Welcome to Norton Eye Care

Date: _____/_____/_____

Patient Information

Name: _____ Nickname: _____

Address:_____

Apt #: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Email Address: _____

Preferred Communication: ☐Phone ☐Email

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Assigned Gender: ☐Male ☐Female Marital Status:☐Single ☐Married ☐Other

Current Gender Identity:☐Male ☐Female ☐Other _____

Preferred Pronouns: ☐He/Him ☐She/Her ☐They/Them ☐Other _____

Guardian: _____

Relationship: _____ Phone Number: _____

Emergency Contact: _____

Relationship: _____ Phone Number: _____

How did you hear about us? _____

Primary Care Physician: _____

Previous Eye Doctor: _____ Last Eye Exam: _____/_____/_____

Social History

Drink:☐Yes ☐No **If yes**; Frequency: _____ Amount: _____

Smoke:☐Yes ☐No **If yes**; ☐Marijuana ☐Tobacco Frequency:_____ Amount:_____

Visual Needs Assessment

Employer: _____ Occupation: _____

Sports/Hobbies:_____

Hours of Computer Usage/ Day: _____ Hours Outside/ Day: _____

Hours Before Reading Fatigue: _____ Daily Driving Distance: _____

I wear: (Check all that apply)

☐ Glasses Full Time ☐ Bifocal ☐ Progressive (No-line Bifocal) ☐ Driving/ Distance Glasses

☐ Reading Glasses ☐ Prescription Sunglasses ☐ Non-Prescription Sunglasses

☐ Safety Glasses ☐ Contact Lenses Contact Brand: _____

How long do you wear your contacts before you throw them away? _____

Do you sleep in your contacts? ☐ Yes ☐ No

Contact Lens Solution: ☐ Opti-Free ☐ BioTrue ☐ Clear Care ☐ Renu ☐ Generic

☐ Other: _____

Personal Medical History

Major Injuries/Surgeries: _____

_____

Medications: _____

_____

Eye Drops: _____

Drug Allergies:_____

Environmental Allergies:_____

Latex: Yes / No

☐ ☐

Personal Medical History (Continued)

Constitutional
- ☐ Cancer
- ☐ Developmental Disabilities
- ☐ Fatigue
- ☐ Other

Neurologic
- ☐ MS
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Tumor
- ☐ Migraine
- ☐ Autism Spectrum Disorder

Cardiovascular
- ☐ High Blood Pressure
- ☐ Stroke/CVA
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congestive Heart Failure

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Sleep Apnea
- ☐ Chronic Obstruction

Ear/Nose/Throat
- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis

Psychiatric
- ☐ Depression
- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Bipolar Disorder

Genitourinary
- ☐ Kidney Disease
- ☐ Prostate Disease
- ☐ STD
- ☐ Pregnant/ Nursing
- ☐ Prostate Hypertrophy

Integumentary
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Cold Sores
- ☐ Shingles

Endocrine
- ☐ Type 2 Diabetes Mellitus
- ☐ Type 1 Diabetes Mellitus
- ☐ Herpes Simplex
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction

Gastrointestinal
- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflux

Musculoskeletal
- ☐ Osteoarthritis
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Celiac Disease
- ☐ Osteoporosis
- ☐ Gout
- ☐ Ankylosing Spondylitis

Hematologic/Lymphatic
- ☐ Anemia
- ☐ Ulcer
- ☐ High Cholesterol

Autoimmune
- ☐ Rheumatoid arthritis
- ☐ Sjogren's
- ☐ Lupus

Personal Ocular/ Eye History

- ☐ Glaucoma
- ☐ Inflammatory Disorder
- ☐ Keratoconus
- ☐ Floaters
- ☐ Eyestrain
- ☐ Age Related Macular Degeneration
- ☐ Cataract
- ☐ Nystagmus
- ☐ Injury
- ☐ Light Sensitivity
- ☐ Double Vision
- ☐ Surgery
- ☐ Strabismus
- ☐ Dry Eye
- ☐ Iritis/ Uveitis
- ☐ Night Vision Difficulty
- ☐ Retinal Degeneration/ Hole/ Detachment
- ☐ Patching
- ☐ Amblyopia
- ☐ Flashes
- ☐ Itchy/ Gritty
- ☐ Other: _____

Family History

Relation? M / F / B / S / Gma / Gpa

Medical
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Thyroid
- ☐ Other: _____

Ocular
- ☐ Glaucoma
- ☐ Cataract
- ☐ Surgery
- ☐ Patching
- ☐ Strabismus
- ☐ Amblyopia
- ☐ Nystagmus
- ☐ Age-Related Macular Degeneration
- ☐ Inflammatory Disorder
- ☐ Retinal Degeneration/Hole/Detachment
- ☐ Keratoconus
- ☐ Corneal Disorders
- ☐ Dry Eye
- ☐ Other: _____

FINANCIAL POLICY

We are committed to providing you with the best possible eye care. We also want to serve you in a manner which is as comfortable and pleasant as possible. In order to achieve these goals, we need your assistance and understanding of our payment policy.

There are two types of health insurance that will help pay for your eye care services and optical products. You may have both types and Norton Eye Care accepts most major insurance plans in both categories: 1. Vision plans (such as VSP, EyeMed, and others) and 2. Medical insurance (such as Blue Cross/Blue Shield, Medicare and others). If you have both types of insurance plans, it may be necessary for us to bill both for your services.

We cannot emphasize too strongly that the extent of your insurance benefits is defined in a contract between your, your employer, and an insurance company. We are not a party to that contract and have no input into any of the decision-making. As your eye care provider, our relationship is only with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility form the date of services. Payments can be made by cash, check, or credit card.

We realize that a temporary financial crisis may affect timely payment of your account. If such a crisis does develop, we encourage you to contact our office immediately for assistance in redefining the payment terms of your account. By keeping the lines of communication open, we can avoid any misunderstandings that would interfere with our positive relationship.

Patient Name: _____ Date of Birth: _____

VISION INSURANCE

Insured's Name: _____

Insured's Date of Birth: _____

Relationship to Patient: _____

Insurance Co. Name: _____

Insured's SS# or ID#: _____

Group #: _____

MEDICAL INSURANCE

Insured's Name: _____

Insured's Date of Birth: _____

Relationship to Patient: _____

Insurance Co. Name: _____

Insured's SS# or ID#: _____

Group #: _____

SECONDARY VISION/MEDICAL INSURANCE (optional)

Insured's Name: _____

Insured's Date of Birth: _____

Relationship to Patient: _____

Insurance Co. Name: _____

Insured's SS# or ID#: _____

Group #: _____

Assignment of Benefit: I hereby assign Norton Eye Care, those insurance benefit payments due to Norton Eye Care, and I authorize my insurance company to make payment directly to Norton Eye Care. I understand I am financially responsible for any deductible or co-insurance and services not covered by my insurance plan.

I understand whether I sign as representative, patient, legal guardian or guarantor, that I am directly responsible and will pay for services rendered and not paid by insurance. An assignment of benefits of any insurance policy or medical reimbursement plan shall not be deemed a waiver of the right of Norton Eye Care, to require payment directly from the undersigned or the patient. Norton Eye Care expressly reserves the right to require such payment.

I have read this form (or have had it read to me) and understand it. I agree that by signing this form, I am bound by what it says, whether I am the patient or someone acting on the patient's behalf. This authorization remains in effect until revoked in writing by the patient or legal guardian.

Signature: _____ Date: _____ Relationship to Patient: _____

NORTON
EYE CARE

Norton Eye Care is pleased to offer a patient portal. This online tool gives you the ability to access your health information and other resources at your convenience- any time of day and from any location! The portal is completely secure, so you can be confident that your private information is protected. Only you-or an authorized representative-can access your information.

Remember: treat your health information like your banking information and use caution when sharing with others!

As a patient of Norton Eye Care, enrolling in Revolution PHR is **free** and will allow you to:

- Securely message with your physician
- Request appointments
- Review your orders, invoices and prescriptions
- Update personal information
- Request prescription renewals
- Confirm and pre-register for your visit
- View visit history and clinical summaries

We hope this new tool will help you take an active role in your healthcare.

If you would like to participate in Revolution PHR offered from Norton Eye Care, please put your email address below, this will be your User ID. You will be provided a temporary password by our office staff and once you sign in for the first time, you will be prompted to create your own password. *If you do not wish to participate, just leave this form blank.*

Email/User ID: _____

Visit www.RevolutionPHR.com to access your Norton Eye Care Personal Health Record (PHR)

NORTON
EYE CARE

2911 Eyde Parkway, Ste 120

East Lansing, MI 48823

Phone: (517)336-4545 Fax: (517)336-0572

PATIENTS AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

Patient Name: _____ DOB: _____

I hereby consent to the disclosure of information contained in my medical record (including if applicable, alcohol abuse, drug abuse, and mental health treatment information) protected under the regulations in TITLE 42 of the Code of Federal Regulations, Part II.

Human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and related complex (ARC) information made confidential by Public Act 488 of 1988 as amended by Public Act 174 of 1989 of the Michigan Health Code.

Hepatitis B, venereal disease, tuberculosis, and other communicable diseases, infections and serious infections made confidential in rule promulgated by the Michigan Department of Public Health pursuant to Public Act 174 of the 1989 Michigan Health Code.

INFORMATION TO BE RELEASED FROM: _____

_____

_____

INFORMATION TO BE RELEASED TO: Norton Eye Care Fax 517-336-0572

_____

_____

PLEASE INCLUDE A COMPLETE COPY OF RECORDS

I understand that I may revoke this authorization at any time and that this authorization pertains to the fulfillment of the above stated purposes and will automatically expire 1 year from the date of signature. I have read the above, and understand the terms and conditions of this authorization.

Patient Signature: _____ Date: _____

Consent for Treatment

I am requesting that health care services be provided to me (or my minor child or the patient named below) at the offices of Norton Eye Care, clinicians, and other personnel. I voluntarily consent to all medical treatment and health care related services that are necessary for me (or the patient named below).

Patient: _____ Date of Birth: _____

Child: _____ Date of Birth: _____

Medical Records Release

_____I consent to let the offices of Norton Eye Care use and disclose health information about me (or the above-named patient). In doing so, I consent to the release of my (or the above named patient's) health information and financial account information to all third-party payers and/or their agents that represent the offices of Norton Eye Care or provide assistance to the offices of Norton Eye Care for the purposes of securing payment from all parties who are potentially liable for payment for my (or above-named patient's) health care.

Notice of Privacy Policies

_____The offices of Norton Eye Care are committed to protecting the privacy of your health and personal information. This information includes both health information and individually identifiable information, such as your name, address, telephone number, or social security number. The offices of Norton Eye Care protect your personal and health information in electronic, written, and oral forms when used throughout our office. We may modify or change our privacy practice when new laws and regulations become effective. Any changes will be effective for all the personal and health information we maintain, including prior information given to our office.

Financial Information

_____Financial Responsibility: Subject to applicable law and the terms and conditions of any applicable contract between the offices of Norton Eye Care and a third-party payer, and in consideration of all health care services rendered or about to be rendered to me (or above-named patient), I agree to be financially responsible and obligated to pay the offices of Norton Eye Care for any balance not paid under the "Assignment of Benefits/Third Party Payers" paragraph below.

Assignment of Benefits/Third Party Payers: In consideration of all health care services rendered or about to be rendered to me (or the above-named patient), I hereby assign the offices of Norton Eye Care all right, title, and interest in and to any third-party benefits due form and all insurance policies and/or responsible third-party payers of an amount not exceeding the offices of Norton Eye Cares regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third-party payers, and other third-parties. I consent to any request for review or appeal by the offices of Norton Eye Care to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or another third-party payer.

I acknowledge that I have received a copy of Norton Eye Care's Policies and Procedures and agree to comply with the terms outlined in the document.

_____ _____

Patient or legal Representative Signature/Date/Time

Relationship to Patient

NORTON EYE CARE

•Keep for your records•

Financial Responsibility Statement & Acknowledgement of Office Policies, Consent to Treat

Insurance Information

It is your responsibility to know the terms and limitations of your policies. Failure to inform us of all your insurance information may result in a denial of benefits and payment in full being owed by you. Your insurance company is required to respond to our claim submission within 30 days. If we receive no response from your insurance company, we may ask you to contact your insurance company or remit payment yourself and seek reimbursement from your insurance company. Medical insurance and vision plans are very different in terms of service and coverage. We are unable to determine which, if any, can be billed until after the examination is completed. When a medical condition is present (diabetes, hypertension, dry eyes, red eyes, allergies, etc.) it may be necessary to file the claim with your major medical carrier. Vision plans do not cover medical problems, just as medical plans do not cover routine glasses and contact lens exams. We are unable to bill your vision plan for the glasses/contact lens portion of your exam on the same day we bill your medical insurance for management of your medical eye problem. Our office does not make these billing rules; they are defined by the insurance carrier.

Financial Policy

Payment is expected at the time service is rendered and before orders are placed. By signing, you agree to be held liable for all expenses, costs, and reasonable court, attorney, and collection agency fees for any delinquent balance. A collection service fee will be assessed for any unpaid balances after 30 days of initial notice of balance due. Our office may assess an administrative fee for completion of any outside paperwork, forms, and charts reviews requested by you.

Appointment Cancellations

We make every effort to confirm appointments 24 to 48 hours before your arrival. Appointment cancellations with less than a 24-hour notice or no shows will be assessed a $35 fee. In consideration of other patients, please make every effort to arrive on time. If you are more than 10 minutes late, we may need to reschedule your appointment.

Vision/Medical Benefits

It is your responsibility to know your coverage and co-pay amounts. Please be aware, unless your insurance plan has specific benefits for contact lens evaluations, you will be expected to pay the contact lens evaluation fee along with your comprehensive exam co-pay and any other non-covered services.

Any out-of-pocket expenses collected from you at the time of service are estimates only. Your insurance will determine your final out of pocket costs. In the event that your insurance carrier determines that you are not eligible at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement, you hereby agree to be financially responsible for any and all charges incurred by you and not paid by the insurance carrier, and any additional collection fees necessary to collect all amounts due. Be aware that any pre-authorizations received by our office are not in any way a guarantee of payment from your insurance carrier. By using your vision/medical insurance, you authorize them to pay Norton Eye Care the benefits otherwise payable to you, the patient, and that the insurance carrier may pay less than the accrual bill for services. After we receive your insurance carrier's response, any and all remaining balances will be due within 30 days. If we do not receive a response from your insurance company within 90 days, we will bill you for the balance due in full. Due to the time limit restrictions imposed by many insurance companies, failure to supply us with the correct insurance information may result in payment in full being owed by you.

Norton Eye Care Satisfaction Policy

In the event that you have difficulty seeing out of your new eyeglass lenses, this office will perform a refraction one time after the initial exam at no cost within 60 days of the date on which the prescription was determined. If you have unresolved medical conditions, this policy does not apply, and you may be charged a fee. You must be able to furnish the glasses/contacts that you had filled with the aforementioned prescription if not filled through our office. A fee to confirm the parameters of a prescription pair of glasses not purchased in our office or online store may apply. Other restrictions apply, ask an associate for details. After 60 days, a fee will be incurred for any recheck. Rechecks will not be performed 6 months after the original exam date and a new exam will be necessary.

NORTON EYE CARE

•Keep for your records•

Norton Eye Care Remake Policy and Frame and Lens Warranty

This office will remake prescription glasses once within 60 days of order at no charge to the patient in cases of prescription change. Any changes required beyond the initial remake or due to patient desiring a restyle will result in fees for the lenses and any treatment charged at 30% off our usual and customary fees. There will be a $25 restocking fee for all returned frames. Any frames or spectacle lens restyle must be redone within the first 20 days of purchase.

Warranties do not cover loss or theft. If you used vision insurance to purchase your glasses, your warranty changes from our standard office warranty to your insurance company's warranty.

Pupillary Distance and Other Eyeglass Measurements

This office takes pupillary distance and other measurements to properly fit prescription glasses as part of the service provided for your eyewear purchase form our office. Patients that do not purchase prescription eyewear through our office will be charged a fee for taking measurements in conjunction with our prescription verification service.

Refund Policy

All orders are final when placed. No refunds are given on custom-made prescription items. If you are unhappy with your glasses for any reason, please bring them back to us so we may change them to meet your expectations. Any contact lenses purchased from our office may be returned less a restocking fee. Opened or damaged boxes cannot be returned. Refunds will not be given on services provided. New contact lens wearers that opt not to complete training and fit will be charged 50% of the fee. If you return within 6 months to try again, you will only be charged the additional 50% of the fee.

Privacy Policy, HIPPA and Your Records

This office follows HIPPA guidelines concerning the privacy of your medical information. We will not release any of your information to anyone without your written prior authorization with the exception of other health professionals and your insurance company as outlined in HIPPA, if applicable. I authorize the release of any medical records to my insurance carrier that is 1.) acquired during my exam and/or treatment, and 2.) any information which may have any bearing on the benefits payable under my plan. A copy of the HIPPA guidelines is available upon request. Under Michigan law, your records will be maintained for a minimum of 7 years. You do agree to allow us to contact you at any phone, wireless number, text, or email address provided by you, which may result in charges to you.

Consent for Treatment

I hereby authorize Norton Eye Care, PLLC and/or such assistants as may be requested by said physician to perform the above noted medical treatment as explained to me. I hereby acknowledge and agree that if my insurance does not cover the treatment authorized above, I will be personally responsible for paying the financial charges for those services.

I understand that this medical treatment is not without risks. The benefits and risks have been explained to me.

Potential risks associated with the medical treatment include but are not limited to the risk of infection on the site of incision, bleeding that may require a secondary procedure, scar tissue formation and discomfort or pain at site.

I accept the treatment recommendation of my physician. I acknowledge that no warranty or guarantee has been made as to the results of this treatment. I understand that any aspect of this consent form that I do not understand can and will be explained to me in further detail by asking my physician. I further certify that my physician has informed me of the nature and character of the proposed treatment, of the anticipated results of this treatment, of the possible alternative treatments choices, and the possible risks, complications, and anticipated benefits involved in the proposed treatment, including non-treatment.

The procedure as stated, including the possible risks, complications, options, and expectations have been explained to me or my representative and consent is thus given as noted by signature.