

Last Name: _____ First Name: _____ M.I.: _____

DOB: _____ Age: _____ SSN: _____ Sex: ☐ Male ☐ Female ☐ Undifferentiated ☐ Decline to Specify

Address: _____

City: _____ State: _____ Zip: _____

*Phone Numbers: Home ☐: _____ Work ☐: _____ Cell ☐: _____

* Check box next to phone number(s) where we may leave a message

E-mail Address: _____

Employer Name: _____ Occupation: _____

How were you referred to NVISION Eye Centers?

☐ Doctor Referral: ☐ Family/Friend/Past Patient – Did they have refractive surgery with us? ☐ Yes ☐ No

* First & Last Name

* Name & Relationship

☐ Internet ☐ YELP ☐ Google ☐ Instagram ☐ Facebook ☐ Drive-by ☐ Benefits Provider

☐ Health/Workplace Event ☐ Newspaper/Magazine/Advertisement ☐ Radio

☐ Other: _____

Which of the following above influenced you the most to schedule an appointment with us? _____

Primary Physician (Full Name): _____ Phone: _____ City: _____

Optometrist (Full Name): _____ Office (Name): _____ City: _____

Has your optometrist discussed Laser Vision Correction with you? ☐ Yes ☐ No

Did they refer you to NVISION? ☐ Yes – Which surgeon were you referred to? _____

☐ No – Who were you referred to? _____

Pharmacy: _____ Phone: _____ City: _____

Primary Insurance: Insurance Co. Name: _____ ID#: _____ Group#: _____

Subscriber Name (if not self): _____ Subscriber's Date of Birth (if not self): _____

Secondary Insurance: Insurance Co. Name: _____ ID#: _____ Group#: _____

Subscriber Name (if not self): _____ Subscriber's Date of Birth (if not self): _____

Vision Insurance: Insurance Co. Name: _____ ID#: _____ Group#: _____

Subscriber Name (if not self): _____ Subscriber's Date of Birth (if not self): _____

Emergency Contact Information/Designated Individuals Release: NVISION Eye Centers may release to, or discuss my personal health information (PHI) (except regarding treatment ☐ , payment ☐ , and/or administrative operations ☐), with the individuals listed below, verbally or in writing. I understand that NVISION will make best efforts to verify the identity of the designated parties before disclosing PHI. I also understand that I may change any of the Emergency Contact Information/Designated Individuals Release information at any time in writing. **Appointment Reminder Release:** ☐ I authorize NVISION may release my name, treatment date, and contact information to a local partnering Optometrist who may prompt me with annual appointment reminder to facilitate follow up care.

Name: _____ Relationship: _____ Ph#: _____

Name: _____ Relationship: _____ Ph#: _____

My signature below indicates that the information provided above is accurate and complete to the best of my ability, and that you acknowledge you were advised of the Notice of Privacy Practices (NPP) for NVISION. Our NPP provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our NPP is subject to change. The notice of Privacy is available on our website at www.nvisioncenters.com and in our office. You may request a copy of the NPP.

Signature of patient (if over 18) or patient's parent or legal guardian

Date

If signed by parent or legal guardian, print name

Relationship

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female ☐ Undifferentiated ☐ Decline to Specify

Glasses/Contact Lenses (Please check appropriate boxes below)

Do you currently wear glasses? ☐ No ☐ Yes If yes, how old are your glasses? _____ Type? _____

Do you currently wear contact lenses? ☐ No ☐ Yes If yes, for how long? _____ Type? _____

Have you ever tried contact lenses? ☐ No ☐ Yes When did you last wear contacts? _____

Allergies (Meds/Latex/Anesthesia): ☐ No ☐ Yes If yes, which ones: _____

Current Medical Problems: ☐ HTN (High Blood Pressure) ☐ Elevated Lipids (High Cholesterol) ☐ Diabetes Type I ☐ Diabetes Type II ☐ Sjogren's

☐ Rheumatoid Arthritis Other: _____

***If applicable, are you currently or possibly pregnant?** ☐ No ☐ Yes | ***If applicable, are you currently breastfeeding?** ☐ No ☐ Yes

Previous Surgeries: _____

Family History (M-Mother, F-Father, S-Sister, B-Brother, MGM/MGF-Maternal Grandmother/Father, PGM/PGF-Paternal Grandmother/Grandfather)

☐ Glaucoma _____ ☐ Diabetes _____ ☐ Cancer _____ ☐ HTN (High Blood Pressure) _____ ☐ Keratoconus _____

☐ Retinal Detachment _____ ☐ Color Blindness _____ ☐ Macular Degeneration _____ ☐ Other _____

Social History (Please check and/or circle appropriate boxes below)

Do you drive? ☐ No ☐ Yes

Do you drink caffeine? ☐ No ☐ Yes

If Yes, type & amount? _____

Do you drink alcohol? ☐ No ☐ Yes

If Yes, amount & how often? _____

Do you smoke tobacco? ☐ No ☐ Yes If yes, how often? _____

Do you currently vape? ☐ No ☐ Yes If yes, with/without Nicotine? _____

If Yes, have you ever tried to quit? ☐ No ☐ Yes

If Yes, when or how long ago? _____

Have you had passive smoke and/or vaping exposure? ☐ No ☐ Yes

Current Medications:

*Include over-the-counter

☐ No ☐ Yes _____

Review of Systems: Do you currently have any of the following symptoms? (Please check the appropriate boxes below)

Environmental Allergies	☐ No ☐ Yes	Polydipsia (Excessive Thirst)	☐ No ☐ Yes	Rash	☐ No ☐ Yes
Food Allergies	☐ No ☐ Yes	Polyphagia (Excessive Hunger)	☐ No ☐ Yes	Arthralgia (Joint Pain)	☐ No ☐ Yes
Chest Pressure	☐ No ☐ Yes	Hearing Loss	☐ No ☐ Yes	Joint Swelling	☐ No ☐ Yes
Chest Discomfort	☐ No ☐ Yes	Constipation	☐ No ☐ Yes	Muscle Weakness	☐ No ☐ Yes
Irregular Heartbeat	☐ No ☐ Yes	Diarrhea	☐ No ☐ Yes	Dizziness	☐ No ☐ Yes
Heart Palpitations	☐ No ☐ Yes	Vomiting	☐ No ☐ Yes	Gait Disturbances	☐ No ☐ Yes
Fatigue	☐ No ☐ Yes	Dysuria (Painful Urination)	☐ No ☐ Yes	Headache	☐ No ☐ Yes
Fever	☐ No ☐ Yes	Hematuria (Blood in Urine)	☐ No ☐ Yes	Emotional changes	☐ No ☐ Yes
Night Sweats	☐ No ☐ Yes	Polyuria (Excessive Urination)	☐ No ☐ Yes	Cough	☐ No ☐ Yes
Cold Intolerance	☐ No ☐ Yes	Bruising	☐ No ☐ Yes	Wheezing	☐ No ☐ Yes
Heat Intolerance	☐ No ☐ Yes	Easy Bleeding	☐ No ☐ Yes	Other: _____	

Eye History: Have you ever had or been told you have: (Please check appropriate boxes below)

☐ Cataracts	☐ Cataract Surgery	☐ Herpes Infection of the Eye	☐ Foreign Body Sensation
☐ Glaucoma (High Eye Pressure)	☐ Laser Eye Surgery	☐ Recurrent Corneal Erosion	☐ Irritation or Dryness
☐ Macular Degeneration	☐ Pterygium Surgery	☐ Blurred or Double Vision	☐ Excessive Tearing or Watering
☐ Diabetic Retinopathy	☐ Corneal Surgery	☐ Glare/ Light Sensitivity	☐ Mucous Discharge
☐ Flashes or Floaters	☐ Eyelid Surgery	☐ Distorted Vision / Halos	☐ Redness
☐ Retinal Tear/Detachment	☐ Eye Injury	☐ Loss of Vision	☐ Drooping Eyelids
☐ Keratoconus	☐ Amblyopia (Crossed/Lazy Eye)	☐ Eye Pain or Soreness	☐ Other: _____

☐ I understand that dilating eye drops may be used in my examination and may blur my vision, making it unsafe to drive. I will not attempt to drive until I am certain the effect of the medicine has worn off. The effect of the drops may last an hour or longer.

My signature below indicates that the information provided above is accurate and complete to the best of my ability.

Signature of patient (if over 18) or patient's parent or legal guardian

Date

If signed by parent/legal guardian, print name

Relationship

**ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE OF
PRIVACY PRACTICES AND PATIENT BILL OF RIGHTS**

Patient Name: _____ **Date of Birth:** _____

By signing below, you:

- Acknowledge that you have been informed of the Privacy Practices and Patient Bill of Rights.
- Acknowledge that you have access to a copy of these documents in the center.

Signature of patient

Date

Are you completing this form for someone else?

☐ Check here if you are signing as a personal representative, and complete below. Unless you're the parent of a minor child, please attach documented proof that you are acting on that person's behalf (for example, power of attorney)

Printed name of patient's personal representative

Date

Signature of patient's personal representative

Relationship

References Available on the Internet:

www.hospitalconnect.com/aha/about/pbillofrights.html

www.isrs.org

Other References:

Internal Society for Refractive Surgery Position Paper on Co-Management of Refractive Surgery Pre-operative and Post-operative Care, 2001 available from www.isrs.org

NOTICE TO CONSUMERS

Medical Doctors are licensed and regulated by the:

Medical Board of California www.mbc.ca.gov

Oregon Medical Board www.oregon.gov/OMB

Washington Medical Commission <https://wmc.wa.gov/>

Medical Board of Utah commerce.utah.gov/dopl/physician-and-surgeon

Texas Medical Board www.tmb.texas.gov

Arizona Medical Board www.azmd.gov

PAYMENT POLICY

Name: _____ Date of Birth: _____

BASIC POLICY:

Payment for service is due in full at the time service is provided in our office.

PATIENTS WITH INSURANCE:

LASIK/REFRACTIVE SURGERY Is NOT A COVERED BENEFIT FOR MOST INSURANCE PLANS

Some treatments are billable to insurance, while others are not. NVISION doctors are contracted with Medicare and selective private insurances. If you have OUT-OF-NETWORK benefits and your NVISION provider is not contracted with your carrier, payment is due in full at the time of service. If we are not contracted with your insurance company, you have the ability to submit a claim to your insurance provider and NVISION will supply you with the necessary information to do so. NVISION does not guarantee that your insurance provider will reimburse for services rendered. NVISION is not responsible for denied insurance claims.

We will bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Co-payments and deductibles are due at the time of service. We can only bill for surgeon fees. You must contact the facility where your surgery is performed and inform them to bill facility fees, anesthesia, etc. on your behalf. We cannot guarantee that the facility is in network with your individual insurance company. You must contact the facility prior to your surgery to verify services will be covered. Since your agreement with your insurance is a private one, we do not routinely research why an insurance carrier has not paid or why it has paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full by you.

NON - COVERED SERVICES:

Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

CREDIT CARD PROCESSING FEE:

A 2.5% processing fee applies to credit card payments (debit cards excluded); certain covered services may be exempt depending on your insurance plan.

ASSIGNMENTS OF INSURANCE BENEFITS:

I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in lieu of the original. I understand I am financially responsible to NVISION for the charges incurred.

**I have read, understand and agree to the above financial policy for payment of professional fees.
I understand that I am ultimately responsible for all professional fees.**

Signature of patient (if over 18) or patient's parent or legal guardian

Date

If signed by parent or legal guardian, print name

Relationship

CREDIT OR DEBIT CARD ON FILE:

It is the policy of NVISION Eye Centers that all patients maintain a valid credit or debit card on file as a standard part of registration. Medicaid/Medi-Cal exemption: This requirement does not apply to services covered by Medicaid, including Medi-Cal and other state Medicaid plans. No card on file is required or charged for Medicaid-covered services. I authorize NVISION Eye Centers to retain the card I provide in encrypted form with its PCI-compliant payment processor, and to charge that card any patient-responsibility balance determined after my insurance plan has processed a claim and issued an Explanation of Benefits (EOB), up to \$500 per encounter; any remaining balance above \$500 will be billed through NVISION's standard billing process. This signed authorization constitutes my notice of such charges, and no additional notice will be provided before a charge is processed. This authorization remains in effect until I revoke it in writing.

Signature of cardholder

Date

PATIENT AUTHORIZATION TO RECEIVE THIRD-PARTY ELECTRONIC COMMUNICATION

Name: _____ Date of Birth: _____

Laser Eye Care of California, LLC, Laser Eye Care of California II, LLC, and the subsidiaries that are collectively known as NVISION, utilize third-party services that utilize artificial intelligence capabilities to record patient encounters, create medical record documentation, and also provide electronic communications designed to assist with ensuring timely and accurate patient communications. These communications may come in the form of pre-recorded phone calls, text messages, and links to personalized videos. NVISION would like your consent to utilize these services to transmit limited information to you.

Electronic communications may include:

- Appointment reminders that contain the patient's first name, location of the appointment, and the purpose of the appointment.
- Attempts to collect additional insurance or patient information necessary to obtain prior authorization or treat a particular patient condition, and to provide you with estimates of your financial responsibility (such as your estimated cost share) prior to your appointment.
- Create the patient medical record documentation.
- Attempts to collect out-standing patient financial responsibility.

When applicable standard data rates may apply.

RISKS:

NVISION and our Business Associates will only send the minimal information necessary to accomplish the business or treatment purpose and make every effort to ensure the electronic communications are confidential. There are risks that these communications may be intercepted, and if so NVISION will not be liable for the nefarious use by unauthorized persons.

PATIENT OPT-IN AGREEMENT:

I have been made aware that NVISION uses third-party organizations to send electronic communications such as pre-recorded phone calls, personalized videos, and email. I understand the risks associated with receiving these communications. I have decided to **opt in** to receive electronic communications to my personal contacts below:

Home Phone: _____

Cell Phone: _____ (data rates may apply)

Email: _____

☐ **SMS Text Message Consent:** I agree to receive text messages (SMS) from NVISION Eye Centers at the cell phone number provided above. Message frequency varies.

Patient Signature

Date

Patient Printed Name

RIGHT TO OPT-OUT:

As a patient you have the right to **opt out** of receiving electronic communications at any time. You may do so by contacting NVISION. If you choose to opt out at this time, please check the box below and initial. For text messages, you may opt out at any time by replying STOP.

☐ At this time, I am opting-out of the receiving electronic communications. Patient Initials: _____