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 at least 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

I understand that I am responsible for paying any copays, deductibles, co-insurance, or balances not covered by my insurance. Little Valley Eye Care will check my insurance eligibility as a courtesy, but this does not guarantee payment. If my insurance does not pay or only pays part of my bill, I must pay the remaining balance, including any fees for collections, court costs, attorney fees, and up to a $30 fee for returned checks. A monthly 1.5% (18% annual) interest will be charged to overdue accounts. All balances must be paid within 120 days, or my account may be sent to collections, which may add up to 40% of the principal balance to cover collection costs. By signing, I agree to pay all reasonable fees associated with collection if necessary.

_____ _____ Date: ____/____/_____

Print Patient Name **Patient Signature**
or Guardian Signature if under 18 years of age

LITTLE VALLEY
EYE CARE

Acknowledgment of Notice of Privacy Practices

I read or was given the opportunity to read Little Valley Eye Care, PLLC's Notice of Privacy Practices prior to any services offered. These notices are posted on www.littlevalleyeyecare.com, posted on the walls of Little Valley Eye Care, and a paper copy will be made available on my request.

☐ The Notice of Privacy Practices could not be read due to the emergent nature of the care and will be acquired when possible.

[Optional]

I authorize Little Valley Eye Care, PLLC to release my personal health information to the following individuals:

_____

_____

_____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Patient Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have the legal authority to make medical decisions for the minor and consent to such care. Please indicate any other parent, step-parent, guardian or other individual(s) authorized to make medical decisions for the minor.

_____ _____

Representative Signature Relationship to Patient

_____

Other individuals authorized to make legal decisions for the minor

LITTLE VALLEY EYE CARE

Patient Information & History

PATIENT INFORMATION

Patient's Name: (Last, First, Middle) _____ Referral Source: _____

Birthdate: ____/____/____ Age: _____ Sex: M F

Address: _____ City, State, Zip:_____

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

*Email Address: _____ *Text & Email are for appointment reminders / 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): _____

--*We may ask you for the Patient's SS# or Policy Holder's SS# to verify certain insurances*--

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 (includees oral contraceptives, aspirin, over the counter / 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:
GENERAL (weight loss/gain)	☐	☐	_____
EAR, NOSE, MOUTH, THROAT (Allergies, sinus issues)	☐	☐	_____
CARDIOVASCULAR (heart attack, stroke, clots, etc.)	☐	☐	_____
RESPIRATORY (Asthma, Chronic Bronchitis, COPD, etc.)	☐	☐	_____
GENITOURINARY (Bladder, etc)	☐	☐	_____
GASTROINTESTINAL	☐	☐	_____
ENDOCRINE (Thyroid, Diabetes)	☐	☐	_____
BONES, JOINTS, MUSCLES (Arthritis, muscle/joint pain)	☐	☐	_____
SKIN	☐	☐	_____
NEUROLOGICAL (Headaches, Migraines, Seizures)	☐	☐	_____
ALLERGIC/IMMUNE DISORDERS	☐	☐	_____

LITTLE VALLEY
EYE CARE

Visual Symptom Survey

Please fill out these symptom surveys to help your doctor 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 ○

Do you experience any of the following symptoms?	YES	NO
Functional Vision		
Any Trouble Concentrating?	○	○
Do your eyes fatigue easily?	○	○
Do you have any balance Issues?	○	○
Ever had a concussion or Multiple concussions?	○	○
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?	○	○
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?	○	○