Welcome to J. Micetich, OD & Associates Family Eye Care

Patient Name:_____

Street Address:_____

City:_____ Zip Code:_____

Primary Phone: _____cell or home

2nd Phone:_____ cell or home

may we text you? YES or NO

E-Mail address:_____

Primary members last four of their SS number:_____

*****Please bring up ALL medical and vision insurance cards so we can update the system.*****

We pre-appoint all appointments for next year. We will send you out a reminder and if you can't make it please just call and reschedule.

MORE ON THE BACK..

J Micetich OD & Associates Family Eye Care Center
20 E. North Street, Coal City, IL 60416
Phone: 815-634-4825
Fax: 815-634-4938

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office or from our Web site.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. By signing, you signify that you have no other health or vision insurance (or that you have provided us all insurance information) and agree that, since there is no guarantee of payment by an insurance company, you will be responsible for payment for services received in our office should the insurance not pay. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

_____ _____

Dated Signature of Patient

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

_____ _____

Relationship to Patient Print Name

CONTACT LENS FITTING FEES

We want to thank you for considering a contact lens fitting with the doctors of Family Eye Care Center and want you to understand what is involved with a contact lens fitting. If you have any questions, please do not hesitate to ask.

On the day of your examination, if needed and time permitting, an optician will instruct you on insertion and removal of the lenses. If this is not possible, you will be given a return appointment to meet with one of the opticians for this instruction session. After receiving these instructions, you will wear the lenses for one to two weeks and return for a follow-up examination to evaluate the fit and prescription. If you are a previous wearer and no changes have been made to the fit, you will be free to purchase your prescribed lenses the day of the examination and will not need to go through the "evaluation" phase.

Below are the categories of Fitting Fees. Your fees will be determined by the physician, are **due at the time of the fitting** and are **non-refundable.** If you decided to "up-grade" to a different category (i.e. monovision to bifocals) after the initial visit, additional fees will be added. Fees do not include the price of the contact lenses.

Fitting Fees are as follows:

Renewal of contact lens fit and power, **soft or gas perm** (This re-validates your prescription for one year.)	**$80.00**
Soft: First-time contact lens wearer, Change in brand or type of lens, Refit because of unknown contact lens specifications, Refit because of poor fit or poor visual acuity	**$95.00**
Soft Toric or Standard/Toric Gas Perm: First-time contact lens wearer, Change in brand or type of lens, Refit because of unknown contact lens specifications, Refit because of poor fit or poor visual acuity Monovision Gas Perm toric Soft or Gas Perm bifocal	**$105.00**
Specialty Contact Lenses: Keratoconus Post corneal surgery Other corneal deformities	**$200.00**

-Continued-

NOTICE: Fitting fees cover up to three months of follow-up care. Follow-up care is vital to determine the fit of the lens and to protect the health of your eyes. **If you elect to forego the follow-up care and return beyond the initial three month period, you will be charged a fee of $40.00.** You must have follow-up care in order to purchase contact lenses, unless otherwise authorized by the doctor.

The price of lenses will vary depending on type and prescription. Some types of contacts are not available in complimentary trials, i.e. gas perms or soft lens colors. These lenses must be purchased. They may be returned or exchanged as described in the next paragraph. Most disposable contacts are available in complimentary trials.

Contacts must be paid for in full at the time of dispensing. Changes in the lenses can be made within the first two months. If within the two-month follow-up period, you feel contacts are not for you, we will credit your account if gas perm contacts are returned in good condition, or if soft lens boxes are not expired and are unopened. You may use this credit for other optical purchases for yourself or a family member.

THE FITTING FEE WILL NOT BE REFUNDED OR CREDITED. _____ *(initial)*

Fairness to Contact Lens Consumers Act: This act went into effect February 4, 2004. As stated by this Act, you are entitled to a copy of your contact lens prescription once the prescription is finalized by the examining doctor. Receiving a trial lens **IS NOT** a finalized prescription. A finalized prescription is determined at the follow-up appointment after you have been wearing the trial lenses. **Contact lens prescriptions are valid for one year, per Illinois state law.**

I have read and understand the above information and agree to the terms set forth in this agreement. I also acknowledge that I have had all my questions answered.

_____

Signature of patient or legal guardian Date

Eyewear Lifestyle Questionnaire

Your eyewear is an investment in your personal appearance. It's self expression. Your fashion statement without saying a word. An accessory to help you see better and live better. It's the first thing people see when they look you in the eye.

Your Lifestyle

Your answers to these questions will guide us in recommending the best products to meet your eyewear needs.

Name: _____ Date: _____

How long have you been wearing glasses? _____ Contacts? _____

What percent of time do you wear your glasses? _____ Contacts? _____

Do you wear prescription sunglasses? Yes No

Do you wear non-prescription sunglasses? Yes No

When do you wear your corrective eyewear?

	Glasses	Sunglasses	Contacts
All of the time	☐	☐	☐
For reading/working	☐	☐	☐
For driving	☐	☐	☐
For sports/recreation	☐	☐	☐
Other _____	☐	☐	☐

What is your occupation? _____

Which of the following do you do regularly? (check all that apply)

☐ Night driving ☐ Work outdoors ☐ Commute 20+ min. by car

☐ Work w/ small objects ☐ Work under fluorescent light ☐ Read for long periods

☐ Work on a computer ☐ Travel on airplanes ☐ Watch TV for 3+ hrs/day

☐ Work at a desk ☐ Frequently alternate between indoors & outdoors

☐ Other _____

List all sports and hobbies you participate in: _____

_____

What do you like about your current glasses? _____

_____

What features will be important in choosing your new glasses? (check all the apply)

☐ Image ☐ Frame material ☐ Fit

☐ Durability ☐ Weight ☐ Brand

☐ Fashion trends ☐ Lens type ☐ Lens thickness

☐ Frame color ☐ Lens color ☐ Other

Dr. Recommends: ☐ Contacts ☐ Glasses ☐ Sunglasses

Lens Type: ☐ Single vision ☐ Flat top ☐ Bifocal ☐ Trifocal

☐ Progressive ☐ Executive ☐ Blended ☐ Other _____

Lens coating: _____ Other: _____