NAME (LAST) ________________________ (FIRST) ___________________________ M ☐ F ☐ DOB: _____/_____/_____

ADDRESS: ________________________ CITY ______________________STATE ______ ZIP: ______________

PHONE: ________________________________ Last 4 of SS Number (for insurance purposes): ___________________

INSURANCE SIGNATURE ON FILE:

I hereby assign all medical benefits, including all major medical benefits to which I am entitled to, including Medicare, private insurance and any other health plans, to Lily Vision PLLC DBA Today's Vision Manvel. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment. If my insurance company has not reimbursed Lily Vision PLLC DBA Today's Vision Manvel within 60 days, I may be billed for any services or products that I have received. I understand that I am responsible for the balance due after billing. I understand that a late fee of *$35* may be charged if I do not pay my balance within 30 days after receiving my statement.

NOTICE OF PRIVACY PRACTICES:

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

May we discuss your medical condition with any member of your family? Yes No

If YES, please name the members allowed/relation/phone number:

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CONSENT FOR NON-SECURE EMAIL:

Today's Vision Manvel cannot guarantee the security and confidentiality of an email transmission. Because of the many Internet and email factors beyond our control, we cannot be responsible for misaddressed, misdelivered, or interrupted email. Your health care provider is not liable for breaches of confidentiality caused by yourself or a third party.

Email is best suited for routine matters and simple questions. You should not send us emails for urgent or emergency situations or for matters requiring an immediate response. Time sensitive issues should be taken care of by telephone.

May we email you regarding your medical condition (e.g. Spectacle/Contact Lens RX)? Yes No

Email Address: ____

By signing below, I acknowledge that I agree to release my information for insurance purposes, have reviewed the Notice of Privacy Practices, and understand the risks associated with email communication.

______________________________	______________________________	____________
Patient Name (Printed)/Responsible Party	**Signature**	**Date**

CONTACT LENS & CORNEAL ASSESSMENT:

Contact lenses are medical devices, and thus, require a proper evaluation. With a contact lens and corneal assessment, the doctor assesses your cornea, the clear covering that covers the colored part of your eye, to make sure that it is healthy enough for contact lens wear. The doctor will also need to assess how the contact lenses fit your eye to ensure that the lenses are not too tight or too loose, as this may cause damage to your eye. This may not be covered by your insurance. You will receive a copy of your contact lens prescription once it is finalized by the doctor.

FINANCIAL POLICY:

- Payment is due when services are provided. Optical lenses and frames will not be ordered until balance is paid in full. **There will be no refunds on professional services or custom frame/lenses orders**
- You may have health insurance that may pay a portion of your eye care bill. As a courtesy to you, we will file your claim if we are a participating provider for your insurance plan. **However, if your insurance refuses to pay for your exam, you are responsible for the payment.**
- **You have 90 days to return for a contact lens follow-up or spectacle prescription re-check. After 90 days, there will be a $40 charge, and after 180 days, you will be required to have a complete comprehensive eye exam, as your vision may have changed.**
- **You are responsible at the time of your visit for:**
    - **Co-Payments**
    - **Contact lens & corneal assessment fee (if not covered by your insurance)**
    - **Any purchases not covered by insurance**

FRAMES:

- All frames have a limited, one-year manufacturer's defect warranty on frame defects (such as broken temples) but does not include chewed or intentionally broken frames. **There will be a $35 service fee for any warranty requests**. This is a ONE TIME replacement; additional replacement will receive a 40% discount.

LENSES:

- All lenses are custom made. **If progressive lenses have been ordered and you cannot adapt to them, we will have them remade to single vision, bifocal or trifocal lenses at no additional cost. However, you will not get a refund due to the expenses incurred by the laboratory. If anti-reflective coating or scratch resistance coating is added, a one year limited warranty will be included against manufacturer's defect.** This is a ONE TIME replacement; additional replacement will receive a 40% discount.
- **Within 60 days, if you are not satisfied with your prescription or lenses, please contact us so we can correct the issue at no charge.** If you wait longer than 60 days, unfortunately, there will be extra charges.

CONTACT LENS SUPPLY:

- Unopened, undamaged, unmarked, and unexpired contact lens boxes may be exchanged as a credit toward the purchase of contact lenses or eyewear **within 60 days from date of purchase.**

We offer UNLIMITED cleanings and adjustments for any glasses purchased in our office at no extra charge.

Since prescription eyeglasses/sunglasses (frames, lenses) are a custom order,

** ALL Sales are FINAL. No Refunds or Exchanges. **

My signature below attests that I have received, read, and agree to these return policies.

I certify that I understand that there are no refunds or exchanges and that all sales are final.

I also acknowledge that I have received a copy of my contact lens prescription and understand the financial policy.

______________________________	______________________________	____________
Patient Name/Responsible Party	Signature	Date

EyeWellness Screening

We now offer advanced digital retinal exams! In this comprehensive screening, you will receive:

- **Digital Retinal Photography- *A photo is taken of the inside of your eye (retina) to check for ocular health conditions including diabetes, glaucoma, macular degeneration, and many others*.** Requires NO drops, does NOT affect your vision, and does NOT increase examination time

- **Optical Coherence Tomography (OCT)-** OCT is a fast, non-invasive technique that creates high resolution cross sectional images to allow us to see all the layers of the retina. ***Only the top layer of the retina is seen with normal photos/dilation. The OCT can screen for eye diseases that start in the lower layers and can detect small changes in the back of the eye***. This is extremely important for the diagnosis and management of most eye conditions, such as macular degeneration, glaucoma, and diabetic retinopathy, all of which can lead to partial loss of vision or blindness.

- **This screening is HIGHLY RECOMMENDED since it can detect major eye diseases early on, even if you are having no visual symptoms.**

Dilation

- **Drops are instilled in the eye to check for ocular health conditions.**
- The potential for partial or total loss of vision may exist and, without dilation, may go undetected. It is required if you have experienced sudden cloudiness of vision, especially in one eye, “curtain or veil-like” obstruction of vision, a sudden onset of many “floaters”, or flashing lights off to the side of your vision.
- **Some blurring of vision and glare due to enlarged pupils for about 2 (but sometimes 12) hours. You should not operate heavy equipment or drive an automobile unless you are comfortable with your vision.**
- Increases examination time by 30 minutes

Visual Field Testing

- Detect blind spots (scotomas), which could be a sign of certain eye diseases.
- **Recommended if you have headaches or a family history of glaucoma.**

	I ACCEPT (PLEASE INITIAL)	I DECLINE (PLEASE INITIAL)
EYEWELLNESS SCREENING ($39)		
RETINAL PHOTOGRAPHY ONLY ($27)		
DILATION		
VISUAL FIELD TESTING ($15)		

By signing below, I acknowledge that I understand the importance of dilation, and that in some cases, retinal photography will not replace dilation. I agree to pay for the extra services I have chosen.

________________________________ ________________________________ ____________

Patient Name/Responsible Party Signature Date