Inside Wal*Mart Vision Center
1550 North Main St.
North Logan, UT 84341
435-753-3906

VisionHealth EyeCare PLLC
Optometrist: David J. Langford, OD

PATIENT INFORMATION Today's Date_____

Full Name_____ Date of Birth_____

Address_____City/State/Zip_____

Gender: Male / Female Occupation_____Hobbies_____

Home # (____) _____-_____ Cell/Work # (____) _____-_____ Email:_____

How did you hear about our office? (check all that apply) [ ] Saw Optical and Walked In [ ] Yellow Pages
[ ]Dr. _____ [ ]My friend _____ referred me

All information provided is kept strictly confidential. You are responsible for all charges incurred, and full payment is due at the time of exam. You are responsible for any charges not covered by your insurance, and known co-pays must be paid at the time of service. Dr. Langford accepts the following insurances (circle yours):

AlwaysCare Altius BlueCross(including MedAdvantage) IBEW(#57) CSI DMBA
Spectera **Davis** **Block** **Avesis** **NVA** **Advantica** **Superior**
PEHP Advantage/Preferred/CHIP Preferred (but NOT Exclusive) Utah MedicAID/PCN(*not* TPL or Molina)

I can bill any of the above insurances *if* it is your PRIMARY insurance. If your primary insurance company wasn't listed, you must pay for the exam in full. Upon request, Dr. Langford can provide a receipt which includes the codes needed by your insurance company so that you can attempt to get reimbursed.

□ Please give me a receipt because my insurance company is _____.

Where and When of Last Eye Exam:_____

MEDICAL AND EYE HISTORY

Medical Doctor: _____Last Medical Exam: _____

Allergies to Medications [ ] No [ ] Yes explain_____

List any medications you take (including vitamins, home remedies, over the counter, and oral contraception):

_____

_____

List all major injuries or surgeries you have had:

_____

Do you use any form of tobacco? Y or N _____

Describe your consumption of alcohol _____

Health Conditions	Self	Relative	None	Eye Conditions	Self	Relative	None	Symptoms	Y	N
Allergies	□	□	□	Glaucoma	□	□	□	See double?	□	□
Asthma	□	□	□	Cataracts	□	□	□	Frequent headaches	□	□
Cancer	□	□	□	Macular Degeneration	□	□	□	Floaters or flashes	□	□
Diabetes	□	□	□	Retina Problem	□	□	□	Dryness	□	□
Heart Disease	□	□	□	Lazy Eye	□	□	□	Itching	□	□
High Blood Pressure	□	□	□	Eye Surgery	□		□	Redness	□	□
Thyroid Problems	□	□	□	Eye Injury	□		□	Other_____		
Other_____	□	□		Other _____	□	□		Pregnant	□	□

Please explain any positive findings: _____

_____

Patient (or Guardian) Signature_____ Date_____

Printed Name if Guardian_____

(For office use only: Doctor signature after reviewing completed form:_____)

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www.visionhealtheye.com

1550 N Main St.
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T: 435-753-3906
F: 435-753-3918

Reason for Visit

Patient name_____Patient date of birth ___/___/_____

Reason for visit today? _____
Please check the exam service(s) you desire (bold indicates most common options):

□ **Routine Vision Exam**: $50. Includes glasses prescription and eye health assessment. Now includes dilation at no extra charge! (*see below if you want to opt out of dilation).

□ **Contact Lens Evaluation**: Level 1 $30 or Level 2 $40 (plus the Vision Exam above)
Assessment of fit and vision with contact lenses. A Vision Exam within 6 months is a prerequisite for this service (and if done elsewhere, must bring proof of exam like a dated glasses Rx). This evaluation is required to be given a prescription for contacts. Includes any follow-up visits needed for up to 60 days. Fitting of spherical disposable lenses are covered in the Level 1 $30 fee. If you require toric lenses for astigmatism, RGP lenses, monovision, or bifocal lenses then doctor charges the Level 2 fee. Usually included is a sample pair of free soft contact lenses, but only if we have your prescription in our trial lens kit (so do not throw away your own contacts until after you speak with the doctor).

□ Foreign Body Removal: $75. Removal of particles from cornea or conjunctiva. (Usually must return for at least one level 2 medical visit.)

□ Medical Eye Visit: Level 2 $45 or Level 3 $65. Assessment of red eyes or other non-glasses but eye-related medical concerns. Fee level depends on exam needed to determine diagnosis and treatment.

*Dilation Information
Dilating drops enlarge your pupils so Doctor has a big window to see everything inside your eye. Required if you have diabetes. Tumors, retina holes or tears, and other sight-threatening problems can develop inside your eyes without you feeling or noticing any problems. Without dilation, the doctor can see the central area inside your eye, but he misses the periphery. If you want a thorough exam, choose to have your eyes dilated and be prepared to be sensitive to sunlight for about 4-5 hours and to see blurry at near. Doctor recommended especially if over age 50 or if myopia is -5.00 or more. Doctor also typically orders dilation drops if you are farsighted to relax the focusing muscles to discover the true degree of hyperopia.

□ **Yes** I want dilation.

□ No, I do not want dilation today and have read the above and understand the risks of not dilating: _____(initial).

FYI: The following options are usually done only when certain medical eye conditions require it:

- Corneal Topography: $20. A map of the clear, front surface of the eye. Doctor recommended for high astigmatism or when keratoconus is suspected. Also recommended if vision not getting to expected levels with glasses.
- HRT2 optic nerve imaging: $30. This is a special test to rule out or monitor glaucoma.
- Complete Visual Fields: $40. A special test to monitor glaucoma or certain brain conditions

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Insurance Information (cont. from page 1):

Policy Holder: _____ ID #: _____

Relationship to patient:_____Copay:_____ Group #: _____

Office Use Only

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Inside WAL*MART Vision Center

CONSENT TO THE USE AND DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

Patient name_____Patient date of birth ___/___/_____

I understand that:

- As part of my health care, VisionHealth EyeCare PLLC originates and maintains health records describing my health history, symptoms, examinations, diagnoses, treatment, and (if applicable) vision and medical insurance information.

- The use and disclosure of my protected health information by VisionHealth EyeCare PLLC is necessary in order to provide me medical and vision care, to carry out the practice's health care operations, and to obtain payment for my examinations and treatments. Your glasses and/or contact lens prescription information is shared with the Logan, Utah Wal*Mart Vision Center as well as your exam fees, exam codes, and diagnoses names and codes are shared to facilitate payment collection.

- I have the option to receive a complete copy of VisionHealth EyeCare PLLC's Notice of Privacy Practices in the office located inside the Logan, Utah Wal*Mart Vision Center and also on the internet at http://www.visionhealtheye.com/hipaa . This document provides a complete description of the use and disclosure of my health information. I have the right to review that Notice prior to signing this consent. I also understand that VisionHealth EyeCare PLLC reserves the right to change the Notice and its privacy practices at any time. If I request, VisionHealth EyeCare PLLC will e-mail me a copy of any revised Notice prior to its implementation.

  - If you provided your e-mail, we will use it only to notify you that your prescription has expired, to advise you of any changes to the VisionHealth EyeCare PLLC Notice of Privacy Practices document, and any official correspondence from the doctor.

- (Optional) Please send my Physician a report after each eye exam regarding my vision and eye health to better coordinate care for my health condition(s). (This is helpful for patients with diabetes, high blood pressure, or other conditions where your doctor asks you to get an eye exam.) My initials_____. My physician's name and info: _____

- I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient signature _____ Dated _____
If you are signing as a personal representative of the patient, describe your relationship to the patient or the source of your authority:

Name:_____ Relationship to Patient:_____