Gilman & Vorster Optometry
Patient Information Update Form

Dear Patient:

Please take a moment to complete this form so we can make sure our records are current and accurate.

Name: _____ Date:_____
Last Name First Middle Initial

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

Date of Birth: _____ SSN: XXX-XX- _____

Best Phone: _____ Alternate Phone: _____
Indicate Mobile / Home / Work Indicate Mobile / Home / Work

Texting Authorized: Yes No

Email address: _____

Name of Person to contact in case of emergency:

_____
Last Name First Relationship

Phone # of above: _____

Health History

Reason for Today's Visit: _____

Date of last Eye Exam: _____ Name of last Eye Doctor: _____

Date of last Physical Exam: _____ Name of Physician: _____

Do you or anyone in your immediate family (mother, father, siblings) have or have a history of the following:

_____ Diabetes ____ High Blood Pressure ____ High Cholesterol ____ Heart Disease ____ Glaucoma

_____ Blindness ____Macular Degeneration ____Lazy Eye ____Thyroid Disease

Do you wear: Glasses?_____ Contacts?_____ Brand: _____ Interested in contacts? ____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

My signature below also acknowledges that I was given the opportunity to receive the Privacy Policy Practices of Gilman & Vorster Optometry, Inc. and that I understand the FTC and Contact Lens Rule. In addition, I hereby give consent to Gilman & Vorster Optometry to evaluate and treat the patient listed above. I understand that my personal health information will be used for treatment, payment, and the coordination of the healthcare needs of the patient.

All patients must sign and date:

_____ _____
Signature of Patient Date

OFFICE POLICIES

In response to the complex healthcare industry, we have taken steps to optimize our operations in order to spend more time on patient care and less time on administration. This requires your help. Please carefully read the items below as they will be strictly enforced. Our goal is to provide high quality, compassionate, and timely healthcare.

CANCELLATION POLICY

Missed appointments represent a cost to us, to you, and to the other patients who could have been seen in the time set aside for you. **If you are unable to keep your appointment, please give 24-hour notice or you will receive a $50 charge.**

Signature: _____ Date: _____

PAYMENTS and INSURANCE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable co-payments and co-insurance for participating insurance companies. We accept cash, personal checks, Visa, MasterCard, Discover, American Express and Care Credit. There is a $25 service charge for returned checks.

We bill participating primary insurance companies as a courtesy to you. You are expected to pay your deductibles and co-payments at the time of service. If we have not received payment from your insurance company, you will be expected to pay the balance in full. You are responsible for all charges.

Medicare does not cover the cost of a refraction for which we charge $40.00. We will gladly bill Medicare for the refraction fee and refund the charge if your secondary insurance reimburses us.

Signature: _____ Date: _____

CONTACT LENSES / FTC Rule

Additional measurements and testing are done to determine a contact lens prescription. Therefore, **we charge an additional fitting fee for contact lenses** at the beginning of the fitting process. Please ask our staff for a detailed fee structure prior to commencing with the contact lens fitting process. You may elect to have your fitting billed to your insurance. However, if you do not return to complete the fitting, your insurance will be billed and you may lose benefits. Fees for custom lenses are due at the initiation of the fitting process. Once the fitting process is completed, your prescription will be released to you to be filled in the manner of your choice. My signature indicates I have received a copy of my finalized contact lens prescription and/or I agree to allow the practice to transmit the prescription via email.

Signature: _____ Date: _____

ANIMALS

Only service animals are welcome in our office. Please let our staff know that your animal is a service animal and what work or task the dog has been trained to perform so that we do not disrupt the animal's performance of these duties.

Signature: _____ Date:_____