

Palmer Family Eye Care
 Joanne Larson, OD/ Andrew Larson, OD
 21 Corporate Dr. Easton, PA 18045
 (610) 258-2442

Name _____ Today's Date _____ Last exam _____
 Address _____ Previous Dr Name _____
 City _____ State _____ Zip _____ D.O.B. _____ Age _____ Sex: M F Other
 Home Phone _____ Medical Insurance ID# _____
 Work Phone _____ Vision Insurance ID# _____
 Cell _____ Martial Status: M W S D Members SS# _____
Social Security Number _____ Member Name _____ DOB _____
 Employer _____ Do you participate in a flex spending account? NO YES
 Occupation _____ How Did You Hear About Our Office?
 E-Mail _____ Friend Relative? Who _____
 Another Health Care Provider? Who? _____
 Yellow Pages/Ad? Which directory? _____

Personal Health History— Please Circle

Glasses	NO	YES
Contacts	NO	YES
Diabetes/Thyroid/Other Endocrine	NO	YES
Heart Problems/High Blood Pressure/Cholesterol	NO	YES
Other Vascular	NO	YES
Arthritis/Back Problems/Other Musculo-skeletal	NO	YES
Headaches/Migraines/Other Neurological	NO	YES
Stomach/GI Problems/Hepatitis	NO	YES
HIV/AIDS/Shingles/Chicken Pox/Cold Sores	NO	YES
Skin/Cancer/Rashes/Other Skin	NO	YES
Hearing Loss/Balance Problems/Ear-Nose-Throat	NO	YES
Anemia/Leukemia/Bleeding Disorders	NO	YES
Smoking/Alcohol/Drug Use	NO	YES

Personal Ocular History-- Please Circle

Glaucoma	NO	YES
Amblyopia/Lazy Eye	NO	YES
Macular Degeneration	NO	YES
Retinal Detachments	NO	YES
Other Retina	NO	YES
Cataracts	NO	YES
Corneal Problems	NO	YES
Dry Eye	NO	YES
Past Eye Injury/Surgery	NO	YES

Family History—Please Circle

Glaucoma	NO	YES
Amblyopia/Lazy Eye	NO	YES
Macular Degeneration	NO	YES
Retinal Detachments	NO	YES
Other Retinal	NO	YES
Cataract	NO	YES
Corneal Problems	NO	YES
Diabetes	NO	YES

Participating Insurance Plan? _____
 Other? _____
 How Will You Settle Your Account Today?--**Please Circle**
 Cash Check Credit Card
 Medications _____
 Eye Medications _____
 Allergies _____
 (Drug/Environmental)
 Family Dr _____

Lifestyle Questions—Please Circle

Problems with glare or reflection?	No	Yes
Sensitivity to light?	No	Yes
Do you spend a lot of time outdoors	No	Yes
Do you work on computers for a long period of time	No	Yes
Do you have more than 1 pair of current Rx glasses?	No	Yes
If you wear glasses, would you benefit form thinner, lighter glasses	No	Yes
Are you interested in a "test drive" of the latest in contact designs?	No	Yes
Do you desire information regarding laser vision correction to decrease or eliminate your dependency on glasses?	No	Yes
Do your hobbies/sports/occupation require special protective eye wear?	No	Yes

Dear Patient,

Thank you for choosing Palmer Family Eye Care for your eye appointments! We are happy you are here. Below is a copy of our practice policies. Please read the following and sign:

According to many insurance companies (including Medicare), we must charge for refractions. **A refraction is the measurement of your vision in order to determine whether or not an eyeglass/contact lens prescription is necessary.** We will provide you with a copy of your prescription, which can be used to purchase eye glasses.

Most medical insurances do not pay for this service, and we are required to charge the patient (chapter 6.3 of the Medicare Handbook). **The refraction fee is \$48.** This fee may be charged for the service, whether or not a prescription is written. If you and the doctor do not feel that a refraction is needed, you may decline the service. As part of our complete exam, we will refract children and adults routinely. This procedure often is covered (in part or full) by vision insurances.

If you are unhappy with your prescription, we will make every attempt to rectify the situation free of charge within 30 days from the date glasses are picked up. Glasses are a custom-made product, and thus we cannot refund any glasses purchases once the order has been placed.

If you are having an eye exam and wear contact lenses, we are required to assess the fit of the contact lenses on an yearly basis. **The annual contact lens fee for this is \$45,** and may not be covered by insurance. This is collected in addition to the fee for an eye examination. If a significant change in your contact lens prescription is indicated, you may need to have a more in depth contact lens fitting. The fees for this are \$75-250, depending on the type of lenses and amount of time spent on the prescription.

We make every attempt to see our patients at the time of their scheduled appointment. We require 24 hour notification if an appointment must be cancelled. IF you arrive **LATE** to your appointment, your appointment may be cancelled or rescheduled. We have a voice mail service that will take your call if you need to cancel your appointment after hours or on the weekend. If the patient (parent or legal guardian) does not contact our office to cancel an appointment, a no-show fee of \$30 may be applied.

You acknowledge that you are providing to us accurate insurance information, and that we have permission to charge the insurance(s) for applicable services rendered. You also acknowledge that you are responsible for all fees and copays associated with your eyecare at our practice.

There are no recording devices of any kind allowed anywhere in the office without written permission. This includes, but is not limited to, photography, videography or audio recordings.

Patients are asked to give at least 48 hours notice for refills on medications to be sent to the pharmacy. Prescriptions will be sent Monday-Friday during normal business hours.

Thanks again, and welcome to Palmer Family Eye Care!

By signing this Form I have read and acknowledged the information listed above.

Patient Signature (parent or legal guardian)

Date