Today's Date: _____

PATIENT INFORMATION

Name_____ SSN_____ DOB_____

First Name Last Name MI

Home Phone: _____ Cellphone: _____

Email Address _____

Address_____ City_____ State_____ Zip_____

Sex: M[ ] F[ ] Marital Status: Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed [ ]

Employer: _____ Occupation: _____

Reason for visit: _____ Last Exam Date: _____

Do you wear contact lenses? **YES/NO** Brand: _____ Hours per day: _____

CONDITIONS

Please check any conditions you have or have had in the past.

☐ Blurred Vision	☐ Eye Infection	☐ Glaucoma	☐ Retinal Disease
☐ Cataracts	☐ Eye Injury	☐ Headaches	☐ Seeing Flashes
☐ Cross Eyed	☐ Eye Surgery	☐ Hypertension	☐ Seeing Halos
☐ Diabetes	☐ Floaters	☐ Loss of Vision	☐ Sensitivity to Light
☐ Double Vision	Dry Eye	Macular Degeneration	Amblyopia (Lazy Eye)

Family History

Disease	Relationship to you
☐ Blindness	
☐ Cataracts	
☐ Diabetes	
☐ Glaucoma	
Macular Degeneration	
Keratoconus	

Medications

List any allergies to medications or substance:
List medications you are currently taking:

INSURANCE INFORMATION

Person responsible for account _____ Relation to patient _____ DOB_____

First Name Last Name MI

Vision Insurance _____ Member ID _____

Medical Insurance _____ Member ID_____ Group # _____

Payment is expected at the time services are rendered, including non-covered portions of insurance.
Note: Most insurance policies pay only a portion of your total charges. If you have questions about your coverage, please contact your insurance company or Human Resource department. We cannot guarantee the accuracy of benefit information given to us by your insurance company.
Please understand that financial responsibility for your account is yours, not your insurance company's.

- I authorize the release of any medical or other information necessary to process insurance claims.
- I authorize payment of medical benefits to Darren F. Osterloh O.D.
- HIPPAA Compliance: I hereby acknowledge that I have seen a posted copy of Darren F. Osterloh O.D.'s Notice of Privacy Practices.

[ ] I have read and understand the above statements.

Signature:_____ Date: _____

OFFICE POLICIES

- Exam fees are to be paid in full at the time of the exam and are **non-refundable.**
- Payment is expected at the time services are rendered, including non-covered portions of insurance.
- Half a payment, if not the full amount, must be made on a materials order, and must be paid for in **full** before they are dispensed to the patient.
- Contact lens prescriptions expire **one year** from the date of the last exam. Orders for contacts lenses will not be filled after that date without a new exam.
  "In 2004, a law was passed that set the expiration date of contact lens prescriptions at one year, or the minimum required by state law, whichever is greater because the FDA considers contact lenses to be medical devices worn on the surface of the eye."
  The prescriptions for contact lenses expire for the same reasons that medical prescriptions expire. Any time you are using a medical product, you should follow up with your healthcare provider at least once per year to identify possible complications.
- Glasses prescriptions expire after **two years**.
- Any changes that need to be made on glasses/contact lens prescriptions after 60 days may be subject to additional charges.
- If a patient cannot adapt to progressive/bifocal lenses within 60 days, the lenses can be remade into a standard bifocal or single vision lens at no additional charge. However, we cannot refund the difference.
- If a patient cannot adapt to polycarbonate lenses within 60 days, the lenses will be remade into regular plastic at no additional charge. However, we cannot refund the difference.
- **There is a 30% restocking fee if you should cancel and/or return your order, to cover lab fees. No exceptions. As it is stated above, you may change the type of lens or material within X amount of days if you cannot adapt.**
- If you use your own frame, you may not hold Dr. Osterloh's staff or the lab responsible for any damages done to frames or lenses during the process of repairing or replacing as we will have warned you of the chance of breakage when using your own frame/older frame.

  If you have any questions concerning these policies and/or our fees, please feel free to ask the staff before you begin your exam.

[ ] I have read and understand the above policies and agree to them as followed.

Signature_____ Date: _____

Reviewed_____ Date_____	Reviewed_____ Date_____
Reviewed_____ Date_____	Reviewed_____ Date_____
Reviewed_____ Date_____	Reviewed_____ Date_____
Reviewed_____ Date_____	Reviewed_____ Date_____
Reviewed_____ Date_____	Reviewed_____ Date_____
Reviewed_____ Date_____	Reviewed_____ Date_____