WELCOME TO MOUNTAIN VIEW EYE

NAME____ DATE OF BIRTH__________ AGE______
FIRST MI LAST

ADDRESS________________________ CITY______________ STATE___ ZIP_______ SSN____-____-____

PHONE__________________ WORK PHONE_________________ CELL PHONE____________________

EMERGENCY CONTACT ______________________________ PHONE ___________________________

PREFERRED WAY OF CONTACT: HOME PHONE WORK PHONE CELL PHONE TEXT

PLACE OF EMPLOYMENT___________________________ OCCUPATION_______________________

DATE OF LAST EXAM AND WHERE____

How did you hear about our office? ___Facebook ___Google ___Newspaper ___Yelp

Who may we thank for referring you to our office?________________________________

EMAIL ADDRESS____
(Necessary for Appt. confirmation. notifying of glasses or contacts). Will not be given out to 3rd party

MARRIED____SINGLE______DIVORCED_______WIDOWED______

When two or more insurances are available, the one used first is your own, with other insurances used second. If you are a dependent of those with insurance the insurance holder with the earliest birth date in the calendar year is used first.

PAYMENT FOR SERVICES IS DUE AT THE TIME OF SERVICE. A 50% DEPOSIT IS REQUIRED ON ALL MATERIALS ORDERED. BALANCES ARE DUE AT THE TIME MATERIALS ARE PICKED UP.

Mountain View Eye Associate provides additional specialized testing, which may at times be billed to your regular "major medical" health insurance. In the event any of these tests are necessary, please authorize payment directly to Mountain View Eye Associates by providing your signature below. Our insurance department will handle all necessary claims. If your insurance does not pay or it is out of network you will be responsible to make payment to us.

______________________________ ______________________________
SIGNATURE DATE

PLEASE RETURN THIS FORM TO THE FRONT DESK AND HAVE YOUR HEALTH AND VISION INSURANCE CARDS READY TO COPY.

mountainvieweye

A MEMBER OF Vision Source

Dr. Fred E. Petrunak • Dr. Michael A. Satryan • Dr. Shawn D. Jones • Dr. Eric M. Rettig

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I, ________________________ acknowledge that I have received a copy of the Notice of Privacy Practices from MOUNTAIN VIEW EYE.

I have listed individuals that are authorized to receive my protected health information. I am aware that I can revoke the authorization for any individual at any time, but must do so in writing.

______________________________ ______________________________

Signature of Patient Date

______________________________ ______________________________

Signature of Patient Representative & Relationship Date

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

The following individuals have my authorization to access my Protected Health Information

Name	Relationship	Date of Birth
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________

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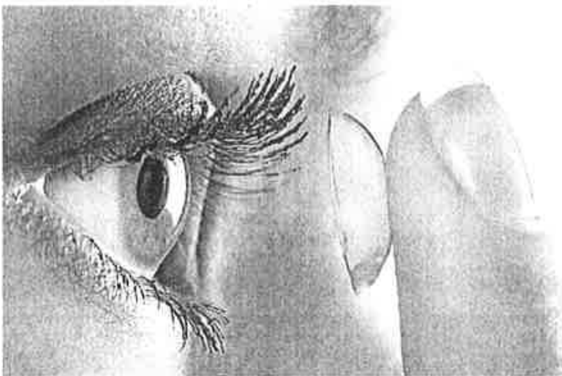
Why are you paying for a Contact Lens Evaluation/Fit?

Insurances cover basic eye examinations for your glasses prescription. Because not everyone wears contact lenses, insurances often will not cover or only partially cover the fitting and evaluation of this medical device. There are many extra steps taken to ensure that your contact lenses fit properly, that you see well out of them, and your eyes remain healthy. They include:

- Extra testing before your exam
- Evaluating the fit, comfort, and vision of the lens
- Evaluating your ocular health, ensuring no issues arise due to contact lens wear or the solutions used to care for them.
- For new wearers: the extra time to teach proper care of lenses as well as teaching you how to handle them and insert/remove them from your eyes.

These steps go above and beyond what is considered a "basic eye exam" covered by your insurance and is why there is an additional fee. If you have any additional question please don't hesitate to ask the Doctors or one of the staff!

Drs. Fred, Mike, Shawn, and Eric



Please sign acknowledging that you have read this form

Signature:____ Date:____________

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