Welcome To Holt Eye Care
Returning Patient Form

Patients Name:_____DOB:_____

Phone/Home:_____Mobile:_____ Text:☐ yes or ☐no

Email:_____

Can we leave a detailed message on your voice mail? ☐ yes or ☐no

Has your address changed since your last visit? ☐ yes or ☐no

Has there been a change in your insurance since your last visit? ☐ yes or ☐no

****Retinal Exam: PLEASE READ and choose only one…**

As part of your comprehensive exam, every year, 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 at no extra charge OR by taking a digital image of the back of your eye, using the Optomap ($33). There are some medical conditions that even after doing the Optomap the doctor may still feel it necessary to dilate your eyes. Please initial by the one you would like to do today. However, you always have the option to decline it.

For Dilation Initial Here:_____ **For Optomap $33 Initial Here**:_____

****The Contact Lens Examination:** **Please check one ☐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. ***Insurance or vision benefit plans may or may not cover and or contribute an allowance. Fees range from $40-$60 for current wearers OR $85-$100 for new contact lens wearers.***

***Medical Release /Authorization (example: the name of your spouse/significant other/or a parent)**

****I give**_____ 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 material such as glasses and or contact lenses**

***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:**_____