinal (acid reflex, Crohn's, other)	o No	o Yes ______________________
Genitourinary (kidney stones, prostate, other)	o No	o Yes ______________________
Musculoskeletal (joint pain/swelling, arthritis, other)	o No	o Yes ______________________
Integumentary (acne, eczema, skin cancer, other)	o No	o Yes ______________________
Neurological (headache, MS, other)	o No	o Yes ______________________
Psychiatric (anxiety, depression, ADHD/ADD, other)	o No	o Yes ______________________
Endocrine (diabetes, thyroid, other)	o No	o Yes ______________________
Hematologic/Lymphatic (anemia, cancer, HIV, other)	o No	o Yes ______________________
Allergic/Immunologic (hay fever, itchy eyes, other)	o No	o Yes ______________________

Are you currently: Pregnant/Nursing? o No o Yes Due Date______________________

Do you use tobacco products? o No o Yes, ____ pack/day o Former Smoker

Drink alcohol? o No o Yes If Yes: _____ drinks/week

Family History Does anyone in your family have any of the following? If yes, please list relationship:

Cataracts	o No	o Yes ___________		Macular Degeneration	o No	o Yes ___________	
Corneal Disease	o No	o Yes ___________		Retinal Tear/Detachment	o No	o Yes ___________	
Crossed/"Lazy" Eye	o No	o Yes ___________		Glaucoma	o No	o Yes ___________	

Contact Lens Evaluations

Contact lens patients require additional testing which is not included in a routine eye exam. Per Georgia state law, contact lens prescriptions are good for 12 months and a yearly evaluation is required for renewal. Fees range from $60 - $175 depending on the complexity. Most insurance companies do not cover this evaluation.

____ Yes, I want a contact lens evaluation. ____ No, I do not want a contact lens evaluation.

Pupil Dilation

Dilation of your eyes allows a more thorough examination of the health inside your eye. This is like looking into a room with the door wide open versus through a door partially open. This allows Dr. Bennett to look for diseases like retinal tears, macular degeneration, cataracts, glaucoma, and more.

Dr. Bennett recommends dilation to all new patients. **Annual** dilation is recommended for all patients over the age of 60, all patients who have high risk conditions (like diabetes, cataracts, or glaucoma) and patients with a high prescription. Once dilated, you may experience blurred vision, especially in your near vision range, and your eye will be more sensitive to light for about 3-5 hours. If you do not have sunglasses with you, we will provide you with a disposable pair when you leave.

___ Yes, I understand the side effects and consent to having my pupils dilated.

___ No, I understand the benefits of dilation, and the risks associated with declining this procedure, and I do not consent to having my pupils dilated.

Retinal Screening Photos

Dr. Bennett recommends a retinal screening **yearly** with your eye examination. This provides a visual record of the inside of your eye to help monitor for changes over time. It is recommended to be done yearly for all ages. The fee for this procedure is $39 and will not be covered by your insurance. After the pictures are taken, Dr. Bennett will show you the images and explain the findings.

____ Yes, I want this procedure. ____ No, I do not want this procedure.

Patient Acknowledgement of Refraction Fee

A **refraction** is performed to measure the strength of your prescription for glasses. A refraction must be done every year at your comprehensive exam, whether there is a change in your vision or not. **Please understand that the $40 refraction fee may not be covered by your insurance, and payment is due at the time of service.** Medicare and many other medical insurance plans consider a refraction a “non-covered” service and require the patients to be responsible for payment. **This fee is already included in the self-pay rate.**

Patient Portal and Prescriptions for Glasses and Contact Lenses

A copy of your finalized glasses and contact lens prescriptions will be available to you through your patient portal. You will receive an email with a link to activate your account.

I have read and understand the above information on this page. I accept full financial responsibility for the above procedures if provided and it not covered by my insurance. I understand that any co-payment or deductible would be separate from and not included in these fees.

______________________________ ______________________________ ________________

Print name of Patient/Legal Guardian Signature of Patient/Legal Guardian Date