POWELL VISION CENTER

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|---|---|---|---|
| Last Name: | First Name: | Nickname: | Male or Female |
| Address:<br>Street: City: State: Zip Code: | | | |
| Birthdate: / / | Email: | Cell Phone #: | Single Married Widowed |
| Employer and Occupation: | SS #: | Reason for choosing our office: Friend/Family<br>Location Google Facebook Insurance | |
| Dependents under 18 (Name and DOB): | | | |

**The following individuals have my authorization to access my healthcare information:**

| | | |
|---|---|---|
| Name: | Relationship: | Date of Birth: |
| Primary Care Physician: | | Preferred Pharmacy: |

## Office Policies

**Insurance:**

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Initials

Vision insurance is designed for determining your prescription for glasses and to cover a routine (non-medical) evaluation of the eyes in a healthy patient. Medical insurance is designed for a medical examination of your eyes, including, but not limited to dry eye, allergies, infections, cataracts and diabetic eye examinations. These rules are set by the insurance companies, and we must comply with them. **Medical Conditions may determine the exam type and required insurance billing**. If you request that we resubmit a claim at a later date (no later than 60 days after date of service), there will be a $35.00 fee. Powell Vision Center is authorized to release all information necessary to secure payment of services.

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Initials

I understand my insurance may have co-pays, deductibles and may not cover every test/procedure that my doctor or I deem necessary, including, but not limited to visual field testing, medical Optomap, OCT testing, contact lens fitting and training. If my insurance denies payment of these tests/services, I am responsible for payment in full and I have the right to appeal to my insurance company.

**Eyewear:**

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Initials

If you purchase glasses elsewhere and find that you are unhappy with the vision, please understand that asking us to troubleshoot all the possible errors that may occur in the production of those glasses takes a good bit of time. For that reason, we will charge you a $75 fee. In the unlikely event that your prescription supplied by the doctor is incorrect, we will refund the fee.

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Initials

I understand that eyewear purchases are custom orders and therefore, all sales are final. Lenses will be replaced free of charge for up to 60 days if my prescription requires adjustment.

**HIPPA notice:**

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Initials

We are required by federal and state law to maintain the privacy of your health information and to inform you about your privacy practices. All information regarding how your information may be used is included in our privacy notice, and you may request a copy of it at any time. By signing this form, you acknowledge that our privacy practices have been made available to you and that you agree to them.

**I hereby certify that I have read all the office policies and that the information provided is complete to the best of my knowledge. I agree to all terms stated herein for myself and all listed dependents.**

Signature of patient (or parent of minor) _____ Date: _____