Welcome to Our Office

Please fill out the information requested so that we may better serve you. Please print. Thank you.

Name: _____ _____
(Last) (First)

Date of Birth: ____/____/____ Soc. Security #: _____
Month Date Year

Address: _____

_____ _____ _____
(City) (State) (Zip Code)

Phone Number: Home: _____ Cell: _____

Work: _____

How did you hear about us? (Circle) Newspaper Radio Other: _____

Account Responsible

If different from above

Person responsible for account _____ _____
(Last) (First)

Relation to patient _____ Birth Date____/____/____ Soc.Security #_____

Address (if different from patient) _____

City: _____ State: _____ Zip code: _____ Phone #_____

Diagnosis Issues

Do you have one or more pair of current glasses?	Yes	No
Do you work on a computer for long periods of time?	Yes	No
If you wear glasses, would you benefit from thinner and lighter lenses?	Yes	No
If you wear bifocals, are you bothered by restricted areas, lines, or head-tilting?	Yes	No
Are you bothered by glare when you drive at night?	Yes	No
If you wear contacts, are you happy with your vision and/or comfort?	Yes	No

DILATION

Eye drops are used that temporarily act to increase the size of the pupils. These drops also temporarily decrease the ability to change focus from one distance to another, mainly near focus. By enlarging the pupils, Dr. Gordy can examine the inside of your eyes more thoroughly, and provide you the very best in eye care. Without pupillary dilation, certain eye diseases and abnormalities can go undetected. The disadvantages to having your eyes dilated include temporary slight stinging upon installation of the drops, blurry vision at near and light sensitivity. *(Your driving may be affected, great caution is advised.)* We recommend a dilated examination for 1) all new patients, 2) patients at risk for, or with pre-existing eye diseases, or 3) routinely every 1-3 years.

I give my consent for pupillary dilation if necessary. [ ] Yes [ ]No _____ (Initial)

ACKNOWLEDGEMENT RECEIPT

By placing a check below, I acknowledge I have been offered a copy of Gordy EyeCare's Notice of Privacy Practices.

[ ] Yes, I would like to receive a copy of Gordy EyeCare's Notice of Privacy Practices.

[ ] No, I do not wish to receive a copy of Gordy Eyecare's Notice of Privacy Practices.

Office Policies

All Services are the Responsibility of the Patient: Gordy EyeCare will gladly bill your primary insurance. I understand that insurance benefits must be determined prior to my exam. If I become aware of insurance coverage after services have been rendered, I agree to personally submit the claim to my insurance company for reimbursement. I understand that when my insurance company requires a referral from my primary-care physician, and I do not furnish the correct referral at the time of service, I will be responsible for payment if my insurance company refuses my claim. I also understand and acknowledge that I am financially responsible for non-covered services and any unpaid insurance balance over 45 days past due. **Please make sure to give us all insurance cards, both medical and vision.**

Services Provided: A refraction is necessary to determine the performance of the visual system and is the first step in evaluating the health of the eye. Although a refraction is also used to determine the need for corrective eyeglasses and/or contact lenses, this practice performs refractions as an essential part of the medical eye examination. A refraction is also necessary to evaluate a patient for surgery and some eye conditions. **Unfortunately, some insurance plans (including Medicare) DO NOT cover the cost of the refraction. In these cases, the patient will be responsible for the refraction charge, $20 on the day of the appointment.**

Payments, Co-pays and Deductibles are Due at Time of Service: I understand that not all services and materials may be covered by my insurance or may exceed benefits or coverage. I agree to pay all payments, co-pays and deductible at the time of service for all services and materials.

Materials: I understand that eyeglasses are custom made to fit each patient's needs. Therefore Gordy EyeCare will not be held responsible for any materials not picked up after 90 days. The initial deposit made for glasses to be ordered will be kept to cover our expenses.

Returned Checks: There is a $30.00 fee for any check returned by the bank. Plus a bank fee of $9.00. This fee will be added to the unpaid balance and must be paid by cash or credit card. If the fee and balance are not paid by the patient, your check will be turned over to Lee County Worthless Check Unit. Also, check writing privileges will be suspended.

Patient's Name: _____ (please print)

Responsible Party
(if not the patient): _____ (please print)

Signature: _____ Date: _____

Explanation of Contact Lens Exam and Fitting Fees

The cost for an annual comprehensive eye exam is $75.00 for private pay patients. This exam includes glaucoma test, dilation (if needed) and overall eye health evaluation; it does not include the evaluation of contact lens. Most insurance companies do not cover the contact lens portion of the eye exam.

A patient currently wearing contact lens, in which the doctor recommends the same type of lens, is required to have a contact lens evaluation annually in order to maintain a valid prescription. The cost for the contact lens evaluation is $30.00.

If you do not wear contact currently and are interested in wearing them or the doctor recommends a different type of lens, a contact lens fitting is required.

There are four levels of contact lens fittings, depending on the type of lens needed and the complexity of the fit. Fitting fees range from $40.00 to $70.00 and the doctor or contact lens technician will explain the fitting charges as they apply.

We offer routine contact lens checks at no charge for the 3 months following your exam; thereafter contact lens related visits are the patient's responsibility. The fee minimum will be $30.00 with the possible addition of a $20.00 refraction if the doctor finds it necessary to perform.

Once you receive your trial contact lens from our office, we will make you a two week follow up appointment. There will be no additional charge for this appointment. You will be required to come in to our office in order for us to release the prescription so you can order contact lens. In order for us to make sure the trials that were given to you fit you properly, we ask that you please wear the trials that you were given to your follow up appointment.

Contact lens exam and fitting fees are non-refundable.

PLEASE CHECK BELOW

_____ YES··· I would like a contact lens evaluation today in order to update my contact lens prescription and have the ability to purchase contacts for the next 12 months. **I understand that the fitting must be paid at the time of service.**

_____ NO··· I do not want a contact lens evaluation today and I understand that I will not be able to purchase contacts without an updated contact lens prescription.

Print Name _____

Patients Signature _____ Date _____

5009 Riverchase Dr. • Bldg. 100 Suite C • Phenix City, AL 36867
Phone: 334-291-5125 • Fax: 334-291-9956 • Email: gordyeyecare@hotmail.com

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