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Welcome to Borders EyeCare Specialists

**PLEASE PRESENT ALL VISION AND MEDICAL INSURANCE CARDS TO RECEPTIONIST**

**First Name** _____ **Middle Initial**___ **Last Name**_____ **Preferred Name**_____

**DOB** _____/_____/_____ **SSN#**_____-_____-_____ **Gender: M / F** **Race: [ ] White [ ] Black [ ] Asian [ ] Other**_____

**Address** _____ **Home Phone (**_____**)-**_____

**City/St** _____ **Zip** _____ **Country** _____ **Cell Phone (**_____**)-**_____

**Email** _____ **Occupation** _____ **Employer** _____

**Parent/Guardian/Spouse/Emergency Contact:**

First Name:_____ Middle Initial:___ Last Name:_____
Gender: M / F Relationship:_____ Date of Birth:____/_____/_____ Phone (_____)-_____-_____

**Primary Care Physician**

**Practice Name** _____

**Doctor Name** _____

**Eye Doctor**

**Practice Name** _____

**Doctor Name**_____

**Vision Insurance Information:** PLEASE PROVIDE CARD TO RECEPTIONIST

Insurance Company:_____

**Policy Holder** First Name: _____ Middle Initial: ____ Last Name: _____

Date of Birth: ____/____/_____ Social Security #: _____-_____-_____

**Health/Medical Insurance Information:** PLEASE PROVIDE CARD TO RECEPTIONIST

Insurance Company:_____

**Policy Holder** First Name: _____ Middle Initial: ____ Last Name: _____

Date of Birth: ____/____/_____ Social Security #: _____-_____-_____

## ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Borders EyeCare Specialists PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I financially responsible for all charges whether or not paid for by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

## RELEASE OF INFORMATION

I authorize Borders EyeCare Specialists PLLC to release or to discuss any information they deem necessary to another health care provider or individual.

## Notice of Privacy Practices Acknowledgement

I have received Borders EyeCare Specialists PLLC Notice of Privacy Practices written in plain language. The Notice provides in detail the uses & disclosures of my protected health information that may be made by this practice, my individual rights, & the practice's legal duties with respect to my protected health information.
Borders EyeCare Specialists reserves the right to change the terms of its Notice of Privacy Practices & make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

**X Signature:** _____ **Date:**____/____/_____
By signing above I have read, understand and agree with all the above statements.



Turn Page Over ->

**Reason for visit today:** _____

**Do you wear glasses? Distance/Near/Both** **[ ] Yes** **[ ] No**

**Do you wear Contact Lens?** **[ ] Yes** **[ ] No** **Are you interested in Contact Lens?** **[ ] Yes** **[ ] No**

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| **Patient Ocular History** | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| **Age Related Macular Degeneration** | **[ ]** | **[ ]** | **Flashes of Light/Floaters** | **[ ]** | **[ ]** |
| **Amblyopia** (Lazy Eye) | **[ ]** | **[ ]** | **Glaucoma** | **[ ]** | **[ ]** |
| **Blindness** (Left / Right / Both) | **[ ]** | **[ ]** | **Laisk/Refractive Surgery:** Year_____ | **[ ]** | **[ ]** |
| **Blurred Vision** (distance/near/both) | **[ ]** | **[ ]** | **Injury to the eye:** Year _____ | **[ ]** | **[ ]** |
| **Cataracts** | **[ ]** | **[ ]** | **Keratoconus** | **[ ]** | **[ ]** |
| **Cataract Surgery:** (Left/Right/Both) Year _____ | **[ ]** | **[ ]** | **Retinal Defects:** _____ | **[ ]** | **[ ]** |
| **Dry Eye** | **[ ]** | **[ ]** | **Retinal Detachment:** (Left/Right/Both) Year _____ | **[ ]** | **[ ]** |

**Other:** _____

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| **Patient Medical History** | **Yes** | **No** | | **Yes** | **No** | | **Yes** | **No** |
|---|---|---|---|---|---|---|---|---|
| **Constitutional:** _____ | | | **Gastrointestinal:**_____ | | | **Neurological:**_____ | | |
| Fever | **[ ]** | **[ ]** | Crohn's Disease | **[ ]** | **[ ]** | Headaches or Migraines | **[ ]** | **[ ]** |
| Cancer: Type_____ | **[ ]** | **[ ]** | Hepatitis A/ B/ C | **[ ]** | **[ ]** | Multiple Sclerosis | **[ ]** | **[ ]** |
| **Cardiovascular:** _____ | | | AIDS: _____ date Dx | **[ ]** | **[ ]** | Seizures | **[ ]** | **[ ]** |
| Heart Disease:_____ | **[ ]** | **[ ]** | STD:_____ | **[ ]** | **[ ]** | **Psychiatric:**_____ | | |
| High Blood Pressure: ____/_____ | **[ ]** | **[ ]** | Ulcer/Reflux | **[ ]** | **[ ]** | Anxiety/Depression:_____ | **[ ]** | **[ ]** |
| High Cholesterol | **[ ]** | **[ ]** | **Genito-Urinary:** _____ | | | **Endocrine:**_____ | | |
| Stroke: _____ year | **[ ]** | **[ ]** | Bladder/Genital | **[ ]** | **[ ]** | Type I Diabetes: A1C_____ | **[ ]** | **[ ]** |
| Vascular Disease:_____ | **[ ]** | **[ ]** | Kidney Disorder | **[ ]** | **[ ]** | Type II Diabetes: A1C_____ | **[ ]** | **[ ]** |
| **Ears/Nose/Mouth/Throat:**_____ | | | Herpes Simplex | **[ ]** | **[ ]** | Thyroid Dysfunction:_____ | **[ ]** | **[ ]** |
| Chronic Cough | **[ ]** | **[ ]** | **Musculoskeletal:**_____ | | | **Lymphatic-Hematologic:**_____ | | |
| **Respiratory:**_____ | | | Arthritis:_____ | **[ ]** | **[ ]** | Bleeding Problems | **[ ]** | **[ ]** |
| Asthma | **[ ]** | **[ ]** | **Integumentary** (Skin)**:**_____ | | | **Allergic/Immunologic:**_____ | | |
| COPD | **[ ]** | **[ ]** | Skin Disease:_____ | **[ ]** | **[ ]** | Rosecea | **[ ]** | **[ ]** |
| Sleep Apnea | **[ ]** | **[ ]** | Shingles:_____ date | **[ ]** | **[ ]** | Lupus | **[ ]** | **[ ]** |

**Other:**_____

## Medications: [ ] No Medication _____

## Allergies: [ ] No Allergies _____

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| **Family History** | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| **Age Related Macular Degeneration** | **[ ]** | **[ ]** | **Glaucoma** | **[ ]** | **[ ]** |
| **Blindness** | **[ ]** | **[ ]** | **Hypertension (High Blood Pressure)** | **[ ]** | **[ ]** |
| **Diabetic** | **[ ]** | **[ ]** | **Retinal Disorder** | **[ ]** | **[ ]** |

**Other:** _____

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**Social History**

**Are you a drugs user? Drug: _____** **Yes [ ]** **No [ ]**

**Do you Consume Alcohol? _____ per wk.** **Yes [ ]** **No [ ]**

**Tobacco Use**

**Do you use tobacco products? _____pk/week** **Yes [ ]** **No [ ]**



Turn Page Over ->

# Borders EyeCare Specialists Policy's:

## Glasses:

☐ **Eyewear Sales**

- Patients/Legal Guardian chooses the frame: We are happy to help but it is your choice.
  - ☐ Borders EyeCare Specialists Frame
  - ☐ Patient Owned Frame
    - Our office assumes **no liability or responsibility** for any breakage, damage or if the frame is lost/missing. If your frame breaks during the lens insertion process you are responsible for the cost of the lens initially made for that frame there will be **NO refund.** Our office is **not** responsible for finding a replacement frame. The initially made lenses can **not be re-used** for a different frame style and our office will not put the lens into a different frame style. Any and all adjustments done to the frame are at **your own risk** we accept no liability or responsibility for any breakage or damage. We can make new lenses for any new frame you choose, but the cost of the replacement frame and lenses will be at your expense **no credit is applied** it is an entirely **new purchase.**
- Patients/Legal Guardian chooses the lens type: We are happy to help but it is your choice.
  - Lens Type Options: Single Vision / Bifocal / Trifocal / Progressive
  - Lens Use Type Options: Distance / Near / Distance & Near / Computer / etc.
- Patients/Legal Guardian chooses the material: We are happy to help but it is your choice.
  - Material Options: CR-39 (Worst) -> Polycarbonate -> Trivex -> High-Index (Best)
- Patients/Legal Guardian chooses the coatings/lens upgrades: We are happy to help but it is your choice.
  - Coating Options: Anti-Reflectant / UV Coating / Scratch Resistance / Transitions
  - Lens Upgrade Options: Rolled and Polished
  - Sunglasses Options: Tint / Mirror Coating / Polarization

**Eyewear Sale Office Policy:**

- There are no **No Changes/No Upgrades/No Downgrades/No Exchanges/No Returns/ No Cancelations/No Refunds**. All decisions are the Patients/Legal Guardian's therefore all sale/decisions are final.
- On average orders take **7-14 Business Days**, however orders may take longer depending on the lab & shipping times, you can **not** cancel an order regardless of how long it takes. Your Insurance company may require glasses to go to their specific lab; we have no control over any aspect of the lens manufacturing. Our office will do everything in our power to ensure the greatest outcome for your glasses. It is not our responsibility to notify you regarding your insurance companies policies, if you have question regarding your insurance please call your insurance company.
- Frames purchased through our office have a **1 year manufacture warranty** this does not cover abuse, lost frame, etc. all warranties are at the discretion of Borders EyeCare Specialists.
- Borders Eyecare Specialists prescriptions and outside prescriptions have a **1 time remake** at no additional charge within **30 days** of the office first notifying the patient that their glasses have arrived. Outside prescriptions must meet **at least 1** of the following requirements:
  - Patient must provide Borders EyeCare Specialists with a prescription change from the original prescriber
  - Refraction only: Borders EyeCare Specialists Doctor fee of $25.00 (Borders Eyecare Specialists are not responsible for any other ocular complication causing reduced vision including but not limited to cataracts, retinal disorders/disease or any other conditions)
  - Comprehensive Eye Exam: examine eye's for other causes of reduced vision fee of $100.00

☐ **PD Measurement: $25.00**

Pupillary Distance Measurements (PD): We do not hold any liability or responsibility for any glasses purchased online, it is your responsibility to find a resolution with the online retailer.

☐ **Glasses Adjustments/Repair (Non-Borders EyeCare Specialists Frames): $10.00**

All Adjustments done are at your own risk Borders EyeCare Specialists accepts NO liability or responsibility for any breakage, damage to the frame or lens, etc.

## Contact lens:

☐ **Soft Contact Lens:** Service Fee $80.00

- Includes one set of trial lens (Exam does NOT include Contact Lens Supply)

☐ **Hard Contact Lens**

- Patients are required to pay in full for the contact lens before any lenses are ordered. There will be no refunds regardless of the outcome. Each contact lens includes two possible remakes with-in 30 Days of the office notifying you your lens have arrived at the office. To qualify for any remakes all lens must be return intact and without damage & unopened, if lens are damaged or not returned, the patient will be charged 100% of the U&C for any additional lenses.

☐ **Rigid Gas Permeable Contact Lens:** Service Fee $250.00 + Material Fee (per lens) $250.00 = $750.00

☐ **Corneal Scleral Contact Lens:** Service Fee $500.00 + Material Fee (per lens) $750.00 = $2,000.00

**Contact Lens Policy's:**

- All service fee's will be paid in full at the conclusion of todays exam **regardless of the outcome**. Fitting fee's are paid for the doctors time/ service. There are **no refunds.**
- Service fee's do **NOT** include materials such as contact lens supply, contact lens solution, etc.
- The follow up period for progress checks and finalizing a contact lens prescription is **30 days** from the time date of the first exam. After one no-show for a scheduled progress check a fee of **$30.00** for subsequent checks may be applied.
- After 30 days, or once a contact lens prescription has been finalized by the doctor an **$80.00** fee will be charged for the re-fitting of an alternate contact lens.

**X Signature Patient/Parent/Guardian:** _____ **Date:** _____

My signature above confirms I have read, understand and agree with all above statements as well as the following: I was provided a copy of my spectacle rx and/or contact lens rx as require by law and the FTC. I was educated on any and all risk related to my spectacle rx and/or contact lens rx including the my purchases. I was educated on any and all charges and agree to pay the agreed upon amount, as well as, any further charges necessary to complete the transaction. I will not hold Borders EyeCare Specialists PLLC or staff/employees responsible for any adverse outcomes. I am solely responsible for any and all fees (legal, processing, etc.) incurred by Borders EyeCare Specialists PLLC related to any of my care. I herby, acknowledge I understand and accept all policies or policies changes made by Borders EyeCare Specialists PLLC.



Turn Page Over ->