DR. MICHAEL B. ALLEE
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4722 WESTERN AVE
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alleevision@gmail.com

ALLEE VISION OPTOMETRY

PATIENT INFORMATION

NAME: _____ D.O.B.: ____/____/____

IF PATIENT IS A MINOR, PARENT OR GUARDIAN NAME:

_____

STREET ADDRESS:_____

CITY_____STATE:_____ZIP:_____

PATIENTS SSN:_____-_____-_____ PLEASE CIRCLE: MALE/FEMALE

HOME NUMBER: _____-_____-_____ WORK NUMBER:_____-_____-_____

CELL NUMBER: _____-_____-_____EMAIL:_____

OCCUPATION OR SCHOOL GRADE:_____

PLEASE LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

_____

_____

_____

PLEASE LIST ANY MEDICATION ALLERGIES THAT YOU HAVE:

_____

_____

DO YOU CURRENTLY DRINK ALCOHOL?	YES	NO
DO YOU CURRENTLY USE TOBACCO?	YES	NO
DO YOU CURRENTLY WEAR CONTACT LENSES?	YES	NO
ARE YOU INTERESTED IN GETTING CONTACTS?	YES	NO

THIS FORM IS FRONT AND BACK. PLEASE FILL OUT BOTH SIDES.

MEDICAL AND VISION HISTORY

PLEASE CHECK ALL THAT APPLY:

___CANCER	___SINUSITIS	___EPILEPSY	___CEREBRAL PALSY
___STROKE	___TUMOR	___MULTIPLE SCLEROSIS	___HYPERTENSION
___HEART DISEASE	___VASCULAR DISEASE	___ASTHMA	___BRONCHITIS
___SLEEP APNEA	___CROHN'S	___ULCER	___HERPES
___KIDNEY DISEASE	___LUPUS	___ARTHRITIS	___COLD SORES
___SHINGLES	___ROSACEA	___DIABETIC	___DRUG ALLERGIES

___PROSTATE DISEASE/CANCER ___THYROID DYSFUNCTION ___MUSCULAR DYSTROPHY
___CONGESTIVE HEART FAILURE ___RHEUMATOID ARTHRITIS ___SJOGREN'S SYNDROME
___NURSING(CURRENTLY) ___PREGNANT(CURRENTLY)

OTHER:_____
_____

FAMILY MEDICAL AND OCULAR HISTORY:
(PLEASE CIRCLE YES OR NO, IF YES PLEASE CIRCLE RELATIONSHIP)

CANCER	NO	YES	---	FATHER	MOTHER	BROTHER	SISTER
DIABETIC	NO	YES	---	FATHER	MOTHER	BROTHER	SISTER
THYROID CONDITION	NO	YES	---	FATHER	MOTHER	BROTHER	SISTER
MACULAR DEGENERATION	NO	YES	---	FATHER	MOTHER	BROTHER	SISTER
GLAUCOMA	NO	YES	---	FATHER	MOTHER	BROTHER	SISTER

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?
(PLEASE CIRCLE YES OR NO)

CATARACTS	YES	NO	DRY EYE	YES	NO
RETINAL PROBLEMS	YES	NO	MACULAR DEGENERATION	YES	NO
GLAUCOMA	YES	NO	DIABETIC RETINOPATHY	YES	NO

ARE YOU CURRENTLY HAVING ANY OF THE FOLLOWING EYE OR VISION CONCERNS?
(PLEASE CIRCLE YES OR NO)

REDNESS	YES	NO	ITCHING	YES	NO
BURNING	YES	NO	TEARING	YES	NO
DISCHARGE	YES	NO	BLURRED VISION	YES	NO
HEADACHES	YES	NO	POOR NIGHT VISION	YES	NO
EYE STRAIN	YES	NO	SENSITIVITY TO LIGHTS	YES	NO
DOUBLE VISION	YES	NO	NIGHT GLARE	YES	NO
TOTAL LOSS OF VISION	YES	NO	FLASHING LIGHTS/FLOATERS	YES	NO

SIGNATURE:_____ DATE:_____

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Patient Name:_____ DOB:_____

Appointment times: Appointments can be made by phone, email, or in person. Please let us know as soon as possible if you cannot make a scheduled appointment so we might use that time for other patients. You understand that we may remind you of appointments by phone, email, or text message.

Individual Photos: We add an individual photo to your patient record. This assists our doctors and staff in providing continuity of care whether you receive care in office,via email, or on the phone. We'll now have a face to go with your name.

Medical vs. Vision Insurance: Medical insurance can be filed for instances like an eye infection or diseases that affect the eyes. Vision insurance usually pays toward an annual routine eye exam, glasses, and/or contacts. We will obtain insurance information on your vision and medical coverage, including copies of your cards.

Payment: Payment is due at the time service is rendered. We accept checks, cash, Visa, MasterCard, American Express and Discover.

Returned Checks: There will be an additional fee of $30 if your check is returned.

Outstanding Balances: We will notify you by mail or phone regarding any unpaid balance. You have the right to ask at the time of service, prior to the test being performed, if any additional charges will be incurred. If you fail to do so you waive the right and will adhere to the customary billing and collection policies.

Contact lenses: Contact lens wear requires additional testing, evaluation and follow-up to ensure proper eye health and performance. There are additional fees associated with a contact lens evaluation beyond a normal eye exam. These fees are annual and are determined by the complexity of the case and time required.

Coordinated care: Should the need arise for a surgical or other consultant in your case, your signature at the conclusion of these forms is your authorization for our doctors to discuss, share and transfer any and all clinical information and data pursuant to your care.

Tardiness: We have the right to reschedule your appointment if you arrive more than 15 minutes after your scheduled appointment time.

Cancellation/No show policy: Should you need to cancel or change your appointment, we do require a 48 hour notice if at all possible. If you fail to give a notice of a minimum of 24 hours prior to your appointment it will be considered a "No Show". If there are three (3) cancellations (less than 24 hours) or "no shows" the patient may be dismissed from Allee Vision Optometry. **There is a no show fee of $40 for each no show.**

I have read and understood all of the above.

Signature:_____Date:_____

THIS PAGE IS FRONT AND BACK. PLEASE READ AND SIGN BOTH SIDES.

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REFUND, RETURN AND CANCELLATION POLICY

Prescription eyewear and contacts can not be returned for a refund. Warranties may apply.

FRAMES
All frames are warranted against defects in workmanship for a period of one year from the date of purchase. Scratches, fatigue, and breakage from obvious abuse are not considered defects. Manufacturer guidelines will apply. Frames can not be exchanged after lenses are made.

USING AN OLD FRAME
If the decision is made to use a frame previously purchased for new lenses, our office or our lab will not be responsible if there is a breakage in the frame while lenses are being made.

FRAME CHOICE WHILE DILATED
If the decision is made to choose a frame while dilated, Allee Vision Optometry is not responsible for dissatisfaction of frame.

PRESCRIPTION LENSES
Lenses will be made and inspected to the specification of the prescription given and with the material and options you have selected. There is no refund given for lenses since they specifically are made to order.

Polycarbonate lenses have a one year scratch warranty with most insurance companies.

Anti-reflective coatings have a one year scratch warranty with most insurance companies.

Lenses can be replaced one time up to 60 days of the original dispense date at no charge if there is difficulty adapting to the new prescription. If there are additional remakes due to adaptation the patient will be responsible for the charges. No refunds will be given. After the 60 day period you will be responsible for the purchase of new lenses.

CANCELLATION POLICY
Once the lab has started your glasses lens order it may not be canceled.

Once your order for contacts has been placed with the distributing company the order may not be canceled.

OUTSIDE DOCTOR'S PRESCRIPTIONS
Per our own policy, we do not accept outside Doctor's prescriptions for glasses or contacts.

SERVICES
Payments for services rendered will not be refunded for any reason.

Signature: _____ Date: _____

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Retinal Exam Consent Form

A retinal exam enables your doctor to have a more complete view in the back of your eye. A retinal exam is extremely important to your eye and overall health. Retinal issues could include macular degeneration, glaucoma, retinal tears and detachments, and systemic diseases such as high blood pressure, diabetes, stroke, and tumors. Please select one of the below options.

Option 1 : Retinal Photo (Optomap)
Optomap is fast, easy and comfortable. The procedure will not require dilating drops (which results in blurred vision and sensitivity to light) and there are no lasting effects.
Optomap provides:

– An in depth view of retinal layers (where disease can start)
– The ability to review your retinal image with your doctor during your exam
– An annual, permanent record for your medical file, which gives your doctor comparisons for tracking and diagnosing potential eye disease.

If the Optomap Retinal Exam is performed as an enhancement to the basic eye exam there will be a fee of either $40.00 or insurance copay. Whichever is less.

Option 2: Dilation
A dilated retinal exam occurs with eye drops installed into the eye, which enlarges the pupil. Upon dilation, your eyes may experience light sensitivity and blurred vision at reading distance for approximately 3 to 4 hours. Distance vision will not be blurred with your glasses.
In most cases, your vision insurance will cover this procedure only if it is performed on the same day as the initial visit. There will be a fee of $30.00 if you elect to have the dilation performed and do not have insurance or on a different day as a routine exam.

Please select **ONE** of the following (If unsure, please select Option 3 and you can discuss it with your doctor):

_____ Option 1: Retinal Photo (Optomap) Consent - $40.00 fee.
_____ Option 2: Dilation Consent-covered by insurance if performed on the same day as routine exam.
_____ Option 3: Doctors discretion with the understanding that there may be a fee.
_____ Option 4: I elect to come back on a different day with the understanding that there WILL be a fee.
_____ Option 5: I understand that dilation and retinal photo (Optomap) enable the doctor to better determine my eye health and elect not to have either performed.

Signature: _____Date: _____

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HIPAA DISCLOSURE

Patient Name:_____ DOB:_____

HIPAA Privacy Rule gives you, the patient, the right to request on uses and discloses of your Protected Health Information (PHI). You also have the right to request confidential communications or that os PHI be made by alternative means, such as sending correspondence to an alternate address or calling a different phone number than what is listed.

Allee Vision Optometry has my authorization to contact me in the following manner:

Home Phone:

- ☐ O.K. to leave a message with detailed information.
- ☐ Leave a message with a call back number only.
- ☐ Please only leave a message with (persons name and relationship)_____

Cell Phone:

- ☐ O.K. to leave a message with detailed information.
- ☐ Leave a message with a call back number only.
- ☐ Other:

Work Phone:

- ☐ O.K. to leave a message with detailed information.
- ☐ Leave a message with a call back number only.
- ☐ Other:

Written Communications:

- ☐ O.K. to mail to my home address.

In case of an emergency please contact (persons name, relationship, phone number)

_____

I hereby acknowledge reading the Notice Of Privacy Practices and understand that I have the right to obtain a paper copy of this notice.

Signature: _____Date: _____

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