Presley Eye Care, PLLC

Fee Schedule:

Eyeglass Exam (no dilation)..... $135
With dilation.....$180
Eyeglass Exam (no dilation) and CL Fitting....$205
Office Visit..... between $85 to $125

Please fill in all of the information below:

Legal Name_____

Preferred Name_____

Birth Date_____ Male / Female_____

Address_____

City/ST/ZIP_____

Home Phone_____

Wireless Phone _____

Patient's Social Security #: _____

Place of Employment: _____

Please fill out the following if the patient is a minor / dependent.

Guarantor's Name_____

Birth Date_____ Male / Female_____

Address_____

City/ST/ZIP_____

Primary Phone_____

Guarantor's Social Security #: _____

Name of insurance: _____

Place of Employment: _____

Please provide the following information if you are NOT the primary policyholder.

Insured's name: _____

Insured's date of birth: _____

Insured's Social Security #: _____

Please indicate if you (or a family member where noted) have had any of the following:

	SELF	FAMILY
High Blood Pressure	☐ Yes ☐ No	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	☐ Yes ☐ No
Macular Degeneration	☐ Yes ☐ No	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	
Eye Turn or Lazy Eye	☐ Yes ☐ No	
Eye Injury or Surgery	☐ Yes ☐ No	
Total Loss of Vision	☐ Yes ☐ No	
Double Vision	☐ Yes ☐ No	
Flashes	☐ Yes ☐ No	
Floaters	☐ Yes ☐ No	
Frequent Headaches	☐ Yes ☐ No	
Asthma	☐ Yes ☐ No	
Thyroid Disease	☐ Yes ☐ No	
Heart Disease	☐ Yes ☐ No	
Cancer	☐ Yes ☐ No	
Stroke	☐ Yes ☐ No	
Arthritis	☐ Yes ☐ No	

Please list any medical conditions you have that are not mentioned above:

_____

Please list any medications you are taking:

_____

_____

_____

Please list any medical allergies you have:

_____

PRESLEY EYE CARE

HIPPA Privacy Policy Acknowledgment

Patient Legal Name: _____

Please select one of the following below:

- o I have received a copy of the Notice of Privacy Policy in office, but I have declined a copy to take home.
- o I have received a copy of the Notice of Privacy Policy in office, and I want a copy to take home.
- o I refuse to acknowledge receipt of the privacy policy. I understand that even though I may refuse to sign this acknowledgment, Provider may still provide treatment to me.

Signature of Patient (or Patient's Legal Representative if Pt. is a minor)

_____

Date: _____

PRESLEY EYE CARE

Screening Retinal Imaging
(Optional Test)

Screening photographs and digital scans are stored on the computer. They can be compared to photographs and scans from future eye exams. These images help the doctor more easily detect the development of vision-threatening diseases over time.

These images are **NOT COVERED** by most insurance plans.

Your out-of-pocket cost for this test would be: **$35.00**.

☐ Yes, I would like screening images taken today.

☐ No, I do not want screening images taken today.

Please note: Even if you choose not to have the screening images taken, the doctor may order these images if there are medical reasons to do so. Medical imaging would be billed to your medical insurance. As with any medical tests, all copays and deductibles would be the responsibility of the patient.

Print Name: _____

Signature: _____ Date:_____

PRESLEY EYE CARE

2885 McCullough Blvd., Suite F
Belden, MS 38826
662-791-0454

PAYMENT: The patient is responsible for all copays, coinsurance, deductibles and any non-covered services on the date of service. Your Rx and materials will not be released until the complete payment is received.

RETURNED CHECK: If a check is returned to Presley Eye Care for insufficient funds, there will be a **$30 returned check fee** added to the amount owed. Once a check is returned, the bill must be paid by credit card or cash.

FILING INSURANCE: As a courtesy, all claims will be filed with the insurance company provided by the patient. We will do our best to accurately verify benefits for services and/or materials. **However, benefits quoted are only an estimate provided by the insurance company, and not a guarantee of payment. Copays and amounts due could change.** Should the insurance deny a claim for any reason, the patient will be responsible for any remaining balances.

RETURNS and REFUNDS: We want each patient to be happy with their eyeglass purchases. However, patients are responsible for selecting their own frames, lens styles and lens features. If a patient is unhappy with the frame or the lenses that were selected after receiving their eyeglass purchase, the patient can restyle to a different frame and/or lenses **within 14 days** of receiving the eyeglasses. The patient will be responsible for a **$50 restyling fee** as well as any differences in the cost of the frames and/or lenses. Most insurances have guidelines for material remakes and refunds by which we must abide.

DR. REMAKES: You are allowed one doctor's remake within **60 days of purchase**. A remake is when a lens is being replaced based on a doctor's change in the Rx. The original frame and lenses **must remain the same**. Most frames have a 1-year warranty from the date of purchase. If a frame breaks because of a manufacturer's defect, **we are required to send ALL pieces** back to the manufacturer for replacement. If a **lens warranty** was purchased there is a **1-year warranty** from the date of purchase as well. **Super Glue / Animal Bites VOIDS the warranty**.

CONTACT LENSES: A contact lens evaluation is required **each year** to update a contact lens prescription. All follow-ups must be completed within **90 days** of the original evaluation, otherwise the patient will be **charged $70** for a new evaluation. **NO EXCEPTIONS!** Contact lenses must be paid in full before ordering. There are no refunds on opened boxes of contact lenses.

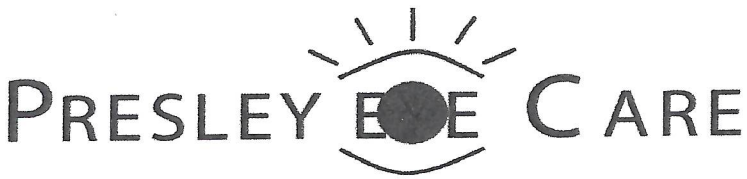
CANCELLATION POLICY: We request a 24-hour notice if you need to cancel or reschedule an appointment. We understand emergencies occur, but please be respectful of our time.

UPDATING PATIENT INFORMATION: It is very important to keep our office up to date on your personal contact information. If we cannot reach you, and there is a problem with a claim, you will be responsible for the charges.

My signature below, confirms I have read and understand the above outlined policies.

_____ _____

Signature of Patient or Guardian Date



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Patient Record Release Form

By signing this form, I permit Presley Eye Care to receive and/or release necessary information and exchange copies of my records to/from any other healthcare providers if needed. I also authorize the release of my patient information and prescriptions to any pharmacy, optical, or contact lens distributors if I choose to order from them in the future. I understand that signing this form is voluntary. By not signing the form, I understand that future transactions make take extra time since Presley Eye Care will need to get required consent for each transaction.

_____ _____

Signature of Patient or Minors Authorized Representative Date

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Family Members and Friends Involved In Patient Care Form

This form documents my request to allow family members and/or friends to be involved in verbal discussions regarding my health care. By signing this form, I permit the Presley Eye Care staff to discuss information about me with the persons listed below. This information may include personal information such as: diagnoses, test results, order information, insurance information, and other service information from Presley Eye Care. I understand that it is my responsibility to make changes to this list if I feel the need arise. I understand that signing this form is voluntary. By not filling out this form, I also understand that I must handle **all** questions pertaining to my insurance, balances owed, or any patient information on my own and no one else is permitted to do so.

Name	Phone	Relationship

Signature of Patient or Minors Authorized Representative

Date