Holt Eye Care New Patient Form

*Patient information: Name:______DOB:_____ _____Mobile:_____Text:□ yes or □no Home Phone Address (including city/state/zip code)_____ *Your Email: is only used for in office professional purposes only, such as; recall and confirming appointments. It will never be shared with any outside persons or sources. *Whom may we thank for referring you? *Medical Release/Authorization (ex: the name of your spouse/significant other/or a parent) _____ permission for Holt Eye Care to communicate with them regarding my Vision treatment or any question regarding billing, and/or my appointments and authorized them to pick up any materials such as glasses and contact lenses** *Vision Insurance: Name of Ins. Company:______ID/Member#____ Policyholder Name: DOB: Relationship to Patient: Employer: *Medical Insurance: _ID/Member#____ Name of Ins. Company: Policyholder Name:_____DOB:____ Relationship to Patient: Employer: **Retinal Exam: As part of your comprehensive exam the doctor needs to look at the back of your eye (retina). The only way to see your retina is through using eye drops to dilate your pupil OR by taking a digital image of the back of your eye, using the Optomap. There are some medical conditions that even after doing the Optomap the doctor may still feel it necessary to dilate your eyes. Please choose only one. However, you always have the option to decline it. *Optomap: The Optomap is highly recommended by Dr. Holt. The Optomap is a digital image (photo) of the retina. Macular degeneration, glaucoma, and diabetic retinopathy can now be seen without dilation for most patients. The fee is \$33 and is not covered by insurance. For Optomap initial here:____ OR *Dilation: If you decline the optomap, Dr Holt will examine your retina with the aid of dilation drops. This is included in your exam at no extra charge. These drops will cause temporary light sensitivity and blurred vision lasting 3 to 4 hours making it difficult to focus on close objects. For Dilation initial here:

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*The Contact lens Examination: □yes □no □maybe State Law requires that contact lens wearers have a contact lens examination every year in order to renew their prescription or buy new lenses. The contact lens exam is not part of the comprehensive eye health or refractive vision test examinations. Contact lens patients require additional testing, time, measuring and monitoring to evaluate the design and fit of their current lenses, the health of the eye as it relates to contacts or in the case of a new wearer, their suitability to wear contacts. The contact lens fee varies with complexity of the lens design and diagnostic fitting time. Insurance or vision benefit plans may or may not cover and or contribute an allowance. Fees range from \$40-\$60 for current wearers \$85-\$100 for new wearers. Only sign, If you checked yes to acknowledging that there is a separate contact lens examination fee and agree to its terms and conditions of the contact lens examination.				
X		//		
Office use only (Comfort rating: BOD 1 2 3 4 5 6				
*Caregiver other than Parent/Guardian (For patients under 18 years old only)				
I am giving the following adults permission to bring my child to their vision appointment's. I understand that only myself and those listed below will have the authority to authorize treatment. I understand that any person bringing the patient in for treatment not listed must have a letter of consent from me or treatment could be refused or delayed. This authorization will remain in effect unless designated in writing that such consent for treatment of minor is cancelled. I will notify Holt Eye Care of any changes.				
NAME (AUTHORIZED CAREGIVER(S) PHONE	RELATIO	ONSHIP TO PATIEN	T	
NAME (AUTHORIZED CAREGIVER(S) PHONE	RELAT	TIONSHIP TO PATIE	NT	
*HIPAA Notice and Acknowledgement: (Please read the attached HIPAA notice and check yes/no)				
I acknowledge that I have been provided the HIPAA	Notice of Pri	vacy Practices	_Yes	_No
*Consent of Payment: Our office policy requires payment upon receipt of services and materials. Payment is expected at the time services are rendered, including insurance co-payments. If for any reason the insurance does not pay what is estimated, the balance will become the patients responsibility. I understand that patient and/or guardian is responsible for payment to this office. If you have vision insurance, we will gladly process your forms. However, we request that you pay your estimated portion when services are rendered. Please remember that our contract for payment is with you and not your insurance carrier. We are happy to bill your insurance as a courtesy to you, when you have provided us with your complete insurance information. We allow 45 days from the date of service for payment from an insurance company. After this period, we ask you to become responsible for payment of all unpaid fees.				
*Signature:		Date:		