Focus Eye Care, Inc.

ESTABLISHED PATIENT UPDATE

Welcome back! Has anything changed?

Name: ____

Address: ____

Phone: ____

Vision /Medical Insurance:____

Have you had any of the following since your last exam?

___Eye injury ___ Prescription medicine change ___ Eye Surgery

___Head injury ___ Eye disease ___ Change in health

Reason for today's visit?

___Yearly exam ___New glasses ___New contacts

___Eye infection/injury ___ Other Issue ______________________________

WE RECOMMEND DAILY DISPOSABLE LENSES OR A 30 DAY CONTINUOUS WEAR LENS FOR YOUR SAFETY AND CONVENIENCE. CONTACT FITTINGS MUST BE PERFORMED YEARLY PER THE GEORGIA LAW O.C.G.A § 31-12-12 (2005), TO ENSURE THE EYE IS HEALTHY ENOUGH FOR CONTINUED CONTACT LENS WEAR. PLEASE ASK YOUR PHYSICIAN OR OPTOMETRIC TECH IF YOU HAVE ANY QUESTIONS.

Additional Recommended Procedures & Pricing: ****Additional to the regular exam fee of $76*

PUPIL DILATION: No charge for this procedure.
The doctor may need to use drops to dilate your eyes. Do you give permission for these drops to be used?
___ I do / ___I do not give permission for diagnostic drops to be instilled in my eyes.

RETINAL PHOTO: *(Vision Insurance will not cover this test).* *****The fee is $18.00 per eye. ($36 for both.)**
We have a retinal camera that takes a photograph of the inside of your eye. This allows the doctor to have a picture to evaluate today and to compare with at future visits. Do you give permission for this test?
___ I do / ___I do not give permission for retinal photos.

FIELDS TESTING: *(Vision insurance will not cover this test).* *****The screening is $18.00.**
We have a computerized state of the art instrument that can assist the Doctor in detecting many medical and ocular diseased which include: Headaches, Stroke, Glaucoma, Retinal Detachment, Brain Tumors, High Blood Pressure, and Diabetes. This screening is quick, painless and does not require dilation**.**
___ I do/ ___ I do not give my permission for a visual field test.

Contact Lens Fitting Fees: ****Additional to the regular exam fee of $76*

(Rarely will insurance plans cover contact lenses or evaluations. Please ask a staff member if you have any questions.)

Spherical Fits (Single Vision): $34.00 including trial lenses and follow-up visits
Toric or Mono Vision Fits (Astigmatism) :$67.00 including trial lenses and follow-up visits
MultiFocal Fits: $94.00 including trial lenses and follow-up visits
Hybrid/Synergeyes Fits: $110.00 including follow-up visits
For **NEW CONTACT LENS WEARERS** there is an additional one time I&R training fee of $14.00

VERIFICATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT. If you are not eligible for insurance benefits, or are eligible for less than full coverage, your signature below indicates that you authorize payment of insurance benefits to your provider on your behalf and you agree to be financially responsible for any balance that is not paid by your insurance plan.
PROFESSIONAL FEES AND COLOR CONTACTS, DAILY DISPOSABLE CONTACTS OR OPEN/DAMAGED CONTACT LENS BOXES ARE NOT REFUNDABLE OR EXCHANGEABLE.
You have 90 days from your exam date to have a prescription adjusted at no cost if error on our part; otherwise a $40 refraction may be charged.

Signed: ____ Date: ________________________

Must be signed by Parent/Guardian if the patient is under 18