Welcome to Colorado Vision Center

Patient Name_____ M/ F Date of Birth _____Age_____
• Single • Married • Other *Best phone number
Address_____ Phone: Home (_____) _____
City _____ State _____ Zip Code _____ Text Y/N Cell (_____) _____
E-Mail_____ Work (_____) _____
Who can we thank for referring you? Yellow Pages, Insurance Company, Friend _____
Employment: • Full Time • Part Time • Homemaker • Student • Retired Other _____
Employer_____Occupation _____
Are you interested in: Refractive (Lasik) surgery? • Yes • No Contact Lenses? • Yes • No

General Health: Circle Yes or No for any condition you now have or have had in the past:

Y/N Gastrointestinal	Y/N Nervous	Y/N Psychiatric	Y/N Ear/Nose/Throat
Y/N Genitourinary	Y/N Endocrine (glands)	Y/N Cardiovascular	Y/N Musculoskeletal
Y/N Blood/Lymph	Y/N Diabetes	Y/N High Blood Pressure	Y/N Integument (skin)
Y/N Respiratory	Y/N High Cholesterol	Y/N Allergy/Immunologic	If female, are you pregnant or nursing Y/N

Do you smoke Cigarettes/tobacco Y/N or abuse Alcohol Y/N
What Medications are you taking now, including vitamins/herbal supplements? _____
_____
_____

Eye Conditions: Circle Yes or No for any conditions you now have or have had in the past:

Y/N Blurred Vision	Y/N Eye Infection	Y/N Headaches	Y/N Seeing Halos	Y/N Lazy eyes
Y/N Cataracts	Y/N Eye Injury	Y/N Itchy Eyes	Y/N Sensitivity to light	Y/N Drooping Eyelid
Y/N Crossed Eyes	Y/N Eye Surgery	Y/N Loss of Vision	Y/N Wear contacts	Y/N Retinal Detachment
Y/N Double Vision	Y/N Floaters	Y/N Retinal Disease	Brand of Contacts_____	
Y/N Dry Eyes	Y/N Glaucoma	Y/N Seeing Flashes	Hours per day _____	

Have any blood relatives had any of the following conditions & their relationship to you:
Y/N Blindness _____ Y/N Diabetes _____Y/N Retinal Detachment _____
Y/N Glaucoma _____ Y/N High Blood Pressure _____
Y/N Cataracts _____Y/N Macular Degeneration _____

If patient is a minor (under 18), supply parent or legal guardian information: Responsibility for payment of services of dependent children, whose parents are divorced /separated, rests with the parent who seeks treatment for the child.
Last Name _____ First Name _____
Address (if different from above) _____
Date of Birth _____ SS#_____ Employer _____ Phone _____

Payment Policy:
1. Payment in full is due at the time of services, we accept: • CASH • CHECK • CHARGE • CARE CREDIT
2. HIPPA (Notice of Privacy Practices) **Please Read,** Copy available at front desk
3. A $25 service charge on all returned checks
4. Contact lens patients need an annual exam and there is an additional fee for the contact fit, which covers 90 days of care. Any visits after 90 days will be subject to an additional fee.
5. Insurance Policy: Very seldom does insurance pay for 100% there will usually be at least co-pay. Your insurance is an agreement between you and your insurance company. Our relationship is with you. Therefore, all charges are ultimately your responsibility, regardless of your insurance status. I assign CVC insurance benefits.
__VSP __Eye Med __Superior Vision __Medicaid __Medicare __CHP+ __UHC __BCBS __Other
Member Name_____ Member DOB _____
Member I.D.# (SSN)_____ Member employer _____

I have read and understand the above policies _____Today's Date _____
02/2014 (Patient Signature or Parent/Guardian if under 18)
PLEASE TURN OVER TO READ OUR OFFICE POLICIES AND SIGN

COLORADO VISION CENTER

OFFICE POLICIES

All doctors will do rechecks at no charge for the first 90 days after initial exam.
Labs have a one time, no charge remake for doctor RX changes within 60 days from purchase.

Exchanging from Progressive to other type of lens will be done within the first 30 days at no charge for equal or lesser amount. This is a courtesy and no refunds will be given.

Changing from lesser to more expensive lens style the difference in paid and due will be collected before product can be picked up within the first 30 days.

Changing frame &/or shape of lens will be allowed one time on any frame/lens and any difference in frame/lens cost will be due before product can be picked up, within the first 30 days.

All drill mounted lenses need to be in either Trivex or High-Index lens material for manufacturer's warranty, all other materials will be charged at 50% for remakes, within the first 30 days. If lenses only are wanted in the following years, know that the frame will need to be sent into the lab for correct placement of the drilled holes.

Anti Glare or AR warranties: Most have a 2 year 1 time replacement for scratch warranties; others are 1 year 1 time replacement.

Foundation XT Scratch protection has a 2 year 1 time replacement warranty.

Buy 2 pairs of glasses at the same time-same patient, second pair of equal or lesser value will be discounted 30% from original price/not insurance price if it was used on the first pair.

Come in occasionally to have your glasses tightened and screws checked, it is not uncommon for them to work loose.

CONTACT WEARERS:

There is an annual fitting fee to renew contact prescriptions. Contact prescriptions expire 1 year from finalized date. There is 90 days of follow up care with the doctor for any contact lens related issues included in the Contact Lens Evaluation fee.

After 90 days a minor office visit will be charged for any visit.

Unopened boxes in sellable condition, no marks on box or missing end tabs, can be returned with a restocking fee of $5.00 for first year after purchase. After 1 year there will a 50% credit for purchase of different contacts or glasses.

All professional fees for examinations are non-refundable if it is decided that contacts are not an option.

Purchase a year's supply (manufacture recommended) of contacts and they can be shipped directly to your home for no additional cost. To have contacts mailed to you from us will be $2.50.

I have read and understand the above policies_____

Patient/Parent or Guardian