EYE DEPARTMENT

Eye Care & Eyewear

PHR Account No:

Welcome to Eye Department. Please complete all the info below.
Date: _____

PATIENT INFORMATION			
Patient Name:	❑ Non-Binary	❑ Female	❑ Male
Address:	Birthdate:		
City, State & Zip:	Email:		
Home/Cell Phone:	❑ Willing to receive communication by email and phone.		
How did you hear about us?	Who referred you?		
Primary Care Physician:	Phone:		
Employer:	Occupation:		
Will we be billing any insurance on your behalf today? YES NO	Insurance Carrier Name:	Insurer ID:	

Medical and family history (check & circle all that apply):

SELF	FAMILY	
❑	❑	Cancer
❑	❑	Neurological
❑	❑	Depression, Anxiety, Bipolar
❑	❑	Cardiovascular
❑	❑	Asthma, Respiratory
❑	❑	Gastrointestinal
❑	❑	High Cholesterol
❑	❑	Muscular, Bones
❑	❑	Diabetes, Endocrine
❑	❑	Thyroid Condition
❑	❑	Arthritis
❑	❑	HIV, Hepatitis
❑	❑	Cataract
❑	❑	Macular Degeneration
❑	❑	Glaucoma
❑	❑	High Blood Pressure
❑	❑	Other:_____

CURRENT SYMPTOMS TODAY
(Check All That Apply)

- ❑ Blurry distance vision
- ❑ Blurry near vision
- ❑ Eye strain
- ❑ Itchy eyes
- ❑ Mucous Discharge
- ❑ Watering
- ❑ Eye Pain
- ❑ Dry Eyes
- ❑ Red eyes
- ❑ Glare problems
- ❑ Double vision
- ❑ New Floaters
- ❑ Flashes of light
- ❑ Eye injury
- ❑ History of wearing an eye patch
- ❑ History of eye surgery
- ❑ Headaches
- ❑ Currently nursing or pregnant

Please List Current Medications:

1.
2.
3.
4.
5.

List Medication Allergies or sensitivities:

1.
2.
3.
4.
5.

EYE DEPARTMENT

Eye Care & Eyewear

Print Name _____

EYE CARE & EYEWEAR WARRANTY INFORMATION

1. One year frame warranty against manufacturer's defects. Please keep original receipt of payment.
2. Select Anti-reflective coatings have one time one year warranty for scratches.
3. 30 day policy on lenses that need to be re-done due to prescription changes.
4. Eye Department will make new lenses to fit in your personal frames but at your own risk. Patient must sign Patient Owned Frame waiver.
5. All sales are final. There are no refunds on completed eyewear.
6. In cases where checks are returned for Non-Sufficient Funds, patient shall be charged $25.
7. The estimated time of completion is 10 to 15 business days.
8. 100% payment is required to start all eyewear jobs.

_____

Patient/or Guardian Signature Date

AUTHORIZATION TO BILL AND FINANCIAL POLICY

By signing below, your signature authorizes Eye Department to request your insurance company to pay this office directly. If the insurance company remits direct payment you will be responsible for all charges of the services and products rendered. As a courtesy to our patients we take the time to verify your insurance benefits, but this does not guarantee payment and Eye Department will not be held responsible for unpaid insurance balances. Any unpaid balance will be transferred to the patient after 90 days, at which time the patient will have an additional 30 days to make payment. If no payment has been made after 30 days Eye Department reserves the right to involve a third party collection agency or attorney.

_____

Patient/or Guardian Signature Date

In accordance with FTC Rule 85FR50668 CFR 16 CFR 315 Document 2020-14206 RIN 3084-AB36; Urban Eye Gallery, LLC dba Eye Department provides all patients with 24hr access online to prescriptions and Patient Health Records (PHR) through RevolutionEHR. Patient acknowledges and accepts this method of electronic delivery and access.

_____

Patient/or Guardian Signature Date

EYE DEPARTMENT

Eye Care & Eyewear

PHR Account No:

Welcome to Eye Department. Please complete all the info below.
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PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Urban Eye Gallery, LLC dba Eye Department to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.
I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.
I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name _____ Date:_____

Signature _____

Relationship to Patient (if Pt. Under 18) _____