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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**

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: _____

Patient Medical History	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Constitutional: _____			**Gastrointestinal:**_____			**Neurological:**_____		
Fever	**[ ]**	**[ ]**	Chron'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 _____

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

Other: _____

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 Glasses Examination Policy:

☐ **PD Measurements/Additional Measurements**

We realize that by asking us to measure your pupillary distance (PD), you are interested in purchasing your eyewear from an online competitor. PD measurements are not automatically taken, it is an additional service taken when purchasing glasses. We are happy to provide you with a copy of your spectacle prescription if that is what you choose.

However, please understand, that the comparison in costs form competitors often reflects the quality of materials you are receiving and does not include the (wo)man-hours for an optical expert to:

- Help you properly select the appropriate frame (frame size does matter)
- Educate you on material options and features that give you your best visual experience
- Verify the lenses once they are received from the lab
- Apply special techniques with complicated prescriptions to improve both cosmetics appearance and performance
- Provide adjustments at any time free of charge.

Proper measurements are extremely important especially for those with higher prescriptions or those needing a bifocal, trifocal or progressive lenses. This includes measurements other than just the PD. Improperly fit eyewear may cause headaches, pinching, pulling sensations, eye strain and fatigue. In children it can induce additional issues such as amblyopia.

The American Optometric Association (AOA) bought 200 pairs of glasses from the 10 most popular online eyewear vendors and tested them. The results were shocking. They found nearly half of the eyeglasses (44.8 percent) had incorrect prescriptions or safety concerns.

☐ **PD Measurement: $25.00** Includes: Pupilary Distance Measurements (PD)	☐ **Care Package: $50.00** Includes: Pupillary Distance (PD), Prescription Verification, Adjustments, Minor Repairs (nose pads & screws for 12 months from the date of purchase)

☐ **Placing New Lenses in a Reused/Patient Owned Frame**

We are happy to make new prescription lenses form your own frame if it's in good condition and fits your face properly. If we accept your frame for re-use, we pledge to use the utmost care in handling it. In a small percentage of cases, the frame material will be worn or brittle to the point that it will not support a new pair of lenses.

In the case that your frame breaks our office assumes no liability for any breakage or any damage to the frame. If your frame breaks during our lens insertion process **you are responsible for the cost of the lens initially made for that frame.** The initially made lenses can **not** be re-used for a different frame style. 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**.

☐ **Eyewear Sales**

We are delighted you have chosen to purchase your eyewear through Borders EyeCare Specialists. Our staff is dedicated to ensuring you love your new look & are comfortable wearing your glasses throughout the day. We are here for any structural adjustments to the frame fit, nose pieces, & temple adjustments at no extra cost to our customers as they need them throughout the year. Your eyewear will be customized for your prescription, head, face, & ocular alignment. Therefore **all sales are final**.

Our staff is available to answer any questions as well as help guide you through your optical experience. However, **all final decision are the patients.** There will be **no refunds, exchanges, cancellations, upgrades, downgrade etc.** once you have completed your order.

On average orders take **7-10 business day**, orders may take longer, patients will be notified as soon as the office receives their order.

All Borders Eyecare Specialists prescriptions: have one remake at no additional charge within 30 days of the office first notifying the patient that their glasses have arrived.

Outside prescriptions: one remake may be done within 30 days of the office first notifying the patient that their glasses have arrived. Requirements for remake of glasses for outside prescriptions:

- Patient must provide Borders EyeCare Specialists with a prescription change from the original prescriber
- Refraction only: Borders EyeCare Specialists Doctor fee of $25.00 (not responsible for any other ocular complication causing reduced vision)
- Comprehensive Eye Exam: examine eye's for other causes of reduced vision fee of $100.00

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 as require by law. I was educated on any and all risk related to my Spectacle Rx and/or purchases. I was educated on any and all charges and agree to pay the agreed upon amount and any further charges necessary to complete the transaction. I will not hold Borders EyeCare Specialists responsible for any adverse outcome. 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.

Turn Page Over ->

Borders EyeCare Contact Lens Examination Policy:

A Contact Lens Service Fee is charged to the patient on an annual basis. Contact lenses are medical devices which require ongoing evaluation to ensure safe and comfortable wear. This service is in addition to your annual comprehensive examination and may include:

- Evaluation of current, or new lens fit on the eye
- Evaluation of corneal, conjunctival and eyelid health as related to contact lens wear
- Mapping of corneal surface and evaluation of changes compared to baseline mapping
- Progress checks related to changes in contact lens prescription or material for **45 days** following the date of initial evaluation and/or fitting of contact lenses.

Our contact lens service fees are as follows:

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

- Non-refundable service fee
- All fees for todays exam'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** available.
- This fee does not include materials (contact lenses).
- This service does include one set of trial lens.
- This service is for soft contact lens patients.

☐ **Rigid Gas Permeable Contact Lens:** Service Fee $250.00 + Material Fee (per lens) $250.00 + $15.00 (tax)

- Non-refundable service fee & material fee
- All fee's for todays exam'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** available.
- This fee does not include materials (contact lenses).
- Before rigid gas permeable contact lens are ordered the patient is required to pay in full for the contact lens.
- This includes two possible remakes for RGP lens with-in 30 Days of the initial date of the RGP fitting (all lens must be return intact and without damage, if lens are damaged or not returned, the patient will be charged 100% of the U&C for any additional lenses)
- This service is for the fitting of rigid gas permeable contact lens.

☐ **Corneal Scleral Contact Lens:** Service Fee $500.00 + Material Fee (per lens) $750.00 + 90.00 (tax)

- Non-refundable service fee & material fee
- All fee's for todays exam'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** available.
- This fee does not include materials (contact lenses). No refunds for materials once
- Before corneal scleral contact lens are ordered the patient is required to pay in full for the contact lens.
- This includes two possible remakes for corneal scleral lens with-in 30 Days of the initial date of the corneal scleral fitting (all lens must be return intact and without damage, if lens are damaged or not returned, the patient will be charged 100% of the U&C for any additional lenses)
- This service is for corneal scleral contact lens patients.

Fitting Agreements:

- The global follow up period for progress checks and finalizing a contact lens prescription is **45 days.** After 45 days a **$30.00** contact lens progress check will be apply.
- After **45 days**, or once a contact lens prescription has been finalized by the doctor a **$80.00** fee will be applied for a refitting into an alternate lens.
- After one no-show for a scheduled progress check a fee of **$30.00** for subsequent checks maybe apply. (In this case a no-show is considered a scheduled appointment that was not cancelled or rescheduled by speaking with someone within 24 hours of the appointment time.)
- Exceptions to any policy are at the discretion of our office and doctor.

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

My signature above confirms I have read, understand and agree with all above statements as well as the the following: I was provided a copy of my contact lens prescription as require by the Federal Trade Commission. Borders EyeCare Specialists PLLC (staff, doctors, etc.) are in compliance with any and all FTC requirements. I have been educated on the risk of contact lens and will not hold Borders EyeCare Specialists PLLC (staff, doctor, etc.) responsible for any outcomes. I understand the FTC has made it so that online retailers can access my complete health records at Borders EyeCare specialists and they can/will request my records on my behalf, without my request. 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.

Turn Page Over ->

Patient Name:_____ **[ ] Scan**

Exam Charges

	Retail		Ins./Dis.		Charge
☐ Comprehensive Eye Exam (Copay/Charge)	$100.00	-	$_____	->	$_____
☐ Contact Lens Exam (Copay/Charge)	$80.00	-	$_____	->	$_____
☐ Medical Eye Exam(Copay/Charge)				->	$_____
				Total Charge	$_____

Ins.:_____
☐ Yes
☐ No

Optical/Glasses Charges

Frame Selection	Retail		Ins./Dis.		Charge
☐ Frame: _____	$_____	-	$_____	->	$_____
Materials Copay:	N/A		N/A	->	$_____
Lens Selection					
☐ Single Vision: Standard	$100.00	-	$_____	->	$_____
☐ Single Vision: High Definition Digital	$150.00	-	$_____	->	$_____
☐ Bifocal:	$150.00	-	$_____	->	$_____
☐ Trifocal:	$150.00	-	$_____	->	$_____
☐ Progressive: Good	$200.00	-	$_____	->	$_____
☐ Progressive: Best	$400.00	-	$_____	->	$_____
Lens Material					
☐ CR-39:	$0.00	-	$_____	->	$_____
☐ Polycarbonate: (Scratch Coating & UV Protection)	$50.00	-	$_____	->	$_____
☐ Trivex:	$125.00	-	$_____	->	$_____
☐ High Index (1.67):	$150.00	-	$_____	->	$_____
Anti-Reflectant					
☐ Anti-Reflectant:_____	$_____	-	$_____	->	$_____
☐ UV-Coating :	$_____	-	$_____	->	$_____
Transitions					
☐ Transitions:_____	$125.00	-	$_____	->	$_____
☐ Tint:_____	$50.00	-	$_____	->	$_____
				Total	$_____
				Tax (6%)	$_____

Ins.: _____
☐ Yes
☐ No

PD Measurement
Distance
R: _____
L: _____
Near
R: _____
L: _____

Segment Height
R: _____
L: _____

☐ **Additional Cost** $_____

-> **Total: $**_____

Contact Lens

	Retail		Ins./Dis.		Charge
☐ Right Eye Contact Supply:_____ [ ] 12 months [ ] 6months [ ] Trials [ ] Other Number of Boxes_____	$_____	-	$_____	->	$_____
☐ Left Eye Contact Supply:_____ [ ] 12 months [ ] 6months [ ] Trials [ ] Other Number of Boxes_____	$_____	-	$_____	->	$_____
				Total	$_____
				Tax (6%)	$_____

Ins.:_____
☐ Yes
☐ No

-> **Total: $**_____

Grand Total: $_____ **Patient Initials:** _____

Turn Page Over ->