

Douglas Kimball, O.D., Jody Fink, O.D., Jennipher Harper, O.D., Tel Todd, O.D., Joseph LeMay O.D., Sarah Kirkpatrick O.D. F.A.A.O

# New Patient Packet

Welcome to Advanced Eyecare,

We are so excited to have you as a new patient! To make your check in quick and easy we ask that you fill out the following forms in full and email them back to our office at least 24hrs before your scheduled appointment.

We look forward to meeting you!

4265 Fallon Street, Suite B, Bozeman, MT 59718 Phone: 406.587.0668 Fax: 406.587.0396 Email: advanced.eyecare@aecmt.com

91 West Madison Ave, Belgrade, MT 59714 Phone: 406.388.1988 Fax: 406.388.2488 Email: belgrade@aecmt.com



New Updated	Today's I	Today's Date	
Legal First name	MI Last		
Soc Sec # Date of	Birth Marital Status	Sex	
Mailing Address	City	State	
Zip Phone	Email address:		
Employer Name:	Phone:		
	Guardian/Spouse Information		
Parent 1/Spouse Legal First Name	: Last:		
PLEASE CIRCLE ONE OR THE OTHER Date of Birth:	/ Soc. Sec # F	Phone:	
Mailing Address:	City:St	ate Zip	
	Phone		
	e: Last:		
	. Sec # Phone:		
	City:Si		
Do you have insurance? Yes	No If yes, Name of Carrier		
	Soc. Sec # of Card Hol		
	Group Number		
	o If yes, Name of Carrier		
	Soc. Sec # of Card Hol		
	Group Number		
	es No If yes, Work Comp Insurance		
	/ Date: Employer's Name _		
	Supervisor or HR Name		
*** IS LEGAL ACTION OR LI	TIGATION PENDING FOR THIS INJURY? YES	NO	

# PAYMENT IS EXPECTED AT TIME OF SERVICE UNLESS PRIOR ARRANGMENTS ARE MADE. ALL APPOINTMENTS CANCELLED WITHIN 24 HOURS OR NO SHOWS ARE SUBJECT TO A \$50.00 FEE

4265 Fallon Street, Suite B, Bozeman, MT 59718 406.587.0668 F 406.587.0396

91 West Madison Ave, Belgrade, MT 59714 406.388.1988 F 406.388.2488

Asian Hispanic or Lation Have CHECK THE FOLLOWING CONDITIONS THAT APPLY TO Constitution: Respir Developmental Disabilities Cigat Cancer Asth Headache Brorr Other Emp Chu Ear/Nose/Throat: Sie Hearing Loss Ott Sinus Condition Dry Mouth Laryngitis Gastrry Other Colt Veurological: Ulce Multiple Sclerosis Acid Epilepsy Celia Cerebral Palsy Other Tumor Stroke/CVA Gastrry Migraines Acid Epilepsy Celia Carliovascular: Nu Autism Spectrum Prre Psychological: Nu Depression Hee ADD/ADHD Chr Anxiety Other Cardiovascular: Arth High Blood Pressure Oste Stroke/CVA Fibro Muscular Disease Anky Congestive Heart Failure Spor Congestive Heart Failure Conter Primary Medical Doctor:	YOU: atory: ette Smoker ma ichitis hysema conic-obstruction ep Apnea er <u>intestinal:</u> n's Disease s r Reflux c Disease r <u>urinary:</u> hey Disease ostate Disease/Cancer D hign Prostate gnant rsing rpes amydia her	e O Other/Declined  Integumentary: Eczema Rosacea Psoriasis Cold Sores (simplex) Shingles (zoster) Other  Endocrinology: Type 2 Diabetes Type 1 Diabetes Type 1 Diabetes Thyroid Condition Hormone Disorder Other  Hem/Lymph: Anemia Large Volume Blood Loss Ulcer High Cholesterol Other  Allergic/Immunologic Conditions: Drug Allergies Environmental Allergies Rheumatoid Arthritis Lupus Sjogren's Syndrome Other
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Congestive Heart Failure Spor Oste Gou Oth Primary Medical Doctor:	losing	
Oste Gou Oth Primary Medical Doctor:	-	
Gou Oth Primary Medical Doctor:	oporosis	
Oth Primary Medical Doctor:	-	
Primary Medical Doctor:		
NAME AND DOSAGE OF CURRENT MEDICATIONS:		
DRUG OR OTHER KNOWN ALLERGIES:		
LATEX SENSITIVITY? CURRE	NT EYEDROPS:	
Do you have or have you previously had any of the following	eye conditions?	
□ Cataract □ Glaucoma □Macular Degeneration		nal Detachment 🛛 Eye Surgery
Other conditions or concerns:		
Door a member of your family have an have they had any of	the following conditions?	
<b>Does a <u>member of your family</u> have or have they had any of</b> (Please mark <b>M</b> for mother; <b>F</b> for father; <b>B</b> for brother; <b>Si</b> fo		for son)
Cancer Diabetes		igh Blood Pressure
Cataract Macular Degener		laucoma
Jalaraci Widculdr Degener		Iauconid
Do you drink alcohol? YES NO D	ation Gla	
Former Smoker? YES 🗆 NO 🗆		



#### CONSENT TO ASSIGNMENT OF BENEFITS AND PROMISE TO PAY

Benefits to Physician:

I hereby assign all my rights to insurance benefits and instruct my insurance company to make payments directly to **Advanced Eyecare LLC** and/or its physicians for the benefits provided.

Promise to Pay:

I understand and agree that I am responsible for paying for all services provided to me by **Advanced Eyecare LLC.** and its staff. In the event of non-payment of any balance, I agree that I will be responsible for services rendered or have a signed agreed payment arrangement. I agree that I will be responsible for all the costs of collection, including but not limited to interest at the rate of one and a half percent (1.5%) per month or eighteen percent (18%) per year, court cost and fees, attorney fees, and a collection fee of thirty five percent (35%) of the unpaid balance assigned for collection.

Date

Patient Signature

Signature of patient Representative

Relationship

(Required if the patient is a minor or an adult unable to sign)

#### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a Notice of Privacy Practices for **ADVANCED EYECARE LLC.** I understand that my Protected Healthcare Information (PHI) may be used and disclosed for the purpose of TREATMENT, PAYMENT, and HEALTH OPERATION of the practice.

Date

Patient Signature

Signature of patient Representative

Relationship

(Required if the patient is a minor or an adult unable to sign)

4265 Fallon Street, Suite B, Bozeman, MT 59718 406.587.0668 F 406.587.0396

91 West Madison Ave, Belgrade, MT 59714 406.388.1988 F 406.388.2488



#### WRITTEN AUTHORIZATION FOR RELEASE OF PHI

I hereby authorize ADVANCE EYECARE LLC. To discuss my (PHI) Protected Health Information with the following person(s). Should I wish to revoke this authorization, I understand I must do so in writing.

Name:	Phone:	
Relationship:	Expiration Date:	
Name:	Phone:	
Relationship:	Expiration Date:	
Name:	Phone:	
Relationship:	Expiration Date:	
Signature	Today's Date	

4265 Fallon Street, Suite B, Bozeman, MT 59718 406.587.0668 F 406.587.0396 91 West Madison Ave, Belgrade, MT 59714 406.388.1988 F 406.388.2488



### **Contact lens Examination**

A contact lens examination requires additional testing and assessment by your doctor that are not preformed during an annual comprehensive eye examination. Although contact lenses are considered medical devices, they are not considered medically necessary (with some exceptions). For this reason, service and fitting fees associated with contacts are often not a covered benefit under most insurance policies. The contact lens service and fitting cost will be the responsibility of the patient if insurance does not include that benefit. Patients can expect the service and fitting fee for contact lens to vary between 50.00-120.00 dollars.

The additional assessment and follow up care (commonly referred to as the contact lens "fitting") provided for successful contact lens wearers includes:

### **Tear Film Analysis:**

Your tear ducts and your body's ability to produce tears are evaluated in order to determine whether you will be able to comfortably wear contact lens. Additionally, the amount of tears you produce may determine which of the new contact lens materials will work most effectively on you.

### Corneal Assessment:

Using a keratomer or a corneal topographer, your doctor will measure the curvature of your cornea (the clear front surface of your eye) to access the proper base curve of your contact lens. Additionally, the doctor will provide a more comprehensive assessment of the surface of the cornea with a biomicroscope, in order to assure that surface integrity can support contact lens wear.

### **Pupil and Iris Measurements:**

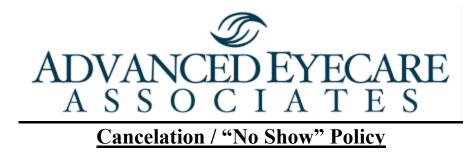
Both pupil and iris (the colored part of your eye) size determination can be very important in ascertaining the best contact lens design for you.

### **Follow Up Visits:**

In most cases you will leave our office with a free trial of contact lens and if you are new to contacts we will provide education on how to properly insert and remove contact lens as well as comprehensive lens care and eye health guidelines. Follow up visits are needed within the first two months to ensure your best vision and wearing comfort. These follow ups will be included with your original contact lens examination charge.

- o I have read and understand the contact lens examination information
- I consent to obtaining electronic delivery of RX by patient portal

Signature:



At Advanced Eyecare Associates our goal is to provide exceptional eyecare to our patients in a timely matter. We have enabled a "no show" and cancellation policy that helps us to better utilize available appointments for our patients who are seeking eyecare. The following policy is for patients who fail to keep their scheduled appointment with our office.

We ask our patients to please be courteous and call Advanced Eyecare Associates if you are no longer able to make your scheduled appointment. This time will be reallocated to someone who is in urgent need of eyecare. Available appointments are in high demand and your early cancellation will give another patient sooner possible access to eyecare.

- Patients who fail to show up for their scheduled appointment or who do not notify the office about needing to cancel or reschedule their appointment 24 hrs prior will be subject to a 50.00 "no show/cancellation fee". Patients who "no show" their scheduled appointments will be asked to wait 4 months before coming in again for their annual exam in addition to the 50.00 "no show" charge. In the event of an actual emergency where prior notice could not have been given, consideration will be given, and a one-time exception may be granted.
- These fees are not covered by insurance and are therefore the sole responsibility of the patient.
- I have read and understand the policy stated above and will except any charges given to me as the result of a "no show" or late cancellation.

Signature:
------------

Date: \_\_\_\_\_

### Additional Services Included

### with Membership

- ✤ 40% savings on lost glasses within one year of purchase.
- Good for the terms of the membership.
- Free lifetime adjustments and cleaning with glasses.
- ✤ Free refills on lens cleaning solution.
- Free contact lens trials in case of lost or damage.
- Free shipping on year supply of contacts.
- ★ Free frame case replacements.
- **\*** Free cleaning cloths.

### 406 Preferred Patient Plans

\*All Advanced Eye Care warranties apply. Please speak with an AEC team member to enroll
\*Membership not to be combined with other offers, insurance plans or items on sales.
\*Membership renewed annually at date of purchase.

This is a private discount plan. This cannot be billed or used with any other insurance or savings plans. If your doctors deem anything medically necessary, AEC will bill your insurance accordingly and this discount will not apply.

**Patient Signature:** 

Date:

**Patient Printed Name:** 

#### **Plan Purchased:**

- □ 406 Platinum All Inclusive Plan
- $\Box$  406 Gold Plan
- □ 406 Silver Exam & Contact Lens Plan





 $4 \mathcal{D} h$ PREFERRED PATIENT PLANS



# ALL INCLUSIVE Plan

**\$149**/year of membership

## Savings Included:

- 30% off annual comprehensive exam and refraction
- 20% off Optomap retinal imaging

30% off first pair of prescription glasses20% off prescription lenses only30% off second pair of prescription glasses

20% off non-prescription sunglasses15% off all accessories

15% off contact lens evaluation and related service

15% off contact lenses

### 4*©*6 Gold



### Savings Included:

30% off annual comprehensive exam and refraction20% off Optomap retinal imaging

30% off first pair of prescription glasses30% off second pair of prescription glasses

20% off non-prescription sunglasses15% off all accessories



### 4@6 Silver

Exam & CONTACT LENS Plan

**\$79**/year of membership

# Savings Included:

30% off annual comprehensive exam and refraction20% off Optomap retinal imaging

15% off contact lens evaluation and related service15% off contact lenses

20% off non-prescription sunglasses 15% off all other related products (solution, eye drops, etc.)



\*Each additional family member: 30% savings on annual membership