eye clinics of seattle

Patient Registration

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Mx.

Legal Name (Last, First): _____

Middle Name: _____ **Name Preference:** _____

Parent(s)/Guardian(s):_____ **DOB:** _____

Sex (as reported to insurance): ☐Male ☐Female ☐Rather Not Disclose **Pronouns:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Preferred Phone # _____ ☐Cell ☐Home ☐Work

Email: _____ ☐ I would prefer NOT to receive text/email notifications

SSN:_____ (for insurance purposes only)

Employer: _____ **Occupation:** _____

****IF YOU HAVE ADDITIONAL COVERAGE BEYOND WHAT'S NOTED, PLEASE NOTIFY A STAFF MEMBER****

Primary Vision Insurance: _____

Primary Insurance Holders Name**:** _____ DOB:_____

Relationship to Patient: _____ SSN (if not self): _____

Medical Insurance: _____

Primary Insurance Holders Name**:** _____ DOB _____

Relationship to Patient:_____

☐ I would like to authorize a family member or personal representative to access my medical records or handle billing on my behalf (separate form required).

All eye doctors at Eye Clinics of Seattle recommend the Optomap retinal scan for routine eye exams. The Optomap retinal scan allows us to screen for serious conditions in your eye like retinal tears and detachments, without the need for dilating your pupils. The Optomap retinal scan is quick and convenient compared to having your eyes dilated which takes 15 minutes to set in and another 4-6 hours of blurred vision up close afterwards. **If you wish to proceed with the Optomap retinal screening, there is an additional $39 cost that isn't covered by most insurance plans.**

☐ I elect to have the Optomap Retinal Scan performed as part of my eye exam today

☐ I elect to have my eyes Dilated as part of my eye exam today

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OFFICE POLICIES:

- **The evaluation of contact lenses is not included in the comprehensive exam. An additional charge will be issued for this service.** See back of page "contact lens wearers" section for more information.
- All contact lens orders must be paid in full at time of order. All eyewear orders require a minimum deposit of 50% before the order can be processed. Eyeglasses are custom made and cannot be refunded. However, remakes may be necessary to finalize your prescription. One remake will be done free of charge if done within 60 days of dispensing.
- Eye Clinics of Seattle will file insurance claims and await payment from your insurance company, but we cannot guarantee coverage by your insurance company, and you are ultimately responsible for any balances incurred. We will send you a statement if a balance remains, which is due within 30 days of notification. If payment is not received after 90 days, your account will accrue a 1% finance charge every month until payment is made. A $25 fee will be assessed for all returned checks.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT:

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so, or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our front desk.
Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. *A digital copy of this notice is available on our website, www.ecseattle.com.

By my signature below, I acknowledge receipt of the notice of Privacy Practices & Office Policies. This will be retained in your medical record.

Signature_____ Date_____

IMPORTANT INFORMATION FOR CONTACT LENS WEARERS:

The contact lens evaluation is not part of a standard routine eye exam because additional assessment is required to ensure that patients' eye health supports continued use of contact lenses, that the patients' contact lenses fit properly, and that the lenses provide adequate vision/comfort.

The baseline fee for a contact lens evaluation is $85 but may be lower or higher based on the complexity of the lens and fit. This fee includes complimentary follow-up visits as needed for 60 days after your exam and includes samples of contact lenses in your updated prescription. VSP patients usually pay no more than $60 after insurance discounts.

☐ Yes, I would like to continue to wear contact lenses.

☐ Yes, I am interested in wearing contact lenses for the first time.

☐ No, I am not interested in continuing contact lens wear.