Desert EyeCare Center

PATIENT UPDATE FORM

CONTACT INFORMATION

PATIENT NAME: _____
First MI Last

BIRTH DATE: _____ **TODAY'S DATE**: _____

Please **UPDATE ANY CHANGES**, if everything is the same as previous, you don't need to complete.

Phone: _____

Address: _____

Email: _____

Digital Retinal Imaging and Dilation:

The doctors at Desert EyeCare Center conduct thorough eye exams using the most advanced technology available. During your annual eye exam, we aim to evaluate the health of all ocular structures. In order to visualize the internal structures, we must perform either retinal imaging or pupillary dilation (there are situations where both may be indicated). Please select one of the following options:

_____**Optomap Digital Retinal Photos/Imaging (doctor's recommendation)**:
Your co-pay today: $35. The fastest and safest method to check the health of your eyes. These photos take 2-5 minutes to capture and will be reviewed in the exam room. They serve as a permanent record of your eye health and are a useful tool in monitoring your eye health over time. This technology is new to our office and captures a much wider view of the retina than our prior retinal photography.

_____ **Pupillary Dilation**:
Dilation requires the use of pharmaceutical eye drops. This will prolong your visit by 30-45 minutes and may be contraindicated in certain situations such as pregnancy. Side effects often include light sensitivity, blurred vision, inability to read and/or look at digital devices, and fatigue, these symptoms typically last 3-6 hours.

**Please note: some patients may need both photos and pupillary dilation based on their individual needs and/or diagnosis. This will be determined by the doctor during the eye exam.

MEDICAL VS. VISION INSURANCE
Desert EyeCare Center is required by law to follow proper coding and billing for eye/vision examinations.

Your vision insurance will only pay for a “well vision” exam if there is nothing wrong with the health of the eyes, but you suffer from focusing problems like nearsightedness, farsightedness, astigmatism, and presbyopia.

Your medical insurance will only pay for an exam if there is something wrong with the health of your eyes (for example: dry eye, cataracts, contact lens infection, glaucoma, etc.)

INITIALS: _____

Desert EyeCare Center may discuss my medical information and insurance information with:

Name: _____ Relationship: _____

HIPAA NOTICE AND ACKNOWLEDGMENT
I understand that a copy of the Privacy Practices is available to me.

SIGNATURE: _____

I request that payment of authorized insurance benefits be made on my behalf to Desert EyeCare Center (DECC). This is to include medical services rendered by myself and dependents. I assume responsibility for any deductible, co-pay, or other balance not covered by my insurance. Authorization obtained at the time of service does not guarantee payment. As a service to the patient, DECC will submit claims to your insurance carrier. DECC cannot guarantee that these claims will be honored. All denied claims will be billed to the patient. I recognize that it is my responsibility to know and understand my insurance coverage, or lack thereof. I understand that **ALL PROFESSIONAL FEES, GLASSES AND CONTACT LENS ORDERS ARE NON-REFUNDABLE** and due at the time of service. I authorize the doctor to release all information necessary to secure payment of benefits. I agree that I have reviewed DECC’s financial agreement, version VI, and agree to all terms.

SIGNATURE: _____**DATE**: _____