Established Patient Update Sheet

Last Name:_____________________ First Name:_______________________ DOB:________________
Email Address(for providing your electronic medical record summary to you): ______________________

Has your contact information changed since your last visit? YES NO
New Address:__________________________ City: ___________________ State: _____ Zip:_________
New Phone Number: Home (__) ______________ Work: (__) _____________ Cell: (__) _____________

Has your insurance changed since your last visit? YES NO
****Please present font desk with new card***

Emergency contact information:

Name:(First)___________________________ (Last):__________________________________

Phone#:_________________________ Email(optional):________________________________

HIPPA PRIVACY RULE
The HIPPA (Health Insurance Portability and Accountability ACT) notification describes in detail how your medical information may be used and disclosed. It also describes how you can access the information. I have been offered a copy of North County Laser Eye Associates HIPPA Notice of Privacy Practices.

REFRACTION POLICY
Insurance companies will only pay for services that it determines to be "Medically Reasonable and Necessary." Refractions (examinations used to determine the prescription of your contacts and glasses) are most often deemed to be non-medical, and therefore are not covered by your health insurance. The cost of the exam is $85, and I understand that I will be held personally responsible for the payment.

CONTACT LENS SERVICES POLICY
There may be separate fees incurred for contact lens services. Contact lens services are typically not considered a part of routine coverage. Coverage may depend upon the specific vision insurance plan and how the benefits are used. These fees may vary depending on the level of services rendered.

INFORMATION REGARDING DILATION DROPS
Dilating drops are used to dilate or enlarge the pupils of the eye to allow a better view of the inside of your eye. These drops blur vision for a length of time and cause light sensitivity. I understand that my vision will be altered and I should use caution while driving or otherwise arrange for transportation. I hereby authorized North County Laser Eye Associates to administer dilating drops.

PATIENT BALANCE RESPONSIBILITY
I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account and for any professional or diagnostic services rendered as well as any glasses or contacts ordered. I authorize payment of medical benefits payable to the physician. A copy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or changes in any of the information provided on the patient information sheet. I understand that there will be a $25 late fee for any unpaid balance on my account after 2 balance due notices. I understand that my account will be sent to collections after final letter, and that I am responsible for additional $25 administrative fees. I also authorize this office to release my spectacle or contact lens prescription at my request.

Patient Signature:____ Date: __________________

Parent/Guardian Signature(If patient is a minor):_______________________________Date____________

Printed name of Parent/Guardian and relation to minor:____

Current Medication Form

*VERY IMPORTANT: Please list **ALL** current medications that you are taking.*

Medication Name ***(eye drops, pills, patches, injections etc.)***	**Dosage**

Preferred Pharmacy:____