PATIENT INFORMATION

Full Legal Name_____ Date of Birth____/____/_____

☐ Male ☐ Female ☐ Other Ethnicity - ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Island ☐ Caucasian ☐ Other

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Domestic Partner ☐ Seperated Social Security #_____

Mailing Address_____City_____State_____Zip_____

Home Phone_____Preferred Contact #: ☐ Home ☐Cell

Cell Phone_____Can we contact you via text messages? ☐ YES ☐ NO

Email_____Can we contact you via Email? ☐ YES ☐ NO

ADDITIONAL INFORMATION

Employer/School_____**Occupation**/Current Grade_____

Spouse_____ DOB_____/_____/_____ Cell_____

Emergency Contact Name_____Phone #_____Relationship_____

GUARDIAN INFORMATION (if under 18 years of age)

Father's Name_____ DOB_____/_____/_____

Employer_____ Social Security #_____

Mailing Address_____City_____State_____Zip_____

Mother's Name_____ DOB_____/_____/_____

Employer_____ Social Security #_____

Mailing Address_____City_____State_____Zip_____

WHO CARRIES INSURANCE

Name:_____ Employer_____ DOB_____/_____/_____

Authorization For Benefits and Medical Release and Acknowledgment of Privacy Practice
I authorize insurance payments directly to Laramie Peak Vision, LLC. I further authorize the release of any information necessary to process claims on my behalf. I understand and agree that I am financially responsible for any charges incurred by me or any family members regardless of insurance. I further understand that any legal fees or interest charges from collection of these fees shall be my responsibility. I acknowledge thatI have received a copy of Laramie Peak Vision, LLC Notice of Privacy Practices related to HIPAA.

I request the following people have access to my medical information:_____

_____

Signature:_____ Date_____

Laramie Peak Vision, LLC

Patient Medical History

Name of Primary Care Doctor:_____

Please check any conditions that apply to you:

Constitution
__ Developmental Disabilities
__ Cancer

Ear/Nose/Throat
__ Hearing Loss
__ Sinusitis
__ Other_____

Neurological
__ Multiple Sclerosis
__ Migraine
__ Autism Spectrum Disorder
__ Other_____

Psychological
__ Depression
__ Attention Deficit
__ Anxiety Disorder
__ Other_____

Cardiovascular
__ High Blood Pressure
__ Stroke
__ Heart Disease
__ Congestive Heart Failure
__ Other_____

Respiratory
__ Asthma
__ Emphysema
__ Sleep Apnea
__ Other_____

Gastrointestinal
__ Ulcers
__ Acid Reflux/Gerd
__ Celiac Disease
__ Other_____

Genitourinary
__ Kidney Disease
__ Prostate Cancer
__ Benign Prostate Hypertrophy
__ STD
__ Other_____

Musculoskeletal
__ Arthritis
__ Fibromyaligia
__ Muscular Dystrophy
__ Osteoporosis
__ Gout
__ Other_____

Integumentary/Skin
__ Eczema
__ Rosacea
__ Psoriasis
__ Herpes Simplex/Cold Sores
__ Herpes Zoster (Shingles)
__ Other_____

Endocrine
__ Type 1 Diabetes
__ Type 2 Diabetes
__ Thyroid Dysfunction
__ Hormone Dysfunction
__ Other_____

Hemotologic/Lymphatic
__ Anemia
__ Blood Loss
__ High Cholesterol
__ Other_____

Immune System
__ AIDS
__ Lupus
__ Sjogren's Syndrome
__ Other_____

Are you pregnant or nursing? □ Yes □ No

Are you allergic to any medications? □ Yes □ No
If yes, please list the medications:_____

Please list any other allergies (food, environmental, etc.)_____
_____

Have you ever experienced or been diagnosed with any of the following?
(Please check all that apply)

__ Glaucoma
__ Cataracts
__ Macular Degeneration
__ Retinal Detachment
__ Eye Injury (please explain)_____
__ Eye Surgery (please explain)_____
__ Double Vision
__ Crossed Eye/Eye Turn
__ Amblyopia
__ Keratoconus
__ Eye Infections
__ Watery Eyes
__ Chronic Headaches
__ Flashes of Light in Your Vision
__ Floaters in Your Vision
__ Dry/Itchy Eyes
__ Other_____

Do you use: ☐ Check if none of these apply to you
☐ Alcohol ☐ Tobacco ☐ Smoke/IV Drug Use ☐ Former Smoker

Current Medications (Rx or Over the Counter) Please list any medications you are currently using.
If you take more than the area provided, please provide a list for us to copy.

_____ _____ _____

_____ _____ _____

<u>Family</u> Medical and Eye History
Please note who of your **Parents, Siblings, or Children** have any of the following:

Cancer_____
Type 1 Diabetes_____
Type 2 Diabetes_____
High Blood Pressure_____
Hyper Thyroid_____
Hypo Thyroid_____
Cataracts_____
Macular Degeneration_____
Glaucoma_____
Retinal Detachment_____
Other Significant Family History (please specify)_____

Laramie Peak Vision, LLC
Financial Protocol

- Payment is expected at time of service.
- Divorce Parents: We are not a party to the divorce agreement. Both parents are responsible for vision/medical bills of minor children.
- We file claims with most insurance companies provided we have current insurance information, including a copy of the insurance card.
- Payment of half down and the balance at pick up is required on all orders.
- Copays and deductibles are due at the time of service.
- Balances over 30 days are assessed a finance charge of 18% APR (1.5% per month).
- Following 90 days of nonpayment (and LPV attempts to collect), past due accounts will be turned over to collections.
- Returned checks are subject to a $30.00 NSF fee and applicable postage and legal fees.
- Patients are responsible for any emergency fees incurred, even if the insurance denies payment.
- Previous collections or NSF check accounts: Any future appointments require the balance to be paid in full at the time of the exam and/or material's purchase with cash or credit card.

I,_____, hereby acknowledge that I have read, understand, and agree to all of the terms and conditions listed above.

Signature:_____Date:_____

Laramie Peak Vision

Financial Policy
HIPAA Acknowledgement

We are committed to providing you with the best possible care, and we are available to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions regarding our fees, financial policy, or your responsibility. All services and special order items including prescription glasses and sunglasses are non-refundable. We accept cash, check, Visa, and Mastercard for your convenience and expect payment when services are rendered.

As a courtesy we will file your insurance claim for you as long as you provide all the required information. For example: copy of all insurance cards, insured's social security number, insured's date of birth, and the insured's employment information are all required.

I understand and agree that I am ultimately responsible for the balance of my account for any professional services rendered including but not limited to charges incurred from any and all exams, office visits, additional testing, contact lens fits, contact lens boxes, or glasses and glasses repairs of any kind regardless of having insurance or not. If I choose to not pay any outstanding balance, I could be responsible for court costs and attorney's fees, and interest charges of 1.5% monthly on any outstanding balance not paid that is sent to small claims court. In the event of collection procedures, attorney fees and court costs are my responsibility. I also understand that the delinquency fee with regards to collections will be equal to 50% of the principal amount owed.

I authorize the release of medical information or any other information as needed to submit an insurance claim for myself or any other dependent child with whom I have financial responsibility for. I authorize the use of the signature below on all insurance submissions. I authorize the payment of insurance benefits to Laramie Peak Vision.

Patients under the age of 18 should be accompanied by a parent or legal guardian. The parent who signs the financial policy form is responsible for payment of services. In the event the minor comes unaccompanied to our office, we MUST have a signed authorization for treatment form as well as payment services rendered.

I hereby acknowledge that I have received and/or read a copy of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Policy.

I certify that I have read and understand the financial and HIPAA Privacy Policy of Laramie Peak Vision

_____
Patient Printed Name

_____ _____
Patient/Parent/Guardian Signature Date