

OPTOMETRIST
DR. STEVEN C. MOORE & ASSOCIATES

WELCOME TO OUR OFFICE

Please give your **Major Medical Insurance Card** to the receptionist. Insurance card must be presented prior to your exam. No refunds will be given on work already in progress. **The contact lens portion of the exam and the contact lens fittings are your responsibility and must be paid in full at the time of the exam.**

How were you referred to our office? _____ **Today's Date:** _____

Name _____

Reason for Visit: _____ Marital Status: _____

Social Security Number of Patient: _____ Birth Date: _____

Age: ____ Sex: ____ Occupation: _____ Employer: _____

Street Address: (Home) _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Email Address: _____

Current Medications: _____

Any Known Allergies? _____

Do You Have Any of the Following?:

Diabetes: _____ High Blood Pressure: _____ Kidney Problems: _____

History of Heart Surgery: _____ Recent Dental Work: _____

Glaucoma: ____ Eye Disease: ____ Past Eye Surgery: ____ Past Eye Injuries: _____

Last Eye Exam Date and Doctor: _____

Primary Physician's Name: _____

Major Medical Insurance Info:

Insurance Company: _____ Phone #: _____

Type of Plan: HMO / PPO / EPO / OPEN ACCESS / MAJOR MEDICAL

Primary Insured: _____ DOB: _____ SS#: _____

Employer: _____ Group # _____

ID#: _____ Policy #: _____ Medicare: _____

Vision Coverage Info:

Covered By: VSP / EYEMED / COMMUNITY EYECARE / MAJOR MEDICAL

Primary Insured: _____ DOB: _____ SS#: _____

CONTINUED ON BACK...

OPTOMETRIST
DR. STEVEN C. MOORE & ASSOCIATES

Financially Responsible Party (if different from patient):

Name: _____ Relationship to Patient: _____

DOB: _____ SS#: _____ Employer: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

*We are not responsible for breakage or tears if lenses are inspected or polished. If you choose to have new lenses put into your current frame, we are not responsible for breakage or damage.

Payment is expected in full at the time of the examination.

Responsible Party Signature: _____

*We recommend an annual eye exam to maintain your best vision and guard against ocular health problems. A dilated exam is also recommended every year. Also, if you choose not to have your eyes dilated, we offer the Optos System. In most cases this system eliminates the need for dilation; however, Optos is not covered under insurance at this time. If you prefer the Optos scan in place of dilation, please sign below.

Responsible Party Signature: _____

Patient Responsibility Statement

I, _____, understand that even though Dr. Moore's Office calls to verify eligibility and benefits, this is not a guarantee of payment. I allow assignment of my insurance benefits to Dr. Steven C. Moore. I will be financially responsible for payment of all charges incurred for services received from this doctor's office.

Responsible Party Signature: _____

****Contact Lens Patients:***

A **contact lens evaluation is an addition** to a routine eye exam. It includes all follow-up visits necessary to provide you with a healthy proper fit. We will use as many diagnostic/ trial lenses as needed. Trial lenses are supplied at no cost to you. However, we receive trial lenses based on orders placed by our patients. Therefore, there will be a service charge of \$10.00 for spherical lenses and \$20.00 for toric or multifocal lenses (specialty lenses will be priced accordingly). This service charge will be applied toward the purchase of your contact lens order after a final Rx has been written. Also, contact lens patients ordering a one year supply of contact lenses will receive a 10% discount on non-prescription sunglasses (Maui Jim, Oakley, etc.).

Responsible Party Signature: _____

Dr. Steven C. Moore & Associates

Thank you for choosing Dr. Moore for your contact lens needs. We assure you we are committed to your eye health and comfort. Below we have compiled contact lens terminology and procedures that you should know.

Primary Health Exam: This is an annual exam that evaluates your eye health and vision correction needs. Dilation/ Optos is recommended every year.

\$129 Established Patient \$157 New Patient \$40 (Optos) Replaces Dilation

Contact Lens Evaluation: Determines the curvature, power and diameter of the contact lenses that you will be prescribed. A diagnostic set of contacts is included. Your prescription is evaluated to best suit your lifestyle and vision needs.

Premium \$95 Toric \$160 RGP I \$200 RGP II \$300 Synergeyes \$300 Keratoconus/ IC \$500

Training: All New contact lens wearers will be trained by our staff on proper procedures of insertion, removal, and solution care. A starter kit of solutions will be provided. \$55

Contact Lens Follow-Up: 1 follow up visit is included in your evaluation fee for Single Vision contact lens wearers. Toric and Bifocal contact lens evaluations are limited to 4 visits within the first 3 months. If you do not return for your contact lens check before the lenses you are wearing has expired, you will be charged \$30.00 for the office visit and a dispense fee for the new lenses. Additional fee of \$30.00 per visit will be charged to you for difficult extended fittings, past the initial 4 visits. A fee of \$30.00 will be charged if your follow up care exceeds the above mentioned time frame. These fees are due at the time of office visit.

ADDITIONAL FEES ARE CHARGED FOR SHIPPING OF RETURNED SPECIALITY LENSES, IF MORE THAN 4 RETURNS ARE MADE ON YOUR CONTACTS. AN OFFICE VISIT FEE WILL BE CHARGED FOR MEDICAL VISITTS CAUSED BY OVER WEAR, ABUSE, OR INFECTION. Your medical insurance will be billed for these visits. Co-pay is due at time of office visit.

Refunds: Professional services are non-refundable. Refunds on specialty contact lenses are 80% of their cost, minus their shipping and handling fees.

Patient Signature _____ Date _____
Understands office policy on professional contact lens fees.