

Welcome to Savvy Eyes, and thank you for entrusting us with your eye care needs!

Attached are some documents that all new patients need to complete. If there are multiple members of your family coming in at the same time, we ask that you fill out one packet for each patient. We ask that you fill these forms out ahead of time so we can serve you more efficiently in the office.

Pages 1 & 2 include basic demographic information, insurance information, personal and family eye health history, and personal and family general health history. If you are currently taking several medications, you can attach a copy of your medication list rather than write them all on this form.

Page 3 is an acknowledgement of receiving a copy of our privacy practices policy. The actual policy should be included in this email as a separate attachment. Please sign and date this form.

Page 4 is a signature page acknowledging that you will be using insurance for any part of your exam or order for glasses or contact lenses. If you're using Medicare as your insurance, please sign the bottom paragraph. If you're using any other insurance company, please sign only the top paragraph.

Page 5 explains our contact lens evaluation policy. Please sign and date only if you will be needing a new or updated contact lens prescription.

Page 6, the last page, is a consent for our iWellness scan which takes pictures of the retina and does an ultrasound of the layers of the retina. This is non-invasive, takes less than two minutes, and gives the doctor a better view of the health of your eyes. **Dr. Manos recommends this to ALL of our patients, including children, but particularly those with high blood pressure or diabetes or anyone with a family history of macular degeneration, glaucoma, or any other eye disease. Dr. Manos will go over the results of this test with you in the exam room.** It's just a \$39 copay on your insurance. Please sign & date the appropriate line.

You may email or fax back all of these documents. If you can't email them back, you can always bring them with you to your appointment. Email: savvyeyes@yahoo.com Fax: 702-437-5196

We promise you won't have to complete new documents every year. We simply need new patients to complete them once, and we'll keep them in your patient record.

PATIENT FORM

PAGE 1 OF 2

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

PAGE 2 OF 2

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?

**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 or other reason described as

- ☐ By signing this, I agree to allow communication with Savvy Eyes through standard non-encrypted 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

Non-Medicare (Private) 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 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 2026 is \$283.00. 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 \$45.00 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.

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:

Standard Evaluation: \$75.00

(Spherical Lens)

Toric Evaluation: \$95.00

(Astigmatism Lens)

Multifocal/Specialty Evaluation: \$125.00

(Multifocal, Monovision, RGP, SynergEyes Hybrid Lens)

*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: _____



In an effort to provide a more thorough eye exam, Savvy Eyes has incorporated the iWellness Exam™ SD-OCT as part of our comprehensive eye exam. Like an MRI of the eye, but taking only seconds to perform, the iWellness Exam™ 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. Such diseases include glaucoma, macular degeneration, cancer in the eye, signs of diabetes and high blood pressure in the eye, and congenital conditions which can cause blindness in children. 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 Dr. Manos will review with you during your examination today. There is a \$39 copay for this noninvasive test. 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

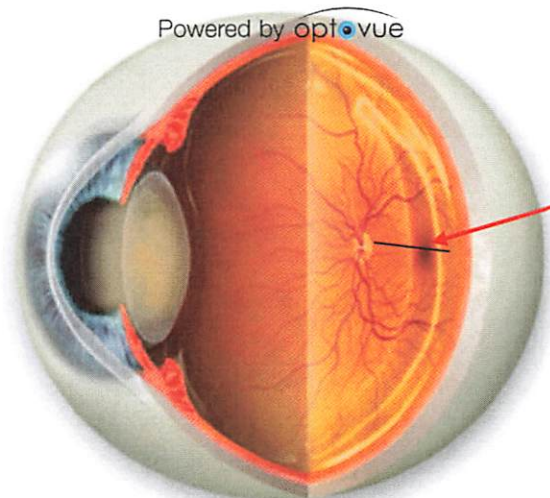
I choose NOT to have the iWellness Exam at this time.

Patient signature

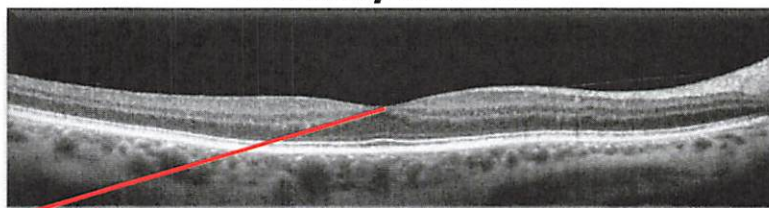
Date



Powered by optovue



Healthy Retina



Unhealthy Retina

