**Elahi Eye Care, Inc.**

**303 McMillan Rd. West Monroe, LA 71291**

**Phone: 318-387-7257** **Fax: 318-325-7034**

| Patient Information | last name | first name | middle | maiden name | phone number |
|---|---|---|---|---|---|
| | | | | | |

| street address/p.o. box/route | city | state | zip | date of birth | age | sex ☐ m ☐ f |
|---|---|---|---|---|---|---|
| | | | | | | |

| occupation | driver's license number | social security number | fax number | cellular phone | e-mail |
|---|---|---|---|---|---|
| | | | | | |

| employer | city | state | work phone ( ) | workman's compensation? ☐ yes ☐ no |
|---|---|---|---|---|
| | | | | |

| marital status | spouse's name | spouse's social security # | spouse's birthdate | spouse's work phone ( ) |
|---|---|---|---|---|
| | | | | |

| spouse's employer and occupation | city | state | zip |
|---|---|---|---|
| | | | |

| Guarantor Information (for children) | last name (father) | first name | middle | phone |
|---|---|---|---|---|
| | | | | |

| billing address/p.o. box/route | city | state | zip | social security number | date of birth |
|---|---|---|---|---|---|
| | | | | | |

| employer | occupation | work phone number ( ) |
|---|---|---|
| | | |

| last name (mother) | first name | middle | phone number ( ) |
|---|---|---|---|
| | | | |

| billing address/p.o. box/route | city | state | zip |
|---|---|---|---|
| | | | |

| social security number | date of birth | employer | occupation | work phone number |
|---|---|---|---|---|
| | | | | |

| Name of relative or friend (not in same household) | name | relationship to patient |
|---|---|---|
| | | |

| address | city | state | zip | phone number ( ) |
|---|---|---|---|---|
| | | | | |

| Referred By | please indicate who referred you so we may thank them ☐ relative ☐ doctor ☐ yellow pages ☐ optometrist ☐ friend ☐ other _____ |
|---|---|
| referring person or doctor's name | has any member of your family ever been treated by our clinic? ☐ yes ☐ no ☐ don't know name(s) _____ |

| Payment/Insurance Information | how will you pay for today's visit? ☐ Medicare ☐ Medicaid ☐ Visa/MC ☐ cash/check ☐ _____ |
|---|---|

| medicare number | medicaid number | medicare supplement | policy number |
|---|---|---|---|
| | | | |

| insurance company | policy number | group number | name of insured |
|---|---|---|---|
| | | | |

**Signature on File:** _____ _____

Beneficiary Name (as written on card) Insurance ID number

I understand that **all** office visits are to be paid at the time services are rendered. I also realize that I may be responsible for payment before filing insurance and authorize the use of my signature on all insurance submissions. For any services rendered, I request that payment of authorized insurance benefits be made to Elahi Eye Care, Inc.

_____

Signature of patient or authorized representative Date

**Regarding the "Do Not Call" Law:** I give Dr. Elahi-Neal or a staff member from the office permission to contact me by phone, text, or email up to two years after my visit.

_____

Signature of patient or authorized representative Date

**Any past eye problem?** _____

_____

**Describe the reason for your visit today.** _____

_____

Medical Doctor _____

## Personal Medical History

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Diabetes |
| ☐ | ☐ | High Blood Pressure |
| ☐ | ☐ | Cataract |
| ☐ | ☐ | Stroke |
| ☐ | ☐ | Crossed Eyes |
| ☐ | ☐ | Arthritis |
| ☐ | ☐ | Asthma/Emphysema |
| ☐ | ☐ | AIDS |
| ☐ | ☐ | Cancer (including skin cancer) |
| ☐ | ☐ | Retinal Detachment |
| ☐ | ☐ | Heart Disease |
| ☐ | ☐ | Heart Attack? |
| ☐ | ☐ | Tuberculosis (TB) |
| ☐ | ☐ | Glaucoma |

## Family History

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Glaucoma |
| ☐ | ☐ | Cataracts |
| ☐ | ☐ | Diabetes |
| ☐ | ☐ | Eye Tumor |
| ☐ | ☐ | High Blood Pressure |
| ☐ | ☐ | Early Vision Loss |
| ☐ | ☐ | Macular Degeneration |
| ☐ | ☐ | Retinal Detachment |

## Social History

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Alcohol |
| ☐ | ☐ | Smoking |

Living Conditions:

☐ Widowed
☐ Married
☐ Nursing Home
☐ Single

## Medications

_____
_____
_____
_____
_____
_____
_____
_____
_____
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_____
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_____
_____

## Past Eye Surgery

_____
_____
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_____

## Other Past Surgeries

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies _____

_____

_____

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# Please read the following statements and sign:

These authorizations shall be binding indefinitely for the date of signature. A copy of this release will be as legal and binding as the original.

## Acknowledgment of receipt of Notice of Privacy:

Also, I understand that my medical information is protected as defined in Elahi Eye Care, Inc. Privacy of Practice statement. I acknowledge that I was provided or had the opportunity to read and understand a copy of the Notice.

_____
Signature of patient or authorized representative Date

## Authorization to Release Information:

Many of our patients allow family members such as their spouse, significant other, parents, or children to call and request the results of tests, procedures, and financial information. Under the requirements for HIPPA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members, you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

**I authorize Elahi Eye Care, Inc. to release my records and/or information to the following individuals:**

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____
4. _____ Relation to Patient: _____

_____ _____
Patient Name (PLEASE PRINT) Date

_____
Patient Signature

# Return Policy for Eyeglasses and Contact Lenses

## Eyeglasses

All sales of prescription eyeglasses are final. If, however, there are any discrepancies between the doctor's prescription and the lenses manufactured by the lab, or between the doctor's prescription and the actual prescription, any adjustments to the prescription lenses are included at no charge within 60 days. All orders are required to be paid in full before being place. Adjustments for glasses and minor repairs are provided for free of charge. Professional services (doctor's visit) are nonrefundable.

All name-brand eyeglass frames are under warranty for any manufacturing defects for up to one year from the date of purchase. This does not include any accidental damage or breakage that has been incurred to the frames.

Though the frames are covered under manufacturer warranties, the manufacturer do not pay for the shipping and handling for the exchange of the defective frames. The patient will be responsible for the **$20.00 shipping and handling fee** for all frame warranties. Also, there will be a 3-frame limit within the year that your prescription is valid. This will need to be paid in full before the frame is ordered and will cover the cost of shipping, handling, and fitting the warrantied frame.

If the eyeglasses are not picked up within one calendar year the materials will become the property of Elahi Eye Care.

## Contact Lenses

Regarding the sales of non-specialty soft contact lenses, any unopened & unmarked boxes may be returned for a full refund or exchange within 60 days of purchase. If the patient does not pick up his/her contact lenses within one year, the materials become the property of Elahi Eye Care.

## Policy for accepting personal checks and bounced checks

Though personal checks are accepted, any bounced checks are subject to a $35.00 fee. This will be paid in addition to the original amount within 60 days. No other services will be rendered to the patient until these fees are paid in full.

_____ _____ _____

Patient Name Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship.

_____ _____

Representative Relationship to patient

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# Notification of Non-Covered Services

Some services, like contact lens fees, are defined as non-covered services and are not medically necessary for your eyes and will not be covered by your insurance (_____). Yet, other procedures like red/irritated eyes and retinal scans or photos, are not paid by your medical insurance (_____) until medical deductibles are met. Please note that these medical visits cannot be filed on you vision insurance plan. Only after your medical claim is filed can we ascertain that your deductibles are met. You will be expected to pay for those services listed below, in full.

Let me reassure you that I will order only the tests and treatments that I feel are necessary for your treatment and care. If you have any questions about whether a service is covered by your health benefits contract, someone in our office will be happy to assist you. Thank you for your understanding.

_____ _____ _____

Noncovered service(s)/ Amount due | Patient signature | Date

# 24 Hour Cancellation & No-Show policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. As a courtesy, and to help patients remember their scheduled appointments, our system sends text message reminders prior to your appointment time. If your schedule changes and you cannot keep your appointment, please contact us within 24 hours of your appointment, so we may reschedule you, and accommodate those patients who are waiting for an appointment.

Therefore, if you do not cancel or reschedule your appointment with at least 24 hours' notice, Elahi Eye Care reserves the right to charge a fee of $35.00 for all missed appointments. This "no-show charge" is not reimbursable by any insurance company. You will be billed directly for it. Multiple "no shows" in any 12-month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients.

_____ _____ _____

Printed Name | Patient Signature | Date

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# Frame Reuse, Adjustment Liability Waiver, Outside Rx

## _____ Adjusting/Repairing Frames

An optician has examined your frame and found the following:

- ☐ The frame is of an unknown age.
- ☐ The frame was not purchased from one of our locations.
- ☐ The frame is out of warranty.
- ☐ The frame materials are weak or have been damaged.

We are happy to attempt to adjust your frame and/or perform minor repairs, but we assume no liability for breakage or further damage to the frame. In the unlikely event that your frame should break or become further damaged, the cost of a replacement frame (and lenses if applicable) will be at your expense.

## _____ Placing New Lenses in a Reused Frame

We are happy to make new prescription lenses for your own frame if it's in good condition and fits your face properly. If we accept your frame for re-use, we pledge to use the utmost care in handling it. But in a small percentage of cases, the frame material will be worn or brittle to the point that it will not support a new pair of lenses. Please be aware that older frame styles are often discontinued by the manufacturer and replacement parts are usually not available. This presents a problem if the frame breaks and can't be repaired. If your frame breaks during our lens insertion process, the lenses initially made for that frame cannot be re-used for a different frame style. We will make new lenses at no additional charge for any new frame you choose, but the cost of the replacement frame will be at your expense.

## _____ Filling Outside Medicaid Prescriptions

We will only fill outside prescriptions one time per patients. We request that all future prescriptions must be from Elahi Eye Care.

(Note: on average, Medicaid only pays $14.96 for the frame and $19.30 for the lenses)

***My signature below indicates that I understand and accept the policy marked.***

Patient Name (Print): _____ DOB: _____

Patient Signature: _____ Date: _____

Office Use Only:

Frame: _____ Color: _____

Eye Size: _____ Bridge: _____ Temple: _____ Optician: _____