Welcome To Dr. Paul Johnson's Office

(Please Print Clearly)

PATIENT INFORMATION:

_____ _____ _____ _____ __F / M__

Last Name First Name MI Nickname Gender

Address:_____ Apt.:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Would you like to receive texts? ☐**Yes** ☐**No**

Birthday: _____/_____/_____ Social Security #:_____

Employer or School:_____ Occupation:_____

☐ Full Time ☐ Part Time ☐ Retired // ☐Single ☐ Married ☐ Divorced

Email:_____ **(Your Email will never be released to a 3rd party)**

***We are no longer sending post card reminders that you are due. IF you would like a reminder please include your Email.**

Parent's or Guardian's name if patient is under 18 years of age, and in case of emergency, who should we contact:

Name:_____ Relationship:_____ Phone #:_____

DILATION

The dilated eye exam is an additional procedure using eye drops and specialized instruments to get the most extensive evaluation of the internal eye structures. Many eye disorders have no symptoms or early warning signs. With dilation beginning problems can be detected ad prevented much earlier. An eye exam cannot be considered a complete exam without dilation. The doctor strongly recommends dilation for the highest standard of care, especially if any of the following apply:

-High Blood Pressure -Frequent or Severe Headaches -Diabetes -Cataracts -Unusual Changes in Vision

-High Nearsightedness -Symptoms of Flashes or Floaters -Personal or Family History of Glaucoma

Many people don't wish to have dilation due to the blurring of near vision and light sensitivity that may last 4 to 6 hours. **We use new milder drops that can wear off faster.**

Please check one:

☐ I **wish** to have dilation done today. ☐ I **do not** wish to have dilation today.☐ Only if the doctor finds it necessary.

Patient Signature:_____ **Date**: _____

If patient is a minor (under 18 years old), the parent/guardian MUST sign this form

PATIENT HEALTH HISTORY **Please check all that apply below:**

Self *(Ocular)*	**Yes**	**Self *(Medical)***	**Yes**	**Family**	**Yes**	**List Who**
Blurred vision		Heart Disease		Heart Disease		
Lazy eye		Diabetes		Diabetes		
Headache/Eye Strain		Glaucoma		Glaucoma		
Double Vision		Cataracts		Cataracts		
Eye Injury		Asthma		High Blood Pressure		
Eye Surgery		High Blood Pressure		High Cholesterol		
Flashes of Light		Thyroid		Other: (Please list below)		
Floaters in Vision		High Cholesterol				
Other: (explain below)		Other: (Please list below)				
Healthy, no complaints		**Healthy, no medical issues**				

Allergies to medications: (Please List)

Do you wear: ☐ Glasses ☐ Contacts If female, are you pregnant? ☐ Yes ☐ No

Patient Signature:_____ **Date**: _____

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CONTACT LENS FITTING/RENEWAL AGREEMENT *PLEASE SIGN AND DATE AFTER READING*

Contact Lens Policy

Advancements in contact lens technology offer the potential of successful contact lens wear to most of our patients. A contact lens is a medical device in contact with the tissues of your eye; therefore, it must fit appropriately to maintain the health of your eyes. A contact lens prescription can only be determined by the careful observation of the lens on the eye and they eye's response to the lens on follow-up visits. Since follow up care is essential, it is your responsibility to keep all appointment and follow all lens care instructions.

The Comprehensive Eye Exam

Before a patient can be fit with contact lenses, a complete medial and refractive eye examination is necessary. This exam is critical to assure the good health of your eyes and to rule out the possibility of any unsuspected, underlying condition that may prevent contact lens use.

Contact Lens Fitting

The goal of contact lens fitting is to find the most appropriate contact lens for each patient's optimal vision and comfort. An enormous variety of types, materials, sizes and colors are offered. We are committed to taking the time and effort to fit your contact lenses properly. Although many patients will need only one fitting session, sometimes this process requires several appointments. In our experience, the extra time, effort and patience are well merited by both your ultimate satisfaction and health of your eyes. All patients being fit into contacts for the first time must go through the fitting process and training. We will not finalize the contact lens prescription until both the patient and the doctor are satisfied with the fit and visual acuity of the contact lens. **We will provide one set of trial lenses.**

Contact Lens Training Session

The patient will be provided with personalized instruction concerning the safe care and usage of contact lenses. Upon completion of successful insertion and removal, the patient may begin wearing the contact lenses and we will schedule the first follow-up appointment. This training is a $25 fee that insurance does not cover per each session.

Follow-Up Appointments

Follow-up appointments are necessary to assure several things:

1. The contact lenses are fitting and moving well
2. The prescription is providing the best possible vision
3. The eyes are remaining healthy
4. There are no problems with insertion or removal
5. The patient understands and complies with the recommended wearing schedule

Annual Contact Lens Check

By law, a contact lens prescription is valid for only one year. All patients are required to come in for an annual contact lens exam. This is necessary to assure that the patient's eyes are healthy and the contact lenses are still fitting well. Contact lens prescriptions cannot be renewed without an annual eye exam. If we are seeing you for the first time, and you have had a contact lens prescription from another office, the doctor will use his judgment to use the prescription from another office for the fitting and prescription of the contacts.

Contact Lens Fee Policy

The fitting fee, which includes 2 follow-up visits within the first 30 days, is determined by the type of lenses prescribed and the difficulty of the fit**. THIS FEE IS NON REFUNDABLE AND DUE AT THE TIME OF SERVICE**. The cost of the fit will range from $55 to $350. ***If an initial fit needs to be changed, you will be charged the difference in the fitting fees between the original fit cost and the final fit cost.***

Service fee of $25 will apply at the discretion of the doctor when additional services are rendered this includes but is not limited to giving additional trials, additional copies of Rx, and release of records.

The Fitting Fee Includes:

- The contact lens fitting
- 2 follow-up visits within 30 days from initial exam- After 1 month the fitting fee ($55 to $350 and a Refraction fee of $55) will be applied if a visit is required
- Diagnostic lenses (one trial pair)

The Fitting Fee Does NOT Include:

- Contact lenses (Costs will vary depending on type of lens prescribed)
- The comprehensive eye exam
- Medical visits

Annual contact lens exam:

It is our office policy that all patients that are currently wearing contact lenses be seen every year for a contact lens examination.

Payment:

Fees for the comprehensive exam, contact lens fitting, or annual contact lens check are due at the time of service.

REFUNDS

There will be NO refund of the exam, fitting, or annual contact lens check fees, **boxes of lenses**, or custom lenses, or colored lenses.

Patient Signature:_____ **Date**: _____

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PRIVACY POLICY AND HIPAA

Patient Printed Name:_____

Please list below the name(s) of any person(s) that we may give any of your information to:
If left blank, you and you alone are the only person who may pick up copies of prescriptions, receipts or any medical devices

Name:_____ Date of birth:_____

Name:_____ Date of birth:_____

Name:_____ Date of birth:_____

Please list below the name of your Primary Care Physician that we may give any of your information to:

Name:_____ Their Phone #:_____

Name:_____ Their Phone #:_____

Patient Signature:_____ Date:_____
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INITIAL below if you would like a copy of Dr. Johnson's Notice of Privacy Practices:

_____ Yes, I would like a copy of Paul S. Johnson's Notice of Privacy Practices.

_____ No, I do not wish to receive a copy of Paul S. Johnson's Notice of Privacy Practices.

NO SHOW/CANCELLATION POLICY/ADDITIONAL COPIES RX

If you fail to provide 48 hours (Monday through Friday) notice for cancellation/reschedule/no show, the fee will be $25 per person scheduled. Three cancellations/reschedules/no shows will result in dismissal from our office. Effective January 01, 2020.

Service fee of $25 will apply at the discretion of the doctor when additional services are rendered this includes but is not limited to giving additional trials, additional copies of Rx, and release of records.

Patient Signature:_____ Date:_____
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PAYMENT

We accept the following forms of payment. ***If paying by check, a valid driver's license is required. Returned checks will be accessed a $25.00 service charge.*** Please sign below that you understand our terms stated above.

Please check below payment type(s):

☐ **Cash or Check** ☐ **Visa/Debit** ☐ **American Express** ☐ **Discover** ☐ **Master Card**
☐ **Flex Spending** ☐ **Care Credit** *(ask about our no interest terms)* ☐ **HealthScope Benefits Card**

Patient Signature:_____ Date:_____

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INSURANCE INFORMATION:

IMPORTANT: We are unable to bill your insurance without a copy of your insurance card & driver's license.

****If using insurance, please complete the following section, if left BLANK insurance will NOT be billed and you will be paying completely out of pocket:****

PRIMARY VISION INSURANCE CO.:_____
Primary/Subscriber Name:_____ Primary/Subscriber DOB:___/___/_____
ID or SS# (REQUIRED): _____ Patient's Relationship to Primary/Subscriber:_____
Employer:_____ Occupation:_____

Address of PRIMARY INSURED if different then PATIENTS own (IF SAME LEAVE BLANK):

Address: (Street, Apt.)_____
City:_____ State:_____ Zip:_____ Phone:_____

SECONDARY VISION INSURANCE CO.:_____
Primary/Subscriber Name: _____ Primary/Subscriber DOB: ____/___/_____
ID or SS# (REQUIRED):_____Patient's Relationship to Primary/Subscriber:_____
Employer:_____ Occupation:_____

Address of SECONDARY INSURED if different then PATIENTS own (IF SAME LEAVE BLANK):

Address: (Street, Apt.)_____
City:_____ State:_____ Zip:_____ Phone:_____

YOUR SIGNATURE IS REQUIRED BELOW (*WHICH WILL ALLOW US TO BILL YOUR INSURANCE COMPANY*.)

I request that payment for any services rend to the patient from the doctor be made to Dr. Paul S. Johnson. I authorize this office to release any medical information about the patient to the Health Care Financing Administration and its agents, as well as any information needed to determine these benefits payable for the related services. I also understand that if my insurance company does not provide payment to Dr. Paul S. Johnson, I will be responsible for the payment of the said service(s).

Patient Signature: _____ Date:_____

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PLEASE TURN THIS PAGE OVER AND CONTINUE

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ABOUT YOUR VISION CARE PLAN & YOUR MEDICAL INSURANCE

There are two types of health insurance that will help pay for your eye health services and products. You may have both types of insurance and Paul S. Johnson, OD accepts most vision care plans and some medical insurance plans in both categories:

(1) Vision Plans

(2) Medical Insurance (such as Medicare).

- **Vision Plans** cover ONLY routine vision wellness exams and may include eyeglasses, sunglasses and contact lenses. Vision plans do NOT provide for MEDICAL EYE HEALTH CARE NEED.

- **Medical Insurance** MUST be submitted for any medical eye healthcare diagnoses and treatment care and follow-up.

- If you have both vision care benefits and medical insurance plans, it may be necessary for us to submit and bill some services to one plan provider and some services to the other plan provider. We will follow a procedure called "Coordination of Benefits" to do this properly and to maximize your best advantage and least cost to you.

- Where some fees for services and products are not paid by your vision plan or medical insurance providers, you will be responsible for them, including deductibles, co-payments and non-provider services as specified by the insurance contract.

Please provide both your vision plan provider and medical insurance card(s) and identification, for your benefit, to our team member so we can make a copy. We will need your medical insurance or Medicare card on file in case we should need it in the future for submitting a claim on your behalf with your insurance.

I understand that if I have a medical issue today that I will have to come back for my glasses/contact lens prescription on a later day. That if Dr. Johnson's office cannot bill my medical insurance that I will have to pay out of pocket and submit for reimbursement. I have read and accept this office procedure.

Patient Signature:_____ Date:_____

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