Dr. Thomas E. Hankenson
Dr. Michelle L. Essex

PRIVACY POLICY ACKNOWLEDGEMENT

I acknowledge I have read and understand the "Notice of Privacy Policy" for Dr. Hankenson, Dr. Essex and Innovative Eyecare.

_____ _____

Signature (If 18 or older) or Parent/Guardian Date

_____

Print Name of Patient

You may disclose any of my health/medical information to:
(examples may include; spouse, parent/guardian, significant other or Primary Care Physician)

Name(s):_____

Address
(optional):_____

I understand I must provide a written change to Dr. Hankenson and Dr. Essex's office to change or delete this request.

_____ _____

Signature (If 18 or older) or Parent/Guardian Date

Welcome to Innovative Eyecare!

To provide the best possible care, please fill in the following information.
This information will remain confidential in your eyecare record.

Today's Date: _____

Patient Name: _____

Date of Birth: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Hobbies or Special Interests:

_____

Parent/Guardian/Responsible Party (If other than patient):

_____

Approximate date of your last complete vision exam: _____

Reason for today's visit? :_____

Do you currently wear glasses? : Yes_____, No_____, If yes, how old are your glasses? ____

Do you currently wear contact lenses? : Yes_____, No_____

If yes, what brand or type? _____ How often do you replace your lenses?_____

If you are a contact lens wearer, or are planning on becoming one, who is using insurance for today's visit please note: there is an additional fee for a contact lens exam. This fee starts at $30, depending on the type of lens you wear and/or if you are a first-time contact lens wearer. The contact lens portion of the exam for first time wearers consists of training needed on how to insert and remove contact lenses as well as caring for and maintaining your contacts, in addition to all follow up visits for three months following the contact lens examination, as well as any additional training that may be needed for the wearer. For patients who currently wear contact lenses, your visit will include: checking the contact to make sure the fit is correct, the tear flow is adequate, and proper amounts of oxygen are being transmitted to the eye, as well as any needed follow-ups for three months following this visit. If you wish to be seen after this three month period there is an additional charge.

Please **initial here** to acknowledge the following:_____ **Opened boxes of contact lenses are non-refundable.**
Innovative Eyecare is not responsible for mis-shipped contact lens orders, please contact your local Post Office.

Personal Medical History

Do you, or have you had any of the following? (Please circle yes or no)

Heart Problems	Yes/No	Diabetes	Yes/No
High Blood Pressure	Yes/No	Asthma	Yes/No
Hepatitis	Yes/No	Allergies	Yes/No
Migraine Headaches	Yes/No	Arthritis	Yes/No
Thyroid Condition	Yes/No	Eye Disease	Yes/No
Eye Injury	Yes/No	Eye Surgery	Yes/No
Women, are you pregnant?	Yes/No	Lasik	Yes/No

Please list any other medical conditions you feel the doctor should know about:

_____

Please list any medications you are currently taking:

_____

Please list any allergies you have to certain medications:

_____

(Please continue on the reverse side.)

Family History

Does/did anyone in your immediate family have any of the following?

Diabetes	Yes/No	Eye Disease	Yes/No
Glaucoma	Yes/No	Blindness	Yes/No
Retinal Detachment	Yes/No	Eye Surgery	Yes/No

Lifestyle Needs Assessment

Do you ever have problems with glare? _____ Do you work at a computer? _____

What did you like most or least about your previous eye wear? _____

Do you have any other visual concerns? _____

Eyeglass wearers: If you are experiencing difficulties with your eyeglasses you have 30 days from the date of purchase to return them so the issue may be resolved. There may be a charge depending on the type of issue.

Please initial to acknowledge the following:_____ANY refund is issued in the form of an in-store credit.

Optomap Retinal Exam

An Optomap provides your doctor with a view of your retina which helps your doctor to evaluate your visual health. This scan can confirm a healthy eye or detect the presence of cataracts, glaucoma, and monitor the eye health in patients with diabetes or high blood pressure. The Optomap Retinal Exam is fast, easy and comfortable. It allows the opportunity for you and your doctor to view and discuss the images of your eye together at the time of your exam. The doctor strongly believes an Optomap is an essential part of your comprehensive eye exam. However, some health plans do not cover the Optomap Retinal Exam which means that you may be responsible for an additional fee of $35.

_____ Yes, I would like an Optomap Retinal Exam and I agree to pay the additional $35 fee if it is not covered by my insurance.

_____ No, I understand the above and choose not to have the Optomap Retinal Exam.

Or

_____ I want a Dilated Exam instead. I am aware that I will be light sensitive with blurry near vision for an average of 3-5 hours.

Insurance Information- Please complete the following portion in full.

Policy Holder's Name: _____ Date of Birth: _____

Relationship to Patient: ___Self, ___Spouse, ___Child, ___Parent, ___Other SSN: _____-_____-_____

Member Number:_____Group Number:_____Insurance Name:_____

Home Phone: _____ Cell Phone: _____ Employer's Name: _____

I understand and acknowledge that my insurance coverage is a contract between me and my insurance company and that I am personally responsible for all medical expenses incurred during evaluation and treatment by **Innovative Eyecare**. It is my sole responsibility to know my insurance benefits. As a courtesy only, **Innovative Eyecare** may call to verify benefits through the insurance company, this however, is not a guarantee of benefits and only when a claim is received by the insurance company will benefits be determined. I understand that as a courtesy my primary insurance will be billed; however, it is my responsibility to follow up on delinquent claims. **Innovative Eyecare** will bill the patient's primary insurance company a total of two times before the total balance incurred becomes the patient's responsibility. **Innovative Eyecare** will give the patient a complete statement showing the amount due and how it was resolved so that it can, in turn, be delivered to the primary insurance company.

Patient or guardian signature:

Please sign to acknowledge the following: _____

Whom may we thank for referring you to our office? _____

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www.checkyearly.com