PATIENT FORM

GENERAL INFORMATION

First, Last, MI, Preferred Name

Street Address

City, State, Zip

Phone, Type

Phone 2, Type

Email

Preferred Contact Method *cell phone* | *email* | *text* | *other (please explain)*

Patient Social Security Number

Date of Birth

Male/Female

Occupation/Employer *full-time* | *part-time*

Marital Status *married* | *single* | *divorced* | *legally separated* | *widowed*

Language, Race, Ethnicity

Emergency Contact Person and Phone

INSURANCE INFORMATION

Vision Insurance

Vision Insurance Member Name

Vision Insurance Member ID#

Vision Insurance Member Date of Birth

Primary Medical Insurance

Primary Member Name

Insurance ID#

Insurance Policy#/Group ID#

Primary Member Date of Birth

Primary Member Social Security Number

Primary Member Employer

Your Relationship to Primary Member *spouse* | *child* | *other (please explain)*

Secondary Medical Insurance

Secondary Medical Insurance Member Name

Secondary Medical Insurance ID#

Secondary Medical Insurance Policy #/Group ID#

Secondary Medical Insurance Member Date of Birth

Secondary Medical Insurance Member Social Security Number

Your Relationship to Secondary Medical Insurance Member

PATIENT FORM

EYE HISTORY

Date of Last Eye Exam

Currently Wear Glasses?

Currently Wear Contacts?

Reason for Today's Visit

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Cataracts	*yes*	*no*	*family*
Crossed Eye	*yes*	*no*	*family*
Glaucoma	*yes*	*no*	*family*
LASIK or RK	*yes*	*no*	*family*
Lazy Eye	*yes*	*no*	*family*
Macular Degeneration	*yes*	*no*	*family*
Retinal Detachment	*yes*	*no*	*family*

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ☐ Blurry Vision *near or distance*
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Infection
- ☐ Eye Pain or Soreness
- ☐ Floaters or Spots
- ☐ Halos
- ☐ Headaches
- ☐ Itching
- ☐ Light Flashes
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy or Gritty Feeling

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

AIDS/HIV	*yes*	*no*	*family*
Allergies	*yes*	*no*	*family*
Arthritis	*yes*	*no*	*family*
Asthma	*yes*	*no*	*family*
Blood/Lymph Disorder	*yes*	*no*	*family*
Cancer	*yes*	*no*	*family*
Diabetes	*yes*	*no*	*family*
Ears, Nose, Throat Conditions	*yes*	*no*	*family*
Gastrointestinal Conditions	*yes*	*no*	*family*
Heart Disease	*yes*	*no*	*family*
High Blood Pressure	*yes*	*no*	*family*
High Cholesterol	*yes*	*no*	*family*
Kidney Disease	*yes*	*no*	*family*
Lupus	*yes*	*no*	*family*
Neurological Conditions	*yes*	*no*	*family*
Psychiatric Disorder	*yes*	*no*	*family*
Seizures	*yes*	*no*	*family*
Skin Conditions	*yes*	*no*	*family*
Stroke	*yes*	*no*	*family*
Thyroid Dysfunction	*yes*	*no*	*family*

Current Medications (prescription and over-the-counter and dosage)

Medication Drug Allergies

Height **Weight**

Are you pregnant or nursing?

Do you smoke?

Have you ever smoked?

Insurance Signature on File

I certify that the information given by me in applying for insurance and/ or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/ or Medicare benefits and I request that payment of these benefits be made on my behalf to Chrys A. Manos, OD for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

_____ _____

Patient/Representative's Signature Date

Medicare Advance Beneficiary Notice (ABN)

Patient's name_____ **Medicare #**_____ **Date**_____

Medicare is your primary health insurance, and for your convenience, our office bills Medicare for your examination. Medicare then reviews all submitted claims, and if approved, reimburses 80% of the approved amount. The remaining 20% (the co-payment) is your responsibility as the Medicare beneficiary.

The Medicare yearly deductible for 2020 is $198.00. If our office is the first to submit Medicare claims for you each year, Medicare will notify us that you have not yet met your deductible for that year. Medicare will not pay for your allowable fees until the deductible is met.

Medicare does not pay for the refractive services, which is the part of your eye exam that determines your prescription. **The charge for your refraction is $30.00 and is your responsibility.**

Medicare only pays for the covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There is a good reason your doctor recommended it.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you may have to pay for them yourself.

1. Read this entire notice carefully.
2. Ask us to explain, if you don't understand why Medicare probably won't pay.

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund any payments I make to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payments, either out-of- pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

_____ _____

Patient/Representative's Signature Date

VISION SOURCE

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Savvy Eyes make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ I have read or had explained to me Savvy Eyes' Notice of Privacy Practice and agree to continue my care with Savvy Eyes under said terms.
- ☐ I was given the opportunity to read Savvy Eyes' Notice of Privacy Practices and declined but wish to continue my care with Savvy Eyes under the terms of Savvy Eyes' privacy policies.
- ☐ I have read or had explained to me Savvy Eyes' Notice of Privacy Practice and do not wish to continue my care with Savvy Eyes under said terms.
- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as

  _____

  _____

- ☐ By signing this, I agree to allow communication with Savvy Eyes through standard email systems (savvyeyes@yahoo.com)

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____

Representative Relationship to Patient

iWellness Exam

Sight threatening diseases such as glaucoma, macular degeneration, diabetic retinopathy and others often have no outward signs or symptoms in early stages, which is why eye exams, including a thorough retinal evaluation, are important to protect vision. In an effort to provide a more thorough eye exam, Savvy Eyes has incorporated the iWellnessExam™ SD-OCT as part of our comprehensive eye exam.

Like an MRI of the eye, but taking only seconds to perform, the iWellnessExam™ provides high definition cross sections of your retina and optic nerve which can reveal signs of disease in exquisite detail that are invisible to traditional examination methods.

This unique technology can help detect potentially vision threatening and systemic diseases in their very early stages. It will also provide Dr. Manos with a permanent baseline record of your retinal examination for comparison during future exams.

As part of your pre-examination work-up, our technician will perform this test which your doctor will review with you during your examination today. The $19 charge is typically not covered by your medical or vision insurance unless being used to actively follow disease. This cost will be added into the price of your visit today. Any questions you have about these tests can be discussed during your examination.

I understand that Dr. Manos strongly recommends an annual iWellness Exam for all patients in order to provide a better level of clinical eye care. I agree to have the iWellness Exam performed today.

_____ _____

Patient signature Date

I choose NOT to have the iWellness Exam at this time.

_____ _____

Patient signature Date

iWellness Exam

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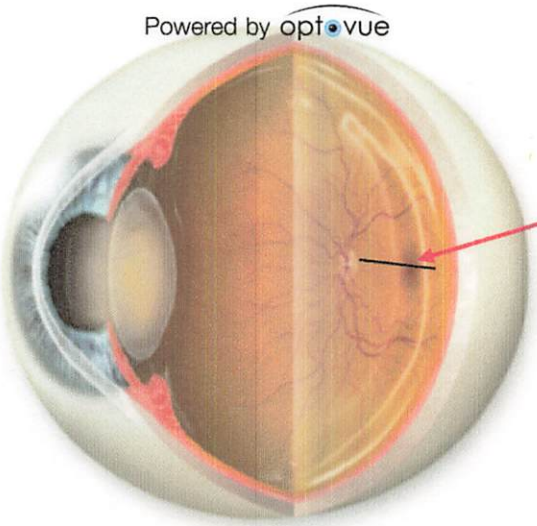
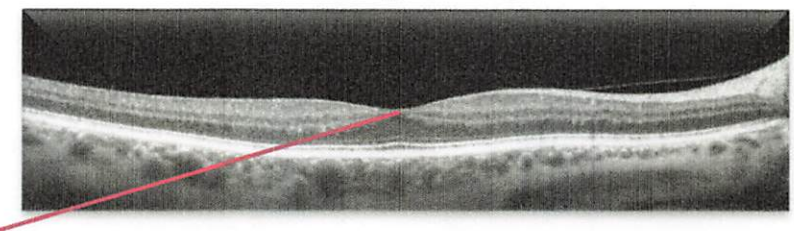
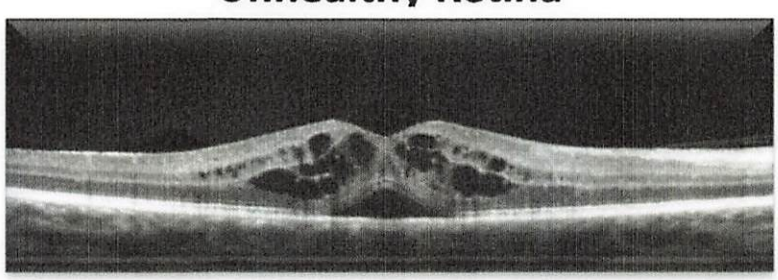


Healthy Retina



Unhealthy Retina



Savvy EYES
Personal, Professional Eye Care

PHONE: 702.437.2889
FAX: 702.437.5196
EMAIL: savvyeyes@yahoo.com

500 E. Windmill Lane, Suite #120 | Las Vegas, NV 89123 | *(in the Windmill Lane Plaza)*

Contact Lens Evaluation Policy

A contact lens evaluation is not included in a routine vision examination. The cost of the contact lens evaluation includes trial contact lenses, as well as the necessary follow-ups to ensure the proper fit and the best vision in your contact lenses. The full evaluation fee will be the patient's responsibility, unless discounted by his/her insurance. Our evaluation fees are as follows:

Basic Spherical Evaluation: $60.00

Specialty Evaluation (Toric, Multifocal, Monovision): $85.00

***Fees for complex contact lens evaluations are higher due to requiring more doctor consultation time, follow-ups, and additional contact lens trials.**

By signing below, I acknowledge that I will be provided a copy of my contact lens prescription at the completion of my contact lens evaluation. If given multiple brands to try, I need to finalize my selection of lenses within 45 days of my exam.

Patient or Guardian's Signature: _____

Date: _____