Email Address: ______________________________

Vision Services Agreement

Vision Services The usual fee for determination of refractive state is $40.00. This is the process of determining the correct optical lens power to allow light to be focused within the eye. The results of the refractive determination can be used to prescribe eyeglasses. Determination of refractive state is separate from the medical evaluation of the visual system.

A contact lens evaluation carries an additional charge ranging from $35.00 to $90.00 depending on the complexity of your contact lens needs and those factors specific to your eyes and eye health. Payment for these services is expected at the time of service, unless the patient (you) present our office with a vision insurance plan. We will honor the policies and prices of your vision plan when it is presented to us before you see the doctor. We will also file your vision plan with your vision company. It is the patient's responsibility to know and understand, before their office visit, the details of their vision plan benefits and to present that vision plan to our office staff.

If you do not know if your insurance provides you with vision coverage, we welcome you to ask your insurance company to fax or email our office a copy of your vision benefits so that we may properly administer any charges. Our email address is youngeyes@icloud.com. Our fax number is 337-857-5550.

If you do not have a complete verifiable vision plan at the time of service and after being medically examined by the doctor and do not have any specific medical diagnoses, we will accept the benefits of your vision plan as payment in full. If, however, you require medical consultation for any specific medical conditions of your eyes there may be additional medically related office visit charges. These charges are separate and apart from your vision plan and the vast majority of these charges are generally covered by your major medical insurance.

Medical Evaluation and Services Our comprehensive medical services include a complete evaluation of the health and condition of your eyes. If you choose to have these services done, you will be thoroughly checked for the presence of eye disease including glaucoma, cataract, retinal disease, corneal pathology, and all other ocular conditions. The doctors' fees for the screening, diagnosis, evaluation, and treatment of your eyes vary depending on the complexity of your particular needs and condition. Usually, these fees range from $120.00 up to $350.00. At the time of your visit, if you have met your deductible, you will only be required to pay the physician specialist co-pay as it is indicated on your major medical insurance plan. We will file the insurance claim with your medical insurer. If your claim is denied, you will be fiscally responsible for the charges, payable within 60 days of the date of your denial. Please let us know, before seeing the doctor, if you have met your deductible of your insurance plan.

Patient Financial Responsibility Contract I, the patient of Dr. Young and Young Eyes LLC have read and understood the above information and agree and understand that I am financially responsible for the fees of the services that I have chosen to utilize today. I understand that Young Eyes LLC will file my medical and/or vision insurance claim, and if that claim is denied/adjusted, I will remit the remaining balance within 60 days of the date of the denial or adjustment. I also understand that I as a patient am responsible for providing Young Eyes LLC with my vision insurance plan before receiving services or products so that my charges may be accurately calculated. I understand that if I do not submit my vision plan at the time of service, I will be responsible for the entire balance of my medical and/or vision products and services. I also understand that Young Eyes LLC cannot be held responsible for researching and reporting the benefits of my vision plan, and **by signing this document I acknowledge that knowing and understanding the benefits of my vision and/or medical insurance is my own responsibility.**

______________________________ ______________________________

Signature Name (Please Print)

Young Eyes LLC

Patient Last Name:______________________________ First Name:____________________ MI______

Address____

City/State/Zip____

M____ F____ Age_________ Date of Birth____________________ Social Security #______________

Home Phone#_______________________ Cell#__________________ Work#___________________

Name & Number of Person not living in home in case of emergency __________________________

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INSURANCE BILLING AUTHORIZATION

I hereby authorize the doctor/facility to release any information including diagnosis and the records of any treatment or examination provided during the period of such care to my insurance company/companies and other health practitioners.

I hereby authorize the doctor/facility to submit insurance claims for services rendered. I understand that if I have more than one insurance company, the doctor/facility may bill multiple insurance companies depending on the nature of the visit. I freely acknowledge and understand that if I have a vision plan I understand that the vision plan (vsp, eyemed, vcp, spectera) pays for routine vision services only(services for eyeglasses and contact lenses only); If I have a medically related condition I understand that the diagnosis, care, and treatment of that condition is billable to my major medical insurance, and I authorize Young Eyes LLC to bill my medical insurance. I understand that my insurance company may pay the doctor/facility less than the full actual bill for these services. I certify that I am fully financially responsible for payment of all services rendered on my behalf or on behalf of my dependents. I also certify that I will pay all collection, attorney, and court/legal fees associated with an unpaid balance on my behalf.

Patient/Parent Signature ____Date__________________

HIPPA STATEMENT

I certify that I have read and that I have understood the HIPPA notice of Privacy Practices Statement.

Patient/Parent Signature ____ Date__________________

Medical History Information

Name: ______________________ Date of Last Complete Eye Exam: ____________

Please check either "Yes" or "No" for each of the following questions

Eyes and Vision

- ☐Yes ☐No Loss of Vision/Blind Spots?
- ☐Yes ☐No Blurry Vision?
- ☐Yes ☐No Dry Eyes?
- ☐Yes ☐No Redness?
- ☐Yes ☐No Excess Tearing?
- ☐Yes ☐No Film or Crust in Eyes?
- ☐Yes ☐No Pain?
- ☐Yes ☐No Light Sensitivity?
- ☐Yes ☐No Night Driving difficulty?
- ☐Yes ☐No Excess glare or halos at night?
- ☐Yes ☐No Crossed Eyes/Lazy Eye?
- ☐Yes ☐No Floaters or Flashes?

Eye Disease and Surgery

- ☐Yes ☐No Cataracts?
- ☐Yes ☐No Glaucoma?
- ☐Yes ☐No Macular Degeneration?
- ☐Yes ☐No Retinal Disease/Detachment?
- ☐Yes ☐No Corneal Disease/Surgery?

Neurological

- ☐Yes ☐No Headaches?
- ☐Yes ☐No Seizures?
- ☐Yes ☐No Dizziness?
- ☐Yes ☐No Nervous/Anxiety ?
- ☐Yes ☐No Stroke?

Cardiovascular

- ☐Yes ☐No High Blood Pressure?
- ☐Yes ☐No Heart Disease?
- ☐Yes ☐No Circulation Problems?
- ☐Yes ☐No Pacemaker?
- ☐Yes ☐No Easy Bleeding?
- ☐Yes ☐No Anemia?
- ☐Yes ☐No Irregular Heartbeat?
- ☐Yes ☐No Cholesterol?

Significant Systemic Conditions

- ☐Yes ☐No Diabetes?
- ☐Yes ☐No Thyroid Disease/Dysfunction ?
- ☐Yes ☐No Asthma?
- ☐Yes ☐No Skin Disorder?
- ☐Yes ☐No Liver Disorder?
- ☐Yes ☐No Kidney Disorder?
- ☐Yes ☐No Cancer?
- ☐Yes ☐No Arthritis?
- ☐Yes ☐No Significant weight loss?
- ☐Yes ☐No High Risk Medication?
- ☐Yes ☐No Smoke Cigarettes? ___Packs/Day? ____Years
- ☐Yes ☐No Drink Alcohol? ____Drinks/Day?

- ☐Yes ☐No Known Drug Allergies?

Family History (parents, grandparents, siblings only)

- ☐Yes ☐No Diabetes?
- ☐Yes ☐No Glaucoma?
- ☐Yes ☐No Blindness?
- ☐Yes ☐No Retinal Disease/Detachment?

Work/Social Visual Demands/Occupation: ____________

- ☐Yes ☐No Need Safety/Protective Glasses
- ☐Yes ☐No Sports Protective Glasses?
- ☐Yes ☐No Prescription Sunglasses?
- ☐Yes ☐No Computer Use?____Hours/Day?
- ☐Yes ☐No Office Work?
- ☐Yes ☐No Extended Driving/Commuting?
- ☐Yes ☐No Hunting/Shooting Glasses?
- ☐Yes ☐No Polarized Fishing Glasses?
- ☐Yes ☐No Golf Glasses?

For Persons 19 years or under

- ☐Yes ☐No Abnormal Prenatal Conditions?
- ☐Yes ☐No Abnormal Developmental History?

☐Yes ☐No Are there any other conditions or complaints? ______________________

☐Yes ☐No Any Past illnesses or surgeries? ______________________

Please list all Medications and Dosage: ______________________

____

Please list any allergies: ______________________

Name of Primary/Referring Physician ______________________

PHYSICIAN'S SIGNATURE: ______________________ Date: ______________