Altitude Optometry

Financial Responsibility and Insurance

All eye examination fees, including insurance co-payments, contact lens evaluation fees, and fees for medical procedures are due in full at the time of service. The doctor's fees are non-refundable. There is a $20 fee for all returned checks.

Some procedures may not be covered by your insurance company. Most vision insurance plans cover a routine eye examination annually or biennially. Many eye conditions require more frequent monitoring or additional procedures that your insurance company may not cover. As a courtesy to you, Altitude Optometry, LLC will bill your insurance carrier to collect for covered services if we are an in-network provider for your benefit plan. Ultimately the balance is your responsibility, and if we are unable to collect from your insurance carrier within 60 days, we will bill you for the remaining balance. Insurance presented after the time of service will not be accepted.

By signing below, I acknowledge that I have read and fully understand and agree to the above Financial Responsibility and Insurance policies. I also acknowledge that I have been offered and/or read a copy of the Notice of Privacy Practices.

_____	_____
Signature of patient or patient's representative	**Today's date**
_____	_____
Printed name of patient or patient's representative	**Relationship to patient or representative's authority to act for the patient**

Authorization For the Use and Disclosure of Individually Identifiable Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Persons/organizations authorized to use or disclose the information: Altitude Optometry, LLC
2. Persons/organizations authorized to receive the information: LensCrafters
3. Specific description of information that may be used/disclosed: My name, address, telephone number, email address and next appointment date(s) and time(s)
4. As part of our recall program, the information will be used/disclosed for the following purposes:
    a. For the purpose of providing LensCrafters coupons and service and product information either from this office or directly from LensCrafters; and
    b. To compare mailing lists with LensCrafters to help avoid duplicate mailings.
5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment: receive payment: or eligibility for benefits unless allowed by law.
6. The organization authorized to use/disclose the information will not receive compensation for doing so.
7. I understand that I may inspect or copy the information used or disclosed.
8. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing, except to the extent that:
    a. Action has been taken in reliance on this authorization; or
    b. If this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.
9. This authorization expires four years from the date of my signature.

_____	_____
Signature of patient or patient's representative	**Today's date**
_____	_____
Printed name of patient or patient's representative	**Relationship to patient or representative's authority to act for the patient**

Altitude Optometry

PATIENT INFORMATION

Today's date:				
Last name:		**First name:**		**M.I.:**
Marital Status:		**Date of birth:**	**Age:**	**Gender:**
Street address:			**Home phone:**	
City:	**State:**	**ZIP Code:**	**Cell phone:**	
Occupation:	**Employer:**		**Work phone:**	

↓ **Email Address:** (we do not send spam or junk mail or share your email address – email address will be used for appointment reminders, etc.) ↓

How did you hear about our office?	☐ Family/Friend	☐ Insurance	☐ Drive/Walk By	☐ Yellow Pages	☐ Other
	☐ AltitudeOptometry.com	☐ LensCrafters.com	☐ Other Internet	☐ Advertisement	

Other friends or family members seen here:	
Do you participate in any hobbies, sports, or special activities? (please list)	

INSURANCE INFORMATION

--Please list your vision ***and*** medical insurance. Please give your insurance card(s) to the receptionist.--

Do you have vision insurance? ☐ Yes ☐ No	If yes, insurance carrier:
Do you have health insurance? ☐ Yes ☐ No	If yes, insurance carrier:
Do you have Medicare? ☐ Yes ☐ No	

MEDICAL HISTORY

Do you have allergies to any medication? ☐ Yes ☐ No	If yes, please list here:
List any medications you take or eye drops you use, and include dosages, if known. Include over-the-counter medications, home remedies, aspirin, oral contraceptives, vitamins, etc.	
List all major injuries, surgeries, and/or hospitalizations you have had	

Are you pregnant? ☐ Yes ☐ No	Are you nursing? ☐ Yes ☐ No		
Approximate date of last eye exam?			
Do you wear glasses? ☐ Yes ☐ No	If yes, how old is your current pair?		
Do you wear contacts? ☐ Yes ☐ No	If yes, how old is your current pair?		
↳ If so, what brand do you wear?		Are they comfortable? ☐ Yes ☐ No	
↳ If not, are you interested in wearing contacts? ☐ Yes ☐ No			
What brand of solution do you use?		**How often do you replace your contacts?**	

Do you, or do any of your family members, currently have or have a history of any of the following conditions?

	SELF	FAMILY	RELATION
OCULAR			
Amblyopia / Lazy Eye	☐	☐	
Strabismus / Crossed Eyes	☐	☐	
Dry Eye	☐	☐	
Cataracts or Cataract Surgery	☐	☐	
Eye Surgery or Therapy	☐	☐	
Eye Injury	☐	☐	
Macular Degeneration	☐	☐	
Glaucoma	☐	☐	
Retinal Detachment / Hole / Repair	☐	☐	
Blindness / Loss of Vision	☐	☐	
Blurred Vision	☐	☐	
Distorted Vision / Halos	☐	☐	
Loss of Peripheral (side) Vision	☐	☐	
Double Vision	☐	☐	
Redness	☐	☐	
Sandy / Gritty Feeling	☐	☐	
Itching, Burning, and/or Watering	☐	☐	
Foreign Body Sensation	☐	☐	
Glare / Light Sensitivity	☐	☐	
Eye Pain or Soreness	☐	☐	
Chronic Infection of Eye or Lid	☐	☐	
Sties or Chalazion	☐	☐	
Flashes / Floaters in Vision	☐	☐	
Tired Eyes	☐	☐	
CONSTITUTIONAL			
Fever, Weight Loss / Gain	☐	☐	
INTEGUMENTARY			
Skin Problems	☐	☐	
NEUROLOGICAL			
Headaches	☐	☐	
Migraines	☐	☐	
Seizures	☐	☐	
ALLERGIC	☐	☐	

	SELF	FAMILY	RELATION
EAR, NOSE, MOUTH, THROAT			
Allergies / Hay Fever	☐	☐	
Sinus Congestion	☐	☐	
Runny Nose	☐	☐	
Post-Nasal Drip	☐	☐	
Chronic Cough	☐	☐	
Dry Throat / Mouth	☐	☐	
RESPIRATORY			
Asthma	☐	☐	
Chronic Bronchitis	☐	☐	
Emphysema	☐	☐	
VASCULAR / CARDIOVASCULAR			
Diabetes	☐	☐	
Heart Pain	☐	☐	
High Blood Pressure	☐	☐	
Vascular Disease	☐	☐	
GASTROINTESTINAL			
Chronic Diarrhea	☐	☐	
Chronic Constipation	☐	☐	
GENITOURINARY			
Genital / Kidney / Bladder problems	☐	☐	
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	☐	☐	
Muscle Pain	☐	☐	
Joint Pain	☐	☐	
LYMPHATIC / HEMATOLOGIC			
Anemia	☐	☐	
Bleeding Problems	☐	☐	
Lupus	☐	☐	
Cancer	☐	☐	
IMMUNOLOGIC	☐	☐	
HIV/AIDS	☐	☐	
PSYCHIATRIC	☐	☐	
ENDOCRINE			
Thyroid / Other Gland Problems	☐	☐	

If you answered yes to any of the above, or have a condition not listed, please explain	

SOCIAL HISTORY

Do you wear sunglasses? ☐Yes ☐No	**Do you smoke?** ☐Yes:_____packs/day ☐No		
Do you consume alcohol? ☐Yes ☐No		**Do you use recreational drugs?** ☐Yes ☐No	
↳ If yes, how often?		↳ If yes, what kind?	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Altitude Optometry, P.C. or insurance company to release any information required to process my claims.

Patient/Guardian signature	**Date** _____/_____/_____
Doctor's Signature	**Date** _____/_____/_____