

Welcome to Drs Sandy & Andrew Mann's office

Patient's Last Name _____ First Name _____ Date of Birth _____ Home Phone _____

Address _____ Town _____ Zip Code _____ M or F? _____ Work Phone _____

Social Security Number _____ Employer _____ Job Description _____ Cell Phone _____

Method of Payment: Private Pay or Insurance Name & Number _____

Primary Insurance Holder is Patient Above-IF NOT, LIST PRIMARY POLICY HOLDER:

Primary Policy Holder's Full Name & Address _____ Date of Birth _____ Social Security Number _____

What visual problems are you having? Blurry Vision, Headaches, Want Contacts, etc...

Date of Last EYE Exam _____ Date of Last MEDICAL/PHYSICAL (NOT EYE) Exam _____

I Have No Drug Allergies OR List Allergies to any Medications _____

I Take No Medications OR List ALL medications you are taking *plus* DOSAGE _____

VSP Insurance only: Please list your weekly consumption of Alcohol _____ and Tobacco _____

Do you or anyone in your family have any of the following? ✓ = Yes, Blank = No

Self / Family

- Glaucoma
- Turned Eyes
- Macular Degeneration
- Diabetes
- Headaches

Self

- See Double (*not* ghosted)
- See Flashes (*not* floaters)
- Use Eyedrops Name _____
- Serious Eye Injuries/Surgery
- Currently or Possibly Pregnant

Self

- Contact Lens Wear
- High Blood Pressure
- Heart Problems
- Breathing Problems
- Other _____

A **Contact Lens Prescription** requires extra visits and extra fees. See Contact Lens Wearer's Agreement.

- I DO want a contact lens prescription I DO NOT want a contact lens prescription

Dilation of the pupil is considered a necessary part of a routine eye examination *every year*. Eyedrops open the pupil, allowing the doctor a complete view of the interior structures of the eye. This facilitates the detection and diagnosis of many diseases, including glaucoma, cataracts, blood vessel leakage due to diabetes and high blood pressure, and retinal holes, tears and detachments, and in some cases, tumours. This is considered a non-covered service by most insurances. There is an additional \$20 fee for this test.

- I DO want my eyes dilated I DO NOT want my eyes dilated

A sophisticated computerised instrument can allow us to provide a more thorough analysis of the health of the entire visual system from the eye to the back of the brain by measuring the **visual field**. Field testing can assist us in early detection of glaucoma, retinal problems and neurological diseases, among other conditions. We strongly recommend that our patients receive a *screening version* of this test. There is an additional \$15 fee for this test.

- I DO want the visual field screening I DO NOT want the visual field screening

Fees for all visits to the office are due and payable at the time of service. There are additional fees for contact lens evaluation. A separate contact lens agreement will specify the maximum number of visits included in contact lens fitting. No refunds will be made if fewer than the number of visits specified are needed. Apart from routine contact lens visits, each visit to this office will involve a separate fee or co-payment. All professional fees are for our time and opinion and are not refundable. Frames and non-custom contact lenses may be returned in their original condition for an in-store credit within 30 days. Eyeglass lenses, custom contact lenses, opened boxes of disposable contact lenses and specially ordered items **cannot be returned**. Low vision devices (other than spectacle lenses) may be returned within 30 days in their original condition and packaging less a 20% restocking fee. The success of any prescription is not guaranteed and the doctor is not financially responsible for remaking glasses or contact lenses. If a progressive lens or any expensive lens prescription is remade as a less expensive lens at no charge as a courtesy, Visionmann will not refund or credit the difference. There is only one optical establishment we know of which refuses to remake glasses at no charge. If you use such a place, you agree that it is against our recommendation and that you do so at your own risk. All insurance benefits or coupons must be presented when filling in this form - they cannot be used after services have been rendered and cannot be presented later for a refund or credit. I understand that I am financially responsible for charges not covered by my insurance and for charges incurred by my dependents. **Low Vision Devices Evaluation or Prismatic Binocularity Assessment (\$75) and Refraction (\$30) are considered a non-covered service by Medicare, Medicaid and most insurances. I agree to pay for this in addition to any co-payment or deductible.** I agree to pay reasonable collection fees, legal fees and court costs regarding collection of unpaid balances. I agree to pay a monthly billing fee of \$15 per month on all balances due over 30 days until my balance is paid in full. I hereby authorize Dr. Mann to release any information necessary to process my insurance claim. HIPAA: I acknowledge that I have been presented with the "Notice of Privacy Practices Policy" of Andrew Mann Optometrist PA and have been offered a copy to keep. I agree to allow Andrew Mann Optometrist PA employees to call my telephone numbers and leave messages and to contact me by mail or email. The messages and correspondence may include identification indicating that they are from Andrew Mann Optometrist PA, its DBA, or an individual employee. **Informed Consent and Request for Treatment:** I hereby request Andrew Mann Optometrist PA and its doctors to examine and treat me. I understand that the examination involves touching the eyes or bringing objects close to the eyes. Tonometry, Gonioscopy, Pulsatile Ocular Blood Flow, Perimetry, GDx, OCT, Visante, fingers, frames, lenses, eyedrop bottles and Contact Lenses may scratch the eyes and I consider this an acceptable risk to take in order to have my eyes examined. Anaesthetic and Dilation eyedrops can cause adverse systemic effects, including fainting/loss of consciousness, interaction with systemic medications, sudden change in blood pressure and heart rate, or even death. I consider these acceptable risks to take in order to have my eyes examined. I hereby request that these tests or procedures be performed when considered necessary by the doctor.

Date _____ Signature of Patient or Guardian (OVER 18) _____