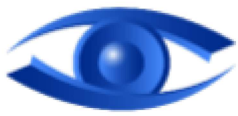


WILLIAMS EYECARE

Patient Information

Last Name ____________________ First Name ____________________

Middle Initial ____________________ ☐ Male ☐ Female

Date of Birth ____________________ Last 4 digits of Social Security __________

Cell Phone ____________________ Email Address ____________________

Billing Address ____________________

City ____________________

State and Zip ____________________

Pharmacy Information

Location ____________________ Phone Number ____________________

Insurance Information

Name of your Vision Insurance ____

Name of your Medical Insurance ____

Primary Insurance Holder's Information:

Last Name ____________________ First Name ____________________

Middle Initial ____________________ ☐ Male ☐ Female

Date of Birth ____________________ Last 4 digits of Social Security __________

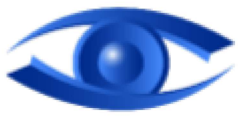
Parent's / Guardian's Information:

Last Name ____________________ First Name ____________________

Middle Initial ____________________ ☐ Male ☐ Female

Date of Birth ____________________

Cell Phone ____________________ Email Address ____________________



WILLIAMS EYECARE

Patient Health Information

Please place a checkmark next to any current condition

- ☐ ***No Medical Conditions***
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Dry Eyes
- ☐ Itchy Eyes
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ LASIK
- ☐ Eye Turn

Please list any other medical conditions

____

____

____

Please list the medications you are taking

☐ ***No current medications*** ______________________

____

____

____

Please list any medications you are allergic to

☐ ***No known allergies***

____

____

____

Social History

Do you drink alcohol?

☐ Never ☐Socially ☐On a regular basis

Do you smoke cigarettes?

☐ Never ☐Socially ☐Currently ☐Former

YOU CAN HELP US BY MAKING THE FOLLOWING DECISIONS BEFORE ENTERING OUR OFFICE. IF YOU HAVE QUESTIONS, PLEASE CAI AND OUR STAFF WILL PROVIDE ANSWERS OVER THE PHONE.

We MUST have your elections prior to your entry into our office.

My visit to Williams Eye Care is because:

- ☐ I want an eye exam (I may or may not need a prescription for glasses)
- ☐ I want an eye exam for contacts
- ☐ I've never worn contacts, but I want an exam to get contact lenses (which includes a glasses Rx)
- ☐ I have an eye problem (such as, red eyes, watery eyes, sudden changes in vision, etc..)

During your eye exam, your Eye Doctor will need to check the health of your eyes Please select your preferred way for us to check the health of your eyes:

☐ **DILATION**	OR	**OPTOMAP** ☐
Eye-drop(s) required		No eye-drop(s), usually
We will need to touch your face		We do not normally need to touch your face
Adds an additional 30 to 40 minutes		Pictures usually take 1-3 minutes
No digital image		We take a digital image of your eyes
Blurred vision lasts 4 to 6 hours		No side effects
$0 extra fee		Extra $39 fee

Please initial next to the services you are coming in for:

______ Routine Eye Exam:

- Billed through your vision insurance
- Prescription rechecks are allowed within 90 days of the exam
- Rechecks after 90 days will be billed as a full exam
- If eye disease is found, the doctor may complete a medical office visit first, or may ask you to come back for one

______Medical Eye Exam:

- Billed through your medical insurance
- Diabetic Eye Exam
- Evaluates Cataracts, Glaucoma, Macular Degeneration
- Dry Eyes, Red Eyes, Flashes, Floaters, Eye-Pain Injuries or Infections

______Contact Lens Evaluation: New and experienced contact lens wearers must have a contact lens evaluation annually along with an eye exam, in order to receive a contact lens prescription. (ask any of the staff members about purchasing contacts and our policy on Insurance, Price Matching and Direct Shipping. It would be our pleasure to serve you).

Contact Lens Evaluation and Handling Agreement:

- Contact Lens Evaluations are a separate fee from the Eye Exam.
- Contact Lens Evaluation fees, without insurance, are between $95-$145.
- Contact Lens Evaluation fees with Insurance vary per your plan. Please see a staff

member for your specific fee.

- Contact Lens prescriptions that change from a spherical to a premium evaluation, may result in an increase in the cost of the Evaluation.
- Contact Lens Evaluations must be paid for the same day as the Eye Exam, but can be done within 90 days of the Eye Exam.
- The Doctor may require a follow-up visit. There is no charge for follow-up visits, up to 3, within the first 90 days of the original exam date.
- If a Patient does not return within 90 days to finalize the prescription, a new exam will be required.
- I will notify the office immediately if I lose or tear one of my trials, prior to returning for my follow-up visit.
- If I purchase contacts, I am unable to return or exchange any open boxes.
- All professional services are non-refundable.

_____ **Refraction (Medicare Patients Only)** Medicare may cover your office visit to see the doctor, but in order to receive a glasses prescription you will need to pay out of pocket for the refraction.

Patient Name ________________________________

Signature of Patient ________________________________ Today's Date __________

(Parents or Guardians must sign if patient is under 18)

I have read and acknowledge all services and office policies outlined above. All insurance must be pre-approved prior to your examination. If we are unable to verify coverage all charges must be paid in full when services are rendered. Additionally, our office can never guarantee coverage or payment for any service provided by our office because insurance companies do not guarantee benefits. If you are not eligible for insurance benefits, or are eligible for less than the pre-approved coverage, your signature below indicates that you agree to be financially responsible for any unpaid balance. Professional fees for services rendered are non-refundable.

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Dr. James A. Williams, O.D., P.C. on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare Services and its agents any information needed to determine these benefits payable to related services. If I have other Health Insurance coverage (as indicated in Item 9 of the CMS -1500 claim or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

Consent to receive a digital contact lens prescription

Contact Lens wearers: By signing this form, I acknowledge that I am receiving a digital copy of my contact lens prescription instead of a paper copy.

I have read and I acknowledge all services office policies outlined above.

______________________________ ______________

SIGNATURE DATE
(PARENT or LEGAL GUARDIAN IF UNDER 18)

Acknowledgement of Notice of Privacy Practices

James A. Williams, O.D., P.C. And Associates

Patient Name ______________________________

I have been made aware of the Notice of Privacy Practices (the "Notice") of the Practice named above and may ask for (if desired) a copy of such Notice to keep for my records.

_______ I acknowledge that I have read the Policy and understand its terms and conditions.

OR

_______ I refuse to acknowledge receipt of the Policy and refuse to read or acknowledge any of the terms and conditions of the Policy. I understand that even though I may refuse to sign this acknowledgment, the Practice may still provide treatment to me.

______________________________ ______________

PRINT NAME OF GUARDIAN or REPRESENTATIVE DATE

______________________________ ______________

SIGNATURE DATE
(PARENT or LEGAL GUARDIAN IF UNDER 18)