



Drs. T. Jeff Russell, Heather H. Winslow, and Slayt W. Ebeling

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

### MEDICAL/OCULAR HISTORY

Drug Allergies: \_\_\_\_\_

Surgical History: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Smoking History: ☐ Current smoker ☐ Former smoker ☐ Never smoker

#### Medical Conditions that Apply to You:

- ☐ Arthritis ☐ Asthma ☐ Cholesterol ☐ Headaches ☐ Heart Disease ☐ High Blood Pressure  
☐ HIV ☐ Lung Disease ☐ Rosacea ☐ Seasonal Allergies ☐ Seizures ☐ Shingles/Fever Blisters  
☐ Stroke ☐ Thyroid ☐ Cancer (please specify type) \_\_\_\_\_  
☐ Diabetes (if yes, most recent blood sugar count \_\_\_\_\_ and date taken \_\_\_\_\_)  
☐ Other: \_\_\_\_\_

#### Eye Conditions that Apply to You (past and present):

- ☐ Cataract ☐ Color Blindness ☐ Corneal Disease ☐ Diabetes ☐ Double Vision ☐ Dry Eye  
☐ Glaucoma ☐ Lazy Eye ☐ Macular Degeneration ☐ Retinal Detachment or Tear  
☐ Glasses – how long \_\_\_\_\_ Other Conditions: \_\_\_\_\_

#### Eye Surgery:

- ☐ LASIK/PRK ☐ RK ☐ Cataract ☐ Glaucoma ☐ Retina ☐ Cornea Transplant

Surgery Details: \_\_\_\_\_

#### Eye/medical conditions of your immediate family:

- ☐ Cataracts ☐ Glaucoma ☐ Diabetes ☐ Blindness ☐ Macular Degeneration ☐ Cornea

Any other type of ocular disease \_\_\_\_\_

#### Contact Lens History

Type of contact lenses you are wearing: ☐ Soft ☐ RGP ☐ Toric ☐ Multifocal ☐ Monovision

How long to you wear one pair of contact lens: ☐ 1 day ☐ 1-2 weeks ☐ 1-2 months ☐ other \_\_\_\_\_

Type of cleaning solutions used \_\_\_\_\_

Any allergies to contact lens solutions \_\_\_\_\_

Any allergies or other problems with contact lenses \_\_\_\_\_

## FINANCIAL/INSURANCE POLICY

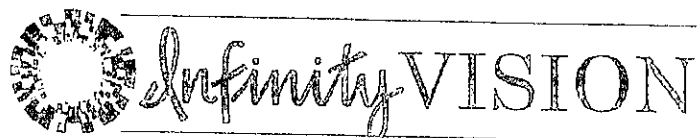
We have contracted with many insurance carriers or managed care networks to be providers on their plan. Contractually, both the provider and the patient have certain obligations under these plans. If you have medical insurance, we are anxious to help you receive your maximum benefits allowed. In order to achieve that goal, we need your assistance and your understanding of our payment policies.

- All payments for services not covered by your insurance plan, or services being filed on an insurance plan, are due at the time of service.
- We must have a copy of your current insurance card at the time of your visit in order to file a claim for you. If we do not have proof of valid insurance, you will be responsible for the full amount of services rendered.
- We will collect all co-payments/or deductibles due at the time of service.
- Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract and are not responsible for knowing the specific benefits of your plan.
- Verification of your benefits does not guarantee payment.
- Not all services are a covered benefit in your insurance contract. Some insurances companies select certain services they will not cover or set maximum limitations. Any services identified as such will be your responsibility and payment will be due at the time of service.

We must emphasize that filing of claims is a courtesy we extend to all our patients. All charges are your responsibility from the date services are rendered. It is understood that temporary financial problems may affect timely payment of your account. If such problems arise, please contact us promptly for assistance in the management of your account.

PLEASE ACKNOWLEDGE YOUR UNDERSTANDING AND AGREEMENT TO THESE TERMS BY SIGNING BELOW: I hereby authorize Infinity Vision, to furnish my insurance company, its representatives or any other insurance company or attorney, the customary medical information requested about me. I understand that Infinity Vision will file my insurance on my behalf and I will be responsible for following up with my insurance company for timely payment of services rendered. I agree to pay in full all balances due that are not paid by the insurance company.

Signature \_\_\_\_\_ Date \_\_\_\_\_



Drs T. Jeff Russell, Heather H. Winslow, and Slayt W. Ebeling

Refraction and Contact Lens Policy

One of the most important parts of your eye exam is the refraction. That is the part of the exam by which we determine the best possible acuity for your eyes, which is an essential piece of medical information that is used to assess your eyes and search for medical conditions and other vision problems. It is NOT a covered service by Medicare and many other insurance plans. The refraction fee is collected at the time of service. This is in addition to any co-payment, co-insurance, or deductible your plan may require. Should your insurance plan pay us for the refraction, we will reimburse you. Additionally, please note that contact lenses used for refractive purposes (i.e. for vision correction) are considered cosmetic by Medicare and most medical insurance plans, and are therefore not covered by insurance.

Yes, I have read the above information and understand that the refraction, contact lens exams, and contact lenses are a non-covered service. I accept full responsibility for the costs of these services and understand they are due at the time of service. I understand that any co-payment, co-insurance, or deductible I may have is separate from and not included in these fees.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**Should you choose NOT to have a refraction and should you break or lose your glasses, we will NOT be able to provide you with a glasses prescription. You will be asked to schedule a return appointment and charged another office visit along with the refraction fee.**



**Drs. T. Jeff Russell, Heather H. Winslow, and Slayt W. Ebeling**  
**Medical Information Privace Notice Summary**

This notice is required by law to inform you of the ways in which we may use your confidential and protected health information.

- 1) For treatment – we may release your medical information to other physicians for consultations, referrals, and coordination of your health care.
- 2) For payment – we may release your medical information to an insurance company or third party about your treatment so we may be reimbursed for your care or to obtain prior approval or to determine if your insurance company will cover the treatment.
- 3) Appointment reminders – we may use and disclose medical information to contact you as a reminder that you have an appointment for medical care or to change an existing appointment.
- 4) Individuals involved in your care or payment for your care – we may release medical information about you to a friend or family member who is involved in your medical care or payment of your medical care.
- 5) Workers compensation – we may release your medical information about you for workers compensation or similar programs.

You have the right to inspect and copy your medical information. You must submit your request in writing to the Privacy Officer. We may charge a fee for the costs of copying, mailing, or other supplies associated with your request. You have the right to request that we amend your medical information if you feel the information is incorrect or incomplete. The request must be in writing and must include the reason you wish to amend your information.

This is a summary of part of the Privacy Practices for InfinityVision. If you would like the complete privacy notice form, please notify the receptionist or one of our staff.

---

Signature of Patient

---

Printed Name and Date