WELCOME BACK TO OUR CLINIC!
We understand you have a choice when it comes to your eye care.
Thank you for choosing to return to My Little Eye Shop LLC!

FULL NAME: _____

What brings you into our office today? _____

I want to wear: ☐glasses ☐soft contacts ☐rigid gas perms ☐None

Have you been diagnosed with any new medical conditions or have any of your medications changed since your last exam? ☐Yes ☐No

Females: Are you currently pregnant or nursing? ☐Yes ☐No

Please read and initial the following statements.

_____ **Consent for treatment:** I/We hereby authorize My Little Eye Shop LLC to administer diagnostic and eye medical procedures as may be necessary for proper health care

_____ **Authorization to release information:** I/We hereby authorize My Little Eye Shop LLC to release any medical or incidental information that may be necessary for medical benefits or in processing of applications for financial benefits. This includes but is not limited to my insurance company.

_____ **Financial agreement:** I understand that I am responsible for payment of all charges. As a courtesy, my primary insurance will be billed for me. It is my responsibility to pay any deductible, co-pay, or any other balance not paid for by my insurance company within 90 days of my insurance company's response to my claim. I authorize insurance benefits to be paid directly to my provider. I understand my insurance benefits as quoted to me at the beginning of this visit is only an estimate. My balance will be estimated and collected at the end of my visit today including deductible and co-insurance if applicable.

_____ **Notice of privacy:** I understand that I may request a copy of My Little Eye Shop LLC's Notice of Privacy Policies.

_____**Optos digital eye scan (refer to laminated sheet for details):**

I am aware of the benefits and the cost of the digital eye scan ($25.00).

☐**Yes! I would like the scan.** ☐**No thanks, I will consider it next time.**

_____**Contact lens evaluation:** I understand that this fee & contact lens training fee is **non-refundable** and that I have a **90-day time period** while trying out contact lenses to have my contact lens prescription finalized or to return to clinic for contact lens follow up appointments. I understand that all contact lens refit request/follow-ups **AFTER** 90-days from the initial contact lens exam date is subject to additional fees.

The contact lens fees are in addition to the basic exam fee of $80.00 when the evaluation is performed on the same day as the exam. When the evaluation is NOT performed on the same day, then the contact lens evaluation is subject to additional fees.

Training Fee for 1st time CLs wearers $20 / Sphere evaluation $25 / Non-Sphere evaluation $40.

(The type of evaluation is determined once your doctor determines your prescription for glasses.**)**

Signature: _____Date: _____

If signing for a minor, please indicate relationship: _____

Please list those individuals with their relationship to you with whom we may communicate exam results:

Name: _____Relationship_____

Name: _____Relationship_____

Emergency Contact: Name/Relationship: _____ Phone: _____