Park City Vision Center, Inc.

Robert S. Briggs, O.D.

Name:______________________ Today's Date:______________

Address:______________________ Phone:______________

City:__________ State:______ Zip:______ Work Phone:______________

E-Mail:______________________ Cell Phone:______________

Guardian (If Applicable):______________________ Occupation:______________

Birth Date:____/____/____ Social Security #:____-____-____ Last Eye Exam:____/____/____

Name Of Medical Doctor:______________________ Dr's Phone:______________

INSURANCE:______________________ Last Medical Exam:______________

Name of Main Member:______________________ Main Members Date of Birth:____/____/____

ID #:______________________ Social Security#:____-____-____

Medical History

Do you have allergies to medication? ❑ Yes ❑ No If yes explain:______________________

____

List any medications you take (including oral contraceptives, asprin, over the counter medications and home remedies):__________

____

____

____

List all major injuries, surgeries and/ or hospitalizations you have had:______________________

____

List any of the following that you have had: crossed eyes, lazy eyes, drooping eyelids, glaucoma, retinal disease, cataracts, eye infections, eye injury, eye surgery, poor near vision or poor distance vision:______________________

____

____

Are you pregnant and/or nursing? ❑ No ❑ Yes

Do you wear glasses? ❑ No ❑ Yes If yes, how old is your present pair of lenses?______________

Have you ever worn contacts? ❑ No ❑ Yes If yes, how old is your present pair of lenses?______________

Type of contacts: ❑ Rigid ❑ Soft ❑ Extended Wear ❑ Other Are they comfortable? ❑ Yes ❑ No

Are you interested in wearing contact lenses? ❑ Yes ❑ No Are you interested in LASIK? ❑ Yes ❑ No

Family History

Please note any family history (parents, grandparents, sibilings, children; living or deceased) for the following conditions:

DISEASE/ CONDITION	**No**	**Yes**	**?**	**RELATIONSHIP TO YOU**
Blindness	❑	❑	❑	______________
Cataract	❑	❑	❑	______________
Crossed Eyes	❑	❑	❑	______________
Glaucoma	❑	❑	❑	______________
Macular Degeneration	❑	❑	❑	______________
Retinal Detactment/ Disease	❑	❑	❑	______________
Arthritis	❑	❑	❑	______________
Cancer	❑	❑	❑	______________
Diabetes	❑	❑	❑	______________
Heart Disease	❑	❑	❑	______________
High Blood Pressure	❑	❑	❑	______________
Kidney Disease	❑	❑	❑	______________
Lupus	❑	❑	❑	______________
Thyroid Disease	❑	❑	❑	______________
Other __________	❑	❑	❑	______________

Social History *This information is kept strictly confidential. However, you may dicuss this portion directly with the doctor if you prefer.*

❑ Yes, I would prefer to dicuss my Social History information directly with my doctor. (Check box)

Do you drive? ❑ No ❑ Yes If yes, do you have visual difficulty when driving? ❑ No ❑ Yes If yes, please discribe:

____

Do you smoke tobacco products? ❑ No ❑ Yes If yes, type/amount/ how long: ____________________

Do you drink alcohol? ❑ No ❑ Yes If yes, type/amount/ how long: ____________________

Do you use illegal drugs? ❑ No ❑ Yes If yes, type/amount/ how long: ____________________

Have you ever been exposed to or infected with: ❑ Gonorrhea ❑ Hepatitis ❑ HIV ❑ Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

System	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	❑	❑	❑
INTEGUMENTARY (Skin)	❑	❑	❑
NEUROLOGICAL			
Headaches	❑	❑	❑
Migraines	❑	❑	❑
Seizures	❑	❑	❑
EYES			
Loss of Vision	❑	❑	❑
Blurred Vision	❑	❑	❑
Distorted Vision/ Halos	❑	❑	❑
Loss of Side Vision	❑	❑	❑
Double Vision	❑	❑	❑
Dryness	❑	❑	❑
Mucous Discharge	❑	❑	❑
Redness	❑	❑	❑
Sandy or Gritty Feeling	❑	❑	❑
Ictching	❑	❑	❑
Burning	❑	❑	❑
Foreign Body Sensation	❑	❑	❑
Excess Tearing/Watering	❑	❑	❑
Glare/ Light Sensitivity	❑	❑	❑
Eye Pain or Soreness	❑	❑	❑
Chronic Infection of Eye or Lid	❑	❑	❑
Sties or Chalazion	❑	❑	❑
Flashes/Floaters in Vision	❑	❑	❑
Tired Eyes	❑	❑	❑
ENDOCRINE			
Thyroid/Other Glands	❑	❑	❑

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/ Hay Fever	❑	❑	❑
Sinus Congestion	❑	❑	❑
Runny Nose	❑	❑	❑
Post-Nasal Drip	❑	❑	❑
Chronic Cough	❑	❑	❑
Dry Throat/ Mouth	❑	❑	❑
RESPIRATORY			
Asthma	❑	❑	❑
Chronic Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑
VASCULAR/ CARDIOVASCULAR			
Diabetes	❑	❑	❑
Heart Pain	❑	❑	❑
High Blood Pressure	❑	❑	❑
Vascular Disease	❑	❑	❑
GASTROINTESTINAL			
Diarrhea	❑	❑	❑
Constipation	❑	❑	❑
GENITOURINARY			
Genitals/ Kidneys/ Bladder	❑	❑	❑
BONES/ JOINTS/ MUSCLES			
Rheumatoid Arthritis	❑	❑	❑
Muscle Pain	❑	❑	❑
Joint Pain	❑	❑	❑
LYMPHATIC/ HEMATOLOGIC			
Anemia	❑	❑	❑
Bleeding Problems	❑	❑	❑
ALLERGIC/ IMMUNOLOGIC	❑	❑	❑
PSYCHIATRIC	❑	❑	❑

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

____

____

____

____

____

______________________________ ____________________

Doctor's Signature *Date*

Park City Vision Center, Inc.
Patient Conditional Agreement and Notices of Privacy Practices

This document is an agreement between Park City Vision Center, Inc., and you the patient.

1. **Treatment Consent:** I consent to treatment with Park City Vision Center, Inc., its physician and staff.
2. **Contact Lens Policy:** A comprehensive visual examination allows us to assess patient's visual health and generates a spectacle prescription. This is the first step for determining a contact lens prescription. *Contact lens care* is the evaluation, trial, fitting, dispensing, training, solutions review, wearing schedule review, and follow-up care required in determining a contact lens prescription. *Contact lens care* charges are additional and vary according to time and complexity. *Contact lens care* is charged annually and is not a covered benefit of most health insurance plans.

Patient Initials X________________

3. **Financial Responsibility:** I understand that I am financially responsible for all charges not covered by my health insurance. If payment of all charges is not made when due, I agree to pay all costs of collection for amounts due, including collection fees, attorney's fees and costs of court. All delinquent accounts may bear interest at the legal statutory rate. I understand that I am financially responsible for fees associated with failing to show to my scheduled appointments or frequent cancellations.
4. **Authorization to bill Insurance:** I authorize Park City Vision Center, Inc. to apply, on my behalf, to Medicaid, Medicare, or any health care insurance for payment of Park City Vision Center, Inc. care services. I confirm that the information I have provided to allow Park City Vision Center, Inc. to apply for payment by any health care insurance is correct. I authorize insurance, health plan, or statutory benefits, settlements and judgments to which you are entitled in connection with your car at Park City Vision Center, Inc. to be paid directly to Park City Vision Center, Inc. In consideration of the health care services provided, you give PCVC an irrevocable assignment to all right you have in your insurance, health plan, statutory benefits, settlements and judgments for which you are entitled, as necessary for payment for your service.
5. **Release of information:** Park City Vision Center, Inc. may release patient information to you, and to people or companies responsible to pay Park City Vision Center, Inc. charges for your care, such as worker's compensation carriers, or your insurance or health benefits company. Park City Vision Center, Inc. also may disclose patient information to your referring or treating health care providers. Park City Vision Center, Inc. may disclose patient information for treatment, payment, and health care.
6. **Acknowledgement of receipt of Park City Vision Center, Inc. Notice of Privacy Practices:** By signing this form, I acknowledge that I have been given access to copy of Park City Vision Center, Inc.'s Notice of Privacy Practices.

BY SIGNING, YOU INDICATE THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO THESE TERMS, AND THAT YOU ARE THE PATIENT, THE GUARANTOR, THE PATIENT'S LEGAL REPRESENTATIVE, OR LEGALLY AUTHORIZED TO SIGN THIS AGREEMENT AND ACCEPT THESE TERMS.

____ ______________________

Patient Name (Please Print) Date

____ ______________________

Signature of Patient or Legally Authorized Representative Relationship

____ ______________________

Signature of Guarantor- Print Name of Guarantor

By Signing you are Agreeing to be Legally Responsible to Pay your Bill

Contact Lens Information

Contact lenses are medical devices regulated by the FDA and are available by prescription only. Professional care must be taken to ensure a proper fit and eye health. Improper fitting, inadequate cleaning or inadequate follow-up care can all lead to disastrous visual consequences such as infection leading to vision impairment or vision loss.

Contact Lens Fitting/Ordering

With the completion of a comprehensive vision exam, a contact lens evaluation will be necessary. This evaluation may be conducted on the same day as the routine exam, or may need to be scheduled at a later date. Depending on your prescription, some diagnostic lenses, such as toric lenses (for astigmatism) or gas permeable lenses (specialty lenses) may have to be ordered. All types of lenses can require multiple trials and multiple visits.

There is an additional fee for a contact lens fitting. The patient will be responsible for this fee, as it is services rendered. Most insurance plans will not cover this additional testing. If the patient decides not to do contacts after the evaluation has been done, this fee is non-refundable.

Fitting Fees:

Soft Lenses	
Spherical Evaluation	$57
Toric (astigmatism) Evaluation	$87
Multifocal Evaluation	$87
Hard Lenses	
Spherical Evaluation	$107
Toric (astigmatism) Evaluation	$127
Multifocal Evaluation	$127
Specialty Lenses (medically necessary)	
Keratoconus Lenses	$350
Scleral Evaluation	$500

Usually a 1-2 week check up is required after a contact lens fitting. **It is important that you show up for your contact lens follow-up wearing your contact lenses**. We will be unable to release a prescription for contact lenses until all recommended follow-up care is complete. If all follow up care is not completed within 60 days of the initial fitting, you may be subject to additional fees.

This form is an agreement of Park City Vision Center's contact lens policy. The doctors and staff at Park City Vision Center will do everything possible to maximize your chances of a successful contact lens experience.

______________________________ ______________________________

Patient Signature/Parent Signature Date