# Clearly Eyecare, LLC

PLEASE PRINT (write as legible as possible and **fill out every question**)

Name: ________________________________ Date of Birth: _____/_____/_________ Date:_______________

Address: ____________________________________________________________________________

City: ____________________ State: _________ Zip Code: ____________Phone Number: __________________

E-mail Address: ___________________________Occupation: ________________Employer: _______________

LAST Eye Exam: ____________Doctor: ___________LAST Medical Exam: ____________Doctor: ______________

Medical Insurance ____________________________ Vision Insurance _________________________________

**PAST OCULAR HISTORY: (Please check if you ever had any of the following)**

___ Eye Infection ___ Eye Injury ___ Lazy Eye ____ Dry Eye ___ Cataract ___ Glaucoma ___ Macular Degeneration

___ Eye Surgery ___ Other: ____________________________________________________________

**PAST MEDICAL HISTORY: (Please check if you have or ever had any of the following)**

___ Hypertension ___ Respiratory Problem ___ Thyroid Problem ___ GI problem ___ Bone/Joint Problem

___ Diabetes ___ Other: ______________________________________________________________

If diabetic, are you type 1 or type 2: _______What year were you diagnosed: _______ What is your Hemoglobin A1c:____%_

Are you allergic to anything (including medications)? □ No. □ Yes. Please list: ______________________________

_____________________________________________________________________________________

Are you taking any medications? □ No. □ Yes. Please list: ___________________________________________

_____________________________________________________________________________________

List all major injuries, surgeries, or hospitalizations: ________________________________________________

_____________________________________________________________________________________

Are you pregnant and/or nursing? □ No. □ Yes. How many weeks pregnant:______________________________

Do you use tobacco products? □ No. □ Yes. Type/Amount/How long: ________________________________

Do you drink alcohol? □ No. □ Yes. Type/Amount/How often: _______________________________

Do you use recreational drugs? □ No. □ Yes. Type/Amount/How often: _______________________________

**FAMILY HISTORY: (**Please note any family history including parents, grandparents, siblings, children; living or deceased)

| CONDITION | NO | YES | RELATIONSHIP | CONDITION | NO | YES | RELATIONSHIP |
|---|---|---|---|---|---|---|---|
| Blindness | □ | □ | ______________ | Diabetes | □ | □ | ______________ |
| Glaucoma | □ | □ | ______________ | Hypertension | □ | □ | ______________ |
| Macular Degeneration | □ | □ | ______________ | Heart Disease | □ | □ | ______________ |
| Retinal Detachment | □ | □ | ______________ | Cancer (type?) | □ | □ | ______________ |
| Retinal Disease | □ | □ | ______________ | Other: ____________________ | | | ______________ |

*The doctor strongly recommends that ALL our patients receive the dilation, visual field testing and retinal imaging as part of our comprehensive and diagnostic evaluation of your eyes and health, although they are NOT required to obtain a prescription for glasses or contact lenses.* ***PLEASE INITIAL NEXT TO THE YES OR NO BELOW.***

**DILATION OF THE EYE**

When the eyes are dilated, the doctor is able to get a broader view of the inside of the eyes. Without a thorough internal examination, serious eye diseases such as diabetic retinopathy, retinal holes/detachment or malignant tumors can be missed. All of these can lead to blindness or even death. If you are experiencing any **floaters or flashes of light**, a dilated examination is **required** to determine the cause. Dilation is recommended for all patients regardless of age. **Diabetic exams**, including those referred by primary care physicians, **must include dilation** in order to accurately assess diabetic changes in the eyes. The side effects of dilation include blurred vision at near (approximately 4-6 hours) and sensitivity to light. The distance vision may also be blurred in some individuals.

(Initials)__________ **Yes**, I do want to have my eyes dilated today for **NO additional fee**.

(Initials)__________ **No**, I do not want to have my eyes dilated at this time. I do not hold Clearly Eyecare, LLC and its employees liable for eye diseases which could have been detected by a thorough dilated examination.

**VISUAL FIELD TESTING**

A visual field analyzer checks for loss of sight or missing areas of vision, both centrally and peripherally. It is possible to map the health of the nerve pathway by this method. Visual field testing can assist us in the detection of glaucoma, retinal problems (such as diabetic retinopathy, tears, holes, and detachments) and some neurological diseases.
This is a non-invasive, painless test that takes approximately 5 minutes for an additional fee of **$15**.
Medical insurance **may** cover this test depending on your policy and/or diagnosis.

(Initials)__________ **Yes**, I do want to have a visual field screening today.

(Initials)__________ **No**, I do not want to have a visual field screening at this time. I do not hold Clearly Eyecare, LLC and its employees liable for eye diseases which could have been detected by the visual field screening.

**FUNDUS PHOTO**

Optos Daytona is an ultra-widefield retinal imaging system that uses scanning laser technology to provide a high resolution 200 degree view of the retina **without the side effects of dilation** and is recommended for all patients regardless of age. This is a non-invasive retinal exam used to detect, diagnose, and treat eye diseases such as diabetes, macular degeneration, and retinal detachments for an additional fee of **$39**. Dilation may still be necessary if a closer, more magnified view is needed.
Medical insurance **may** cover this test depending on your policy and/or diagnosis.

(Initials)__________ **Yes**, I do want to have retinal imaging done today.

(Initials)__________ **No**, I do not want to have retinal imaging done at this time. I do not hold Clearly Eyecare, LLC and its employees liable for eye diseases which could have been detected by retinal imaging.

**NOTICE OF PRIVACY PRACTICES & 30 DAY INCLUSION PERIOD**

1. I have read and understand Clearly Eyecare's Notice of Privacy Practices Form.
2. I also understand that I have 30 days to return to the clinic with any concerns regarding my prescription at no charge. Any visits after the 30-day period may be subject to an additional examination fee due to possible changes in vision.

_______________________________________ _______________________________________
Patient Signature (or Guardian's Signature) Date

**INSURANCE & PAYMENT POLICY**

Insurance may cover none or only part of your fees. If we do not accept direct payment from your insurance plan, you will be required to pay our office at the time of service and submit your receipt for reimbursement from your insurance company. If your insurance does not pay as expected, you are ultimately responsible for all charges. We are not responsible if you are not eligible for benefits. We will be happy to assist you with your claims.

_______________________________________ _______________________________________
Patient Signature (or Guardian's Signature) Date

# CANCELLATION AND NO SHOW POLICY

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment cancellation policy. The policy enables us to better utilize available appointments for our patients in need of medical care.

If it is necessary to cancel your scheduled appointment, we require that you call at minimum 24 hours in advance of your appointment. Your early cancellation will give another patient the possibility to receive timely medical care.

A failure to present at the time of a scheduled appointment will be recorded in your chart as a “no show”. An administrative fee of $25.00 will be billed/charged to your account.

While we understand that situations may arise, it is our goal to prevent no show’s that detour our timely patient care to all patients.

We thank you in advance for your cooperation and understanding.

I acknowledge Clearly Eyecare’s cancellation and no-show policy.

(Sign)________________________ (Print)___________________________ Date:_____/______/______

# REFUND, RETURN AND CANCELLATION POLICY

**PRESCRIPTION EYEWEAR**

**Cannot be returned for a refund.** Warranty and exchanges may apply. See below.

**FRAMES**

All our frames and sunglasses are guaranteed for one year from date of purchase against manufacturer defects, with the exception of frames that are on sale which are not covered under warranty. Frames that are bundled with lens special are not covered by warranty. Warranty covers defects in the structure of the frame or in the coloring of the frame. Accidental damage or loss to frames is NOT covered by warranty (this includes but not limited to: misuse causing frame damage, scratching or tarnish; pet-inflicted damage; destruction or damage by vehicle or other machines; stepping on or sitting on the frame; bending or twisting the frame; damage from chemical exposure; exposure to extreme weather conditions or any other damage not considered a manufacturing flaw). We are not responsible for damage caused by other optical shops during lens fabrication, adjustment or during any other services provided by another business.

Clearly Eye Care, LLC reserves the right to inspect the product upon return and refuse exchange if not deemed defective. All defective frames will be replaced with the identical product. If the product is no longer available, the customer will be contacted to substitute a different color or different model at equal or lesser value.

There will be a $15 shipping fee for a replacement and/or parts.

**PRESCRIPTION LENSES**

Due to the specialized nature of lenses, they are NON-REFUNDABLE and can only be exchanged if deemed defective or if the prescription was determined to be incorrectly made. Clearly Eye Care, LLC is not responsible for prescriptions that are incorrect due to customer providing inaccurate prescriptions (also, outside prescriptions) or pupillary distance (PD) measurements, or any other inaccurate information.

**COATINGS**

**Anti-reflective coatings and scratch coatings** are warranted at no cost to you for a period of one year form the date of purchase. Accidental damage or loss to lenses is NOT covered by warranty (this includes but not limited to: misuse causing lens or lens coating scratches; pet-inflicted damage; destruction or damage by vehicle or other machines; stepping on or sitting on the lenses; damage from chemicals including cooking oil, beauty products or glue; exposure to extreme weather conditions or may other damage not considered a manufacturing flaw). We are not responsible for damage caused by other optical shops during adjustment or during any other services provided by another business.

**NON-ADAPT POLICY**

**Lenses**: If you are not satisfied with the lens performance, the lenses may be exchanged for another lens type, up to the original value. Change must be made within 30 days of original order. **No refunds will be given**.

**Progressive Lenses**: If for any reason you are not able to adapt to using the progressive lenses we will replace them, within 30 days of receipt, with either a pair of single vision lenses for distance or near, or a lined bifocal. **No refunds will be given.**

**CANCELLATION POLICY**

Once the lab has started your order, you may be eligible for a 50% refund.

I understand the policy,

X______________________________

DATE ____________________

**CONTACT LENSES**

Contact lenses are permitted for return only under the following conditions: 1.If an incorrect product or prescription was ordered by Clearly Eye Care, LLC; 2. If the product is defective or expired upon receipt. Opened boxes of contact lenses or contact lens vials are not valid for return (except if defective upon receipt). Incorrect orders placed by the customer may require additional charges for shipping and handling.

1900 University Blvd. Suite 200, Round Rock, TX 78665

# CONTACT LENS PATIENT AGREEMENT

Advancements in contact lens technology offer the potential of successful contact lens wear to most of our patients. A contact lens is a medical device in contact with the tissues of your eye; therefore, it must fit appropriately to maintain the health of your eye's response to the lens on follow-up visits. Since the follow-up care is essential, it is your responsibility to keep all appointments and follow all lens care instructions.

## THE COMPREHENSIVE EYE EXAM

Before a person can be fit the contact lenses, a complete medical and refractive eye examination is necessary. This exam is critical to assure the good health of your eyes and to rule out the possibility of any unsuspected, underlying condition that may prevent contact lens use.

## CONTACT LENS FITTING

The goal of contact lens fitting is to find the most appropriate contact lens for each patient's optimal vision and comfort. An enormous variety of types, materials, sizes and colors are offered. We are committed to taking the time and effort to fit your contact lenses properly. Although many people will need only on fitting session, sometimes this prove requires several appointments. Everyone being fit into contacts must go through this fitting process. We will not finalize the contact lens prescription until both the individual being fit for contact lenses and the doctor are satisfied with the fit and visual acuity of the contact lens. We will provide one set of trial lenses. **Dispensing of trial contact lenses may only be at the time of the original examination and scheduled follow-up visits when a change is required.** A contact lens trial will not be dispensed at other times. Any patient who is changing lens brands must have a new fitting and there may be an additional fitting charge. Please order your supply of contacts at least one week prior to running out of your contact lenses.

## FOLLOW-UP APPOINTMENTS

Follow-up appointments are necessary to assure:

1. The contact lenses are fitting and moving well
2. The prescription is providing the best possible vision
3. The eyes are remaining healthy
4. There are no problems with insertion or removal
5. The patient understand and complies with the recommended wearing schedule
6. **Prescriptions will NOT be written for patients who do not keep follow-up appointments.**

There is no charge for follow-up visits during the first 30 days or the first three follow-up visits, whichever comes first. **All follow up care and office visits after the 30 days period is the responsibility of the patient and are not covered by today's fee. The patient will be assessed a $45.00 refitting fee.**

## ANNUAL CONTACT LENS EXAM

By law, a contact lens is only valid for only a year. All patients are required to come in for an annual contact lens exam. This is necessary to assure that the patient's eyes are healthy and the contact lenses are still fitting well. **Contact lens prescriptions cannot be renewed without an annual exam.** Contact lens exams have a **separate charge** that is NOT included in your medical exam.

## REFUNDS

There will be NO refund on the exam, fitting and evaluation or annual contact lens examination fee.

Patient/Guardian Signature________________________________________Date____________________

Name (Last, First)_____________________________________________Date____________________

# COVID-19 PANDEMIC ESSENTIAL EYE EXAM AND TREATMENT CONSENT FORM

**Patient Name**: ________________________ **DOB**: ____________________ **Date**: _____________

**Please read and initial next to the following statements to indicate your agreement. If you cannot positively affirm to all these questions, you will be asked to postpone or reschedule your visit to a later date.**

_____ I do not currently, nor have I had in the last two weeks, a fever, cough, sore throat, and loss of smell/taste or other cold symptoms.

_____ To the best of my knowledge, I do not have, nor have I been in direct contact with someone who has a confirmed diagnosis of COVID-19 or a presumptive positive COVID-19 test result in the last 30 days.

_____ Neither I, nor anyone living in my immediate household, have traveled outside of the state or country in the last 30 days.

I understand that Clearly Eyecare, its doctors and staff are taking precautions to limit any potential exposure I may have to the COVID-19 virus. I also understand that there is no definitive way to eliminate potential exposure by one hundred percent.

By signing this form below, I agree that I will not hold Clearly Eyecare or any of its doctors and staff personally responsible should I, or someone I come in contact with, become positively or presumptively positive diagnosed with the COVID-19 virus. There are certain inherent risks associated with an eye exam during a pandemic and I assume full responsibility for personal illness that may result and further release and discharge DLV and its doctors and staff for injury, loss or damage arising out of my visit. I understand that COVID-19 infection can lead to illness, disability, or even death and knowingly take the risk of exposure as I deem my eye exam to be essential to the maintenance of my vision.

__________________________ ____________________________ ____________________

PRINT LEGAL NAME SIGNATURE DATE