LITTLE VALLEY EYE CARE
2557 S River Road, Ste B3
St. George, UT 84790
Ph: 435-200-1987

Financial Policies Agreement

REFRACTION

The fee for refraction is $50

The part of your evaluation that determines your glasses prescription is called a "refraction." It is separate from a comprehensive eye examination. Vision discount plans such as VSP & EyeMed, typically include this with your benefits. Some medical insurances, namely Medicare, may not cover this fee.

OPTOMAP RETINAL IMAGING

The copay for this test is $39 per individual, not covered by insurance

As part of every eye exam, we offer to take a picture of the inner part of your eye, called the retina. This often replaces dilating drops and provides an annual, permanent record which gives your doctor comparisons for tracking and diagnosing potential eye disease including macular degeneration, glaucoma, cancer and peripheral retinal disease.

SPECTACLE CANCELLATION and/or REMAKE POLICY

Due to the custom nature of each pair of glasses, we require a deposit of 50% on all eyeglass orders before they will be ordered. The remaining balance will be due at the time of pickup before glasses are dispensed. Any cancellations after lenses have been ordered will be billed at 50% of retail. At the doctors' discretion, patients who are not seeing well with their glasses may have their prescription adjusted at no cost, within 30 days of the original purchase date. Any patient who fails to adapt to their new lenses will have their prescription remade one time into a lens of their choice at no additional charge. **Refunds are not available after 30 days of ordering on all lenses.**

CONTACT LENS EXAM

Most soft contact lens fees range from $75 to $125, vision plan discounts will be applied

Contact lens fitting and evaluation services ARE NOT included as part of a normal ROUTINE EXAM. These are considered distinct services and additional fees apply. Fees are customized according to the complexity of the case and the predicted time necessary to care for the individual patient. Evaluation fees cover the following: fitting, training, sample cleaning solutions, two months of follow up care as well as disposable trial lenses, until the prescription is finalized. Specialty lenses (soft and rigid) and office visits outside the initial two-month period are not included and will be billed accordingly. Contact lens materials require additional fees.

FINANCIAL DISCLAIMERS

It is your responsibly to pay copays, deductible amounts, co-insurance, or any other balance not paid by your insurance

We will attempt to verify your medical insurance and vision discount plan eligibility for services and or materials before your appointment. Verification of eligibility is done as a courtesy only and is not a guarantee of payment. If I have medical insurance or routine vision benefits, I authorize my plan carrier to directly pay Little Valley Eye Care. I also authorize Little Valley Eye Care to release any information required for payment. It is the patient's responsibility to know their coverage, and relay that information to the office staff. Any fees not covered by insurance will be billed to the patient.

If my insurance does not pay, or partially pays, I understand I am responsible for the payment in full or the remaining balance. This includes any collection fees, court costs and attorney fees incurred in collecting the balance. There is up to a $30 fee for returned checks. A 1.5% monthly (18% annual) fee will be added to all accounts not current. Balance must be paid in full by the end of the 120-day period or your account will be turned over to our collection agency. The undersigned specifically agrees to pay all reasonable attorney fees and court costs in the event legal action is taken to collect on an account. The undersigned further agrees to pay an additional amount representing up to 40% of the principal balance if the account is referred to a collection agency or attorney for collections. This additional amount is in recognition of the cost associated with said collection action processing.

_____ _____ Date: ___/___/_____

Print Patient Name Patient/Guardian Signature

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Patient Information & History

PATIENT INFORMATION

Patient's Name: (Last, First, Middle) _____ Social Security#: _____

Birthdate: ___/___/___ Age: _____ Sex: M F (⬆SS for insurance verification)

Address: _____ City, State, Zip: _____

Home Phone: ( ) _____ *Cell Phone: ( ) _____ *SECURE Text okay? Yes No

*Email Address: _____ *Text & Email are for appointment reminders and internal communication only.

INSURANCE INFORMATION

Person responsible for payment (If different from above): _____

Medical Insurance Name: _____

Policy Holder Name, Date of Birth (If different than patient): _____

Vision Insurance Name: _____

Policy Holder Name, Date of Birth (If different than patient): _____

Policy Holder SS# (for insurance verification only): _____

PERSONAL EYE HISTORY

List any personal history of: crossed eyes, keratoconus, droopy eyelids, glaucoma, retinal disease, cataracts, eye infections, injuries:

_____

List any EYE DROPS you use (artificial tears, prescription, ointments, allergy, etc.): _____

PERSONAL MEDICAL HISTORY

List or provide a copy of ALL MEDICATIONS you currently take (including oral contraceptives, aspirin, over the counter and home remedies):

_____

List MEDICATION ALLERGIES you have, if any: _____

FAMILY OCULAR / MEDICAL HISTORY

Please check any family history (living or deceased) of the following conditions: (Check all applied)

☐ Unknown / Adopted

☐ Crossed / Lazy Eye	☐ Retinal Hole, Tear, detachment	☐ Heart Attack / Stroke
☐ Glaucoma	☐ Cancer	☐ High Blood Pressure
☐ Macular Degeneration	☐ Diabetes	☐ Thyroid Disease

REVIEW OF SYSTEMS

Do you currently, or have you ever had any chronic problems in the following areas:

	NO	YES	IF YES, EXPLAIN:
EYES (flashes/floaters, double vision, dry eye, infection, etc.)	☐	☐	_____
EAR, NOSE, MOUTH, THROAT (Allergies, sinus issues)	☐	☐	_____
RESPIRATORY (Asthma, Chronic Bronchitis, COPD, etc.)	☐	☐	_____
ENDOCRINE (Thyroid, Diabetes)	☐	☐	_____
ALLERGIC/IMMUNE DISORDERS	☐	☐	_____
CARDIOVASCULAR (heart attack, stroke, clots, etc.)	☐	☐	_____
SKIN	☐	☐	_____
BONES, JOINTS, MUSCLES (Arthritis, muscle/joint pain)	☐	☐	_____
NEUROLOGICAL (Headaches, Migraines, Seizures)	☐	☐	_____

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EYE CARE

Please fill out these symptom surveys to help your doctor better understand your symptoms better.

How Often do you experience these symptoms?		1	2	3	4	5
	**Headaches** of any severity, usually worse later in the day	Never ○	Not often ○	Monthly ○	Weekly ○	Daily ○
	**Stiffness / pain in neck / shoulders** When you work at a computer or read	Never ○	Not often ○	Monthly ○	Weekly ○	Daily ○
	**Discomfort with Computer /Phone Use** In your eyes after long hours of looking at the screen	Never ○	Not often ○	Monthly ○	Weekly ○	Daily ○
	**Tired Eyes** With increasing feeling of eye fatigue throughout the day	Never ○	Not often ○	Monthly ○	Weekly ○	Daily ○
	**Dry Eye Sensation** more gritty/sandy when looking at screens or reading	Never ○	Not often ○	Monthly ○	Weekly ○	Daily ○
	**Light Sensitivity** Especially with brighter stronger lights like headlights	Never ○	Not often ○	Monthly ○	Weekly ○	Daily ○
	**Dizziness or Motion Sickness or Vertigo**	Never ○	Not often ○	Monthly ○	Weekly ○	Daily ○

QUESTIONNAIRE	YES	NO
Functional Vision		
Any Trouble Concentrating?	○	○
Do your eyes fatigued easily?	○	○
Do you have any balance Issues?	○	○
Ever had a concussion or Multiple concussions?	○	○
Sports Vision		
Do you play sports competitively?	○	○
Plan on playing at elite level (college or above)?	○	○
Have you done vision exercises as part of your training?	○	○
Reading and Learning		
Have you/your child lost interest in reading?	○	○
Do you/your child have trouble concentrating in class/work?	○	○
Do you/your child seem to struggle with schoolwork?	○	○
Has your child been diagnosed with a learning issue?	○	○