

WELCOME TO DELTAVISION OPTICAL

OFFICES OF DRS GREG POPOWITZ & ELLEN DOHR

Patient's Name _____

If minor, who is responsible for patient? _____ Relationship to patient _____

Address _____ City _____ Zip _____

Home Phone _____ Work / Cell Phone _____ Male/ Female

E-Mail Address _____ @ _____ Date of Birth _____ Age _____

Vision Insurance _____ Employer _____

Insured's Name _____ ID # _____ Date of Birth _____

Other Vision Insurance _____

Medical Insurance _____ ID# _____

Primary Care Physician Name and Telephone Number _____

PAYMENT AUTHORIZATION

I hereby authorize payment of my vision/medical benefits to Deltavision Optical. I understand that eligibility and benefits quoted by my Insurance / Medicaid Plan are based on current claim data and I am responsible for any charges not covered by my Insurance / Medicaid Plan. I grant permission for Deltavision Optical to release information from my medical record for claim and case management only.

Signature _____

Date _____

HEALTH HISTORY

Medications: _____

Known Drug Allergies: _____ How long since your last eye exam? _____

Please circle any of the following that apply

High Blood Pressure Diabetes Asthma Allergies Headaches (explain) _____

See Flashes of Light Eye Injury HIV Glaucoma Eye Surgery (explain) _____

See Spots or Floaters Eye Itchiness Stroke Thyroid Eye Disease (explain) _____

Are you pregnant? ____ Months ____ Any other medical conditions we should be aware of _____

FAMILY HISTORY

Diabetes Glaucoma Macular Degeneration Other _____

DO YOU HAVE PROBLEMS WITH THE FOLLOWING

Blurry Distance Vision Reading Problems Glare or Reflections Night Driving Sensitivity to Light Watery or Dry Eyes
Computer Strain Double Vision

ARE YOU INTERESTED IN THE FOLLOWING

Contact Lenses Computer Glasses Prescription Sunglasses Laser Surgery

HIPAA COMPLIANCE ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received / reviewed a copy of NOTICE of PRIVACY PRACTICES.

Patient's Name _____

Signature of Patient / Parent or Guardian _____

Date _____

PROFESSIONAL FEES

COMPREHENSIVE EXAMINATION	\$89.00
MEDICAL OFFICE VISITS	\$55.00 & UP
CONTINUING CONTACT LENS WEAR EVALUATION WITHOUT FOLLOWUP	\$29.00
STANDARD SOFT CONTACT FITTING*	\$79.00
TORIC SOFT CONTACT FITTING*	\$89.00
BIFOCAL SOFT, MONOVISION or RGP*	\$99.00
RGP MULTIFOCAL FITTING*	\$149.00
MULTIFOCAL TORIC FITTING*	\$149.00

***CONTACT LENS FITTINGS INCLUDE UNLIMITED FOLLOW-UP CARE VISITS FOR 60 DAYS FROM THE EXAM DATE.**

- ALL PRESCRIPTION RECHECKS (CONTACTS AND GLASSES) MUST BE COMPLETED WITHIN 60 DAYS OF INITIAL EXAM
- A \$55 OFFICE VISIT CHARGE WILL APPLY IF AFTER 60 DAYS
- A COMPREHENSIVE EXAMINATION CHARGE WILL APPLY IF AFTER 90 DAYS
- ALL FEES ARE NON-REFUNDABLE AND SUBJECT TO CHANGE
- ALL RETURNS ARE SUBJECT TO A 20% RESTOCKING AND SHIPPING FEE
- MEDICAL FEES ARE SEPARATE AND NOT PART OF THE COMPREHENSIVE EYE EXAM

I understand that the above charges are part of Deltavision Optical professional fees and that I am responsible for any expenses not covered by my Insurance / Medicaid Plan.

Patient
Signature _____