Melody O. Quenzer, O.D., Inc.
Eye-Q Optometry
100 Gateway Drive, Suite 130
Lincoln, California 95648
916.434.6225

Patient's Name:_____***D.O.B.***_____

We at Eye Q Optometry are committed to providing the highest level of professional medical care and personal service. By selecting our office you have expressed confidence in our ability to meet this commitment.

PAYMENT PROCEDURE

For every commitment there is an obligation. At Eye Q Optometry we are committed to providing quality eye care and service. Conversely, we feel it is the guardian/patient's responsibility to meet their financial obligation.

* As we see patients from many Insurance Plans, it is impossible for us to know all the covered benefits, co- pays and deductibles for each plan. While it is our intention to assist you, it is still your responsibility to insure that all services rendered by Eye Q Optometry on your behalf are paid in full within thirty (30) days of the statement date. In some instances Eye Q Optometry can not bill your insurance carrier for you. However, you will be provided with all of the information necessary to submit a claim to your insurance company.

* Payments made at the time of service may not represent payment in full for services which are rendered. Additional charges may be warranted once your claim has been submitted due to the complexity of physician services required for treatment.

* The patient's financial responsibility may include co-payments, co-insurance and services not approved or paid by your insurance carrier.

* Balances (after insurance billing) over 30 days old will receive a $10 late fee; every 30 days an account remains delinquent an additional $10 will be applied.

It is important that you bring proof of insurance each time you visit Eye Q Optometry. Failure to do so may mean that we do not have the most recent insurance information. Please make every effort to let us know if your insurance carrier (primary/secondary) or your personal information (address, employer, phone number(s)) has changed since your last visit.

* Incorrect Insurance information that results in re-billing will incur a $10 Rebilling fee.

AUTHORIZATION FOR RELEASE AND ASSIGNMENT OF BENEFITS

* I request that payment of authorized Medicare, Government and any other third party benefits made on my behalf and/or on behalf of all members covered on my insurance plan be made directly to Eye Q Optometry, Dr. Melody Quenzer for services furnished by that provider.
* I authorize the release of medical information about me needed to determine benefits or benefits payable to related services. I permit a copy of this authorization to be used in place of the original.
* Understanding that insurance information and coverage can be very confusing and complicated we are committed to helping you with any questions you may have. Please feel free to call our office and speak with Accounts Payable directly at (916)434-6225.

I have read and understand the policy stated above.

_____ Date:_____

Account Guarantor/Responsible Party's Signature

Eye-Q Optometry

Patient Information

Mr. Mrs. Ms. Date: _____

Name: _____

Address: _____

_____

City: _____ State: _____

Zip Code: _____

Hm Phone: _____

Cell Phone: _____

E-Mail: _____

Birth Date: _____

SSN: _____

Employer _____

Text appts/notifications to: _____

I Give permission to release information to:

How did you hear about us?: _____

PAYMENT POLICY

*****No Refunds/Exchanges*****

1. Payment in full is due at time of service
2. A $30 service charge on all returned checks
3. Insurance Policy--Regardless of any insurance coverage, the total balance due is the legal responsibility of the patient.
4. Any reversal of credit card purchase is subject to a 10% service charge of amount

I have read and understand the above:

Please sign: _____

PRIMARY INSURANCE INFORMATION

Primary account holder:

Primary SSN#(Tricare/Medicare only):

Primary D.O.B.: _____

Vision Insurance Co: _____

Relationship to Patient: _____

Medical Insurance Co: _____

_____

FOR FUTURE PURPOSES

_____ _____

_____ _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Signing this document signifies that you have received a copy of our

Notice of Privacy Practices

*In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The notice of Privacy Practices you have been given describes these uses & disclosures in detail. *When you sign this consent document, you signify that you agree that we can & will use & disclose your health information to treat you, to obtain payment for our services & to perform health care operations, as well as use your information to to contact you via the information provided.Unless we have already treated you/sought payment for our services/performed health care operations in reliance upon our ability to use/disclose your health information in accordance with this consent.

I acknowledge that I have received the Notice of Privacy Practices from Dr. Melody Quenzer at Eye Q Optometry.

X: Date:

If signing as a personal representative of the patient, describe the relationship to patient & source of authority to sign this form:

X:

MEDICARE AUTHORIZATION

I request that payment of authorized M.C. benefits be made to me **or on my behalf to Dr. Melody O. Quenzer for any or all services**.

To the extent permitted by law, I authorize any holder of medical/other information about me to release to Dr. Melody Quenzer any information needed to determine these benefits for related services.

Name:

Print name of Beneficiary/representative & Relationship

Medical History

Last Eye Exam: _____

Last Medical Exam: _____

Any allergies to medications? YES ☐ NO ☐

If Yes, explain: _____

Please attach list of any medications you take including oral contraceptives, aspirin, over the counter medications and home remedies: _____

List all major injuries, surgeries and/or hospitalizations you've had: _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injuries: _____

Review of Systems: Do you currently, or have you ever had any problems in the following areas:

	YES	NO		YES	NO
CONSTITUTIONAL			EARS, NOSE, MOUTH, THROAT		
Fever, Weight loss/gain			Allergies/Hay Fever		
INTEGUMENTARY (skin)			Sinus Congestion		
NEUROLOGICAL			Runny Nose		
Headaches			Post-Nasal Drip		
Migraines			Chronic Cough		
Seizures			Dry Throat/Mouth		
EYES			RESPIRATORY		
Loss of vision			Asthma		
Blurred Vision			Chronic Bronchitis		
Distorted Vision/Halos			Emphysema		
Loss of Side Vision			VASCULAR/CARDIOVASCULAR		
Double Vision			Diabetes		
Dryness			Heart Pain		
Mucous Discharge			High Blood Pressure		
Redness			Vascular Disease		
Sandy/gritty feeling			GASTROINTESTINAL		
Itching			Diarrhea		
Burning			Constipation		
Foreign Body Sensation			GENITOURINARY		
Excess Tearing/Watering			Genitals/Kidney/Bladder		
Glare/Light Sensitive			BONES/JOINTS/MUSCLES		
Eye pain/Soreness			Rheumatoid Arthritis		
Chronic Eye/lid Infection			Muscle Pain		
Sties/Chalazion			Joint Pain		
Flashes/Floaters			LYMPHATIC/HEMTOLOGIC		
Tired Eyes			Anemia		
ENDOCRINE			Bleeding Problems		
Thyroid/Other glands			ALLERGIC/IMMUNOLOGIC		
			PSYCHIATRIC		

If you answered YES to any of the above or have a condition not listed, please explain and list your medications: _____

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with your doctor if you prefer.

☐ Yes, I would prefer to discuss my social history information information directly with my doctor

Do you drive? Yes ☐ No ☐

If yes, do you have visual difficulty when you drive? Yes ☐ No ☐

If yes, describe: _____

_____

Do you use tobacco products? Yes ☐ No ☐

If yes, type & amount per day? _____ How long? _____

Do you drink alcohol? Yes ☐ No ☐

If yes, type & amount per day? _____ How long? _____

Do you use illegal drugs? Yes ☐ No ☐

If yes, type & amount per day? _____ How long? _____

Have you ever been exposed to or infected with:

Gonorrhea ☐ HIV ☐

Hepatitis ☐ Syphilis ☐

Family History

DISEASE/CONDITION	YES	NO	RELATIONSHIP TO YOU
Blindness			
Cataract			
Crossed Eyes			
Glaucoma			
Macular Degeneration			
Retinal Detachment			
Retinal Disease			
Arthritis			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Lupus			
Thyroid Disease			
Other:			

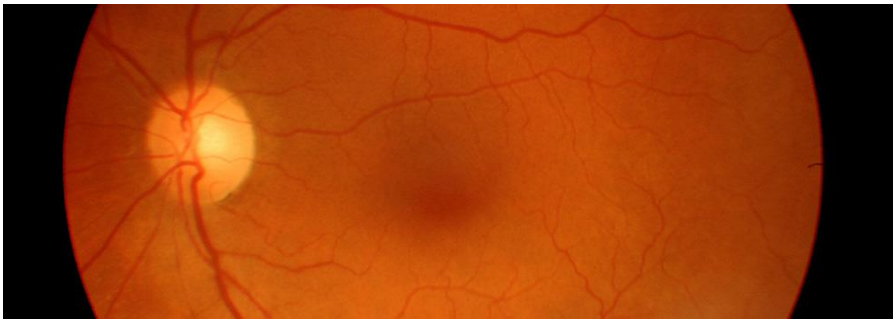
Doctor Signature: _____ Date: _____

Name _____ Date _____

Wellness Retinal Imaging

The retina, or inner lining, of the eye is photographed with a specially designed camera through the pupil of the patient. The painless procedure produces a sharp view of the retina, the retinal vasculature, and the optic nerve head from which the retinal vessels enter the eye. This image is used to document conditions such as diabetic retinopathy, age related macular degeneration, glaucoma, macular edema and retinal detachment. This is especially helpful to document if you have a family history of these or other medical conditions.

The fee for this part of the eye exam is $39.
___ Yes, I want to have retinal photos taken of my eye for documentation.
___ No, I do not wish to have retinal photos taken.



Name _____ Date _____

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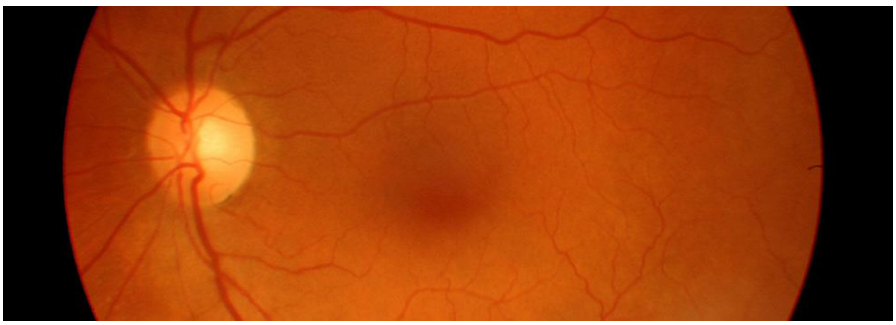

Are you interested in contact lenses or currently wear contact lenses?

Are you interested in contact lenses or currently wear contact lenses, our doctors can discuss your options with you. Our recommendations are **individually** tailored to each patient and are based on many factors, including your glasses prescription, visual needs, overall health and eye health. Because of this, **if the contact lens prescription is not finalized within 30 days there will be 40.00 re-refraction/ trial lens fee added to the account.**

What is a contact lens fitting/re-fitting? *Contact lens fittings and re-fittings are* a **separate** part of a comprehensive eye examination and require additional testing. Patients hoping to wear contact lenses require more of the doctor's time and expertise. In order to prescribe contact lenses, an eye doctor must complete several additional tests: 1. Evaluate the health of the eye, paying close attention to the cornea, eyelids and conjunctiva and how contact lens wear will affect the health of the eye. 2. Determine the proper contact lens prescription based on each individual patient's glasses prescription, vision needs and corneal health and curvature. A contact lens prescription is different and separate from a glasses prescription. 3. Examine the contact lens on the eye to ensure proper alignment with the cornea and lids. 4. Measure the vision with the contact lenses on the eye and make adjustments as indicated. Contact lens examinations and fittings and refittings have different levels of difficulty, depending on the type of contact lenses needed, the visual requirements of the patient and the health of the patient's eyes.

Why is the contact lens fitting/re-fitting separate from the comprehensive eye examination fee? Most insurance companies require doctors to separate routine comprehensive eye examination fees from any services performed due to contact lenses. More time and testing are required for a patient who wears contact lenses (even with those who have a history of contact lens wear); therefore, most insurance companies consider contact lens services as additional and separate evaluations from the eye examination.

What is a contact lens prescription? Contact lenses are medical devices that can only be dispensed by a prescription. Contact lens prescriptions expire after **one year** (or sooner if the doctor determines a medical reason for a shorter expiration date). They must be regarded with the same caution you would use for prescription drugs, which include prescription expiration dates and follow-up visits with your eye doctor. Your contact lens prescription will include the power of your contact lenses, the type of contact lenses you wear, the shape of the contact lenses (curvature) and any other information determined by the doctor to be necessary for a proper contact lens fit. Your eyes go through gradual changes in size, shape and physiological requirements (such as need for moisture etc.) while wearing contact lenses. These changes can affect the health of the cornea and need to be monitored at least every year. The federal government requires contact lens prescriptions to expire after one year for these reasons.

What if I (or my dependant) is unable to wear contacts? Contact lenses are not for everyone. Sometimes due to eye health, or other extenuating circumstances someone is unable to wear contacts. The procedures and charges associated with contact lens fittings are not a guarantee that you (or your dependant) will be able to wear contacts as an optical Rx alternative. Despite this, you are responsible for the charges associated with any exam, fitting, and training involved in the contact process. By signing this you acknowledge that Eye-Q Optometry staff has provided you (or your dependant) with the best service and best resources at their disposal to help make wearing contacts a viable alternative to a glasses prescription, and you are responsible for paying for those services, despite the results

I have read the above; understand and agree with the office policy regarding contact lens fitting/re-fittings and related charges.

I am interested in contact lenses: _____

- **I have worn contact lenses: _____**
- **I have not worn contact lenses: _____**

I currently wear contact lenses and want my contact lens prescription renewed: _____
I currently wear contact lenses, I do not want to renew my contact lens rx at this time: _____
I am not interested in contact lenses: _____

Patient signature: _____Date:_____

Technician office staff signature: _____Date:_____

Eye-Q Optometry

Contact Lens Fitting Agreement

All new fittings include cornea evaluation, keratometry measurements, refraction, insertion and removal training, contact lens trials **(not applicable to RGPs)** and all follow-ups up to **30 days**.

Preliminary In-Office New Fitting (credit to new fit if pursued)---------- $20.00
Spherical/Astigmatism soft contact lens new fitting----------$95.00/112.00
Multifocal/Bifocal soft contact lens new fitting----------$105/125.00
RGP new fitting----------$150/180.00

All re-fittings include cornea evaluation, keratometry measurements, refraction, contact lens trials **(not applicable to RGPs)**, and all follow-ups:

Spherical/astigmatism soft contact lens re-fittings----------$70/85.00
Multifocal/Bifocal soft contact lens re-fittings----------$80/95.00
RGP re-fittings----------$80/98.00

This agreement includes all follow-up appointments for **30 days**. After an initial fitting period of **30 days**, all professional services will be billed at our usual and customary fees.

Usual and customary fees after 30 days are:

Follow-up visits---------- $35.00 per visit
Spherical trials---------- $30.00 per pair
Astigmatism trials---------- $35.00 per pair
Multifocal trials---------- $40.00 per pair

RGP additional contact lenses costs to be determined depending upon make and manufacture.

**CONTACTS PURCHASED ON-LINE FROM UNKNOWN SITES MAY BE COUNTERFEIT. IF PATIENT PURCHASES CONTACTS ONLINE AND REQUIRES A CONTACT LENS CHECK—A FOLLOW UP VISIT OF $35 WILL BE CHARGED

****All re-fittings are not covered by insurance. Insurances have their own copays. Ask receptionist what your copay may be upon check in.**

Any RGP contact lenses used for fitting MUST be paid for at time of service or when costs have been determined depending upon make and manufacturer.

Contact lens prescriptions will only be released after the entire fitting process is successfully completed and all fees are paid in full.

Patient signature: _____Date: _____
CL dispenser/trainer signature: _____Date: _____