Vision Clinic at Foxhill

2001 46th Avenue, Greeley, CO 80634

Patient Name: _____ Today's Date: ____/_____/_____

Date of Birth ____/___/_____ Height_____ Weight_____ Occupation_____ Allergies ❑Yes ❑NO

Address:_____ Phone Number _____Email_____

Communication preference: ❑Text ❑Email ❑Home Phone ❑ Cell Phone ❑ Postal

Please provide any changes in health history from your last exam. (Please list any current medications);

_____

_____

_____

Are you currently experiencing any problems with your eyes?

_____

Do you wear contact lenses? ❑Yes ❑No On a scale of 1 to 10, how comfortable are your contact lenses? _____

There are areas of the retina that cannot be seen without the OptoMap Retinal Exam or Dilation. A wide-field view is important in detecting macular degeneration, glaucoma, diabetes, tumors, and retinal detachments.
Choose one:
❑ I would like the Optomap Retinal Exam (Picture, No side effects, see bottom laminate page for more information)
❑ I would like Dilation (With drops, you will have blurry vision and light sensitivity and may require a driver)

Financial Responsibility (Person Financially Responsible for Patient named Above)

I understand that Vision Clinic at Foxhill does not participate with some insurance companies and that payment is due at the time services are rendered. I agree to these payment terms and guarantee payment to Vision clinic at Foxhill for any services provided to this patient named above. A rebilling (finance charge) of $0.75 minimum, maximum 1.5% per month, 18% per annum is added to an account when payment is not made as agreed or arrangements changed or when no payment has been received within the last month.

_____ _____

Signature of Guarantor Date

The submitting of insurance claims by Vision Clinic at Foxhill is a courtesy to our patients. We will provide the information requested by the insurance carrier, however, should the insurance carrier refuse payment the account is the responsibility of the patient.

Patient or authorized person's signature

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits or insurance reimbursement to any party who accepts assignment of the claim or to myself if assignment is not accepted. By providing us with your landline or cell phone number(s), you give express authorization to contact you at those numbers. This applies to any future landline or cell phone number. Phone calls to you may utilize automated dialer technology. Providing your phone number is not a condition of receiving our services.

_____ _____

Signature Date