**PATIENT INFORMATION HUDSON VALLEY EYE DOCTOR DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Mr. Miss. Ms. Mrs. Dr Marital Status: Single Divorced Married Widow

Last Name First Name MI Nickname

Address: City State Zip

Phone: Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

e-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ e-mail [ ] NO [ ] YES TEXT [ ] NO [ ] YES

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Student: full/part-time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **GUARANTOR, RELATIONSHIP** [ ] SELF If you are filling this form out for your child, please list **YOUR i**nformation here

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guarantor’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_e-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

**Health / Major Medical Insurance**: Name of Insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appointment cancellation or no show without 24 hour notice incurs a charge of $50.00. All Co-Pays and unpaid deductibles are due at the visit. Payments accepted: Cash Debit Card Credit Card CareCredit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I authorize release of information to all my insurance companies.

2. I authorize my insurance company to send payment directly to my doctor.

3. I understand that I am responsible for my bill, and there may be charges that my insurance company does not cover, and I will pay for those non-covered services.

4. I give my consent to electronic filing of my insurance claims and prescriptions.

5. I understand that it is my responsibility to obtain a referral for service if it is required by my insurance company.

If I do NOT have the necessary referrals required by my Insurance company, I will be responsible for payment of the services rendered.

**Print Patient’s Name Patient’s Signature (Guarantor/Guardian) Date**

**Lifestyle Questionnaire** : Answers assist us in assessing your visual needs.

**1. What do you like about your current pair of glasses and or contact lenses?**

**2. What don’t you like about your current pair of glasses and or contact lenses?**

**3. Your activities (circle all that applies:** Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cooking sewing needlepoint/knitting board games soldering/welding painting golf

Woodworking art skiing/skating/snowboard motocycle/motorcross autorepair cards

Crafts fishing boating nature/birding snorkeling/scuba/swim electrical sports

Musical instruments gaming hunting target shooting/archery gardening/landscaping

**4. Does your work entail unusual visual demands?**

Driving Distance viewing Outdoor work Natural or artificial lighting caustic environment

Near work Indoor work clean room abrupt changes in light level clean room

Position microscope/telescope Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Are you bothered by glare from any of the following? (circle all that apply)**

Night driving/headlights haze fluorescent lights LED lights smart phone

Sunshine/UV exposure tablets computer screen other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. What electronic devices do you use and how much time do you spend on each device?**

Smart Phone\_\_\_\_\_\_\_\_ Tablet\_\_\_\_\_\_\_\_\_ Video Games\_\_\_\_\_\_\_\_\_\_\_\_\_ IPod\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other electronic devices:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you wear Blue-blocking eyewear? [ ] NO [ ] YES

Do your eyes tire or do you have fluctuating vision while using these devices? [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. Do you use a computer/ laptop?** [ ] NO [ ] YES How many screens/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Distance from your eyes to the computer screen?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Laptop screen?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Screen Position?** Right Left Center **Screen Top** [ ] straight ahead [ ] below line of sight

How many hours a day are you using the computer/laptop work and home?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8. Do you currently use more than one pair of glasses?** [ ] NO [ ] YES

Bifocals Distance Golf Scuba specs Tennis Shooting Ski goggles Swim goggles

Trifocals Reading Sunglasses Driving Hobby Sports/safety Hobby

Progressive computer Intermediate Music Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9. Contact Lenses** [ ] NO [ ] YES Type and Brand:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Disinfection system:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How many hours of wear?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all family members living at home:

Name Last Eye Exam Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hudson Valley Eye Doctor**

**PLEASE READ COMPLETELY AND KEEP FOR YOUR RECORDS**

Advancements in contact lens technology off the potential of successful contact lens wear to most of our patients. A contact lens is a medical device in contact with the tissues of youreye; therefore, it mut fit appropriately to maintain the health of your eyes. A contact lens prescription can only be determined by the careful observation of the lens on the eye and the eye’s response to the lens on the follow-up visits. Since follow-up care is essential, it is your responsibility to keep all appointment and follow all lens care instructions.

**THE COMPREHENSIVE EYE EXAM**

Before a patient can be fit with contact lenses, a complete medical and refractive eye examination is necessary. This exam is critical to assure the good health of your eyes and to rule out the possibility of any unsuspected, underlying condition that may prevent contact lens use.

**CONTACT LENS FITTING AND EVALUTATION**

The goal of contact lens fitting is to find the most appropriate contact lens for each patient’s optimal vision and comfort. An enormous variety of types, materials, sizes and colors are offered. We are committed to taking the time and effort to fit your contact lenses properly. Although many patients will need only one fitting session, sometimes this process requires several appointments. In our experience, the extra time, effort and patience are well merited by both your ultimate satisfaction and the health of your eyes. All patients being fit into contacts for the first time must go through the fitting process. We will not finalize the contact lens prescription until both the patient and the doctor are satisfied with the fit and visual acuity of the contact lens. **We will provide one set of trial lens for new fits and change in prescription. If additional lenses are necessary, due to damage or lost lens, there will be a fee of $5.00 per lens to cover the cost of the lenses (\*\*except for specialty diagnostic trials and the fee is manufacturer based)**Any patients who are changing lens brands must also have a new fitting. A fitting does not have to be performed on the day of the comprehensive eye exam and can be performed in an additional appointment slot.

**CONTACT LENS TRAINING SESSION**

The patient will be scheduled for a personalized instruction concerning the safe care and usage of contact lenses. The first training session will be 30 minutes long. If additional time is needed, it will be necessary to schedule a second 30-minute training session at a different time. Upon completion of successful insertion and removal, the patient may begin wearing the contact lenses and we will schedule the first follow-up appointment.

**FOLLOW-UP APPOINTMENTS**

Follow-up appointments are necessary to assure several things:

1. The contact lenses are fitting and moving well

2. The prescription is providing the best possible vision

3. The eyes are remaining healthy

4. There are no problems with insertion or removal

5. The patient understands and complies with the recommended wearing schedule.

There is no charge for follow-up visits during the first 45 days after receipt of contacts. Follow-up visits after that time will be charged at $47.00 and will be due on date of service.

**ANNUAL CONTACT LENS CHECK**

By law, a contact lens prescription is valid for only one year. All patients are required to come in for an annual contact lens exam. This is necessary to assure the patient’s eyes are healthy and the contact lenses are still fitting well. Contact lens prescriptions cannot be renewed without an annual exam.  **If we are seeing your for the first time, and you have had a contact lens prescription from another office, we will consider it a new fit.**

**IF YOU ARE INTERESTED IN CONTACT LENSES TODAY, PLEASE READ AND SIGN:**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_

**CONTACT LENS FEES:** The refraction fee

The cost of a comprehensive eye exam

The cost of the contact lenses

Specialty Diagnostic trials

Instruction/training for contact lens wear CONTACT TYPE NEW FIT YEARLY CONTACT LENS EXAM

Yearly exam that entails problems No Problems or changes in Lens

Soft Lenses DW 128.00 100.00

Extended Wear 226.00 194.00

Toric Disposable 136.00 105.00

Monovision 148.00 125.00

Multifocal Disposable 272.00 137.00

RGP new 272.00 125.00

RGP multifocal (custom lens) 357.00 226.00

Scleral/Complex (custom lens) starting at 500.00

Contact Lens Instruction/Lesson $20 per 30 min/session

**ABOVE FEES DO NOT INCLUDE THE COST OF THE CONTACT LENSES. ALL FEES INCLUDE 30 DAYS OF FOLLOW-UP CARE AT N/C. ADDITIONAL FOLLOW-UP VISITS ARE $45.00 EACH**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BY LAW, WE CANNOT GIVE OUT CONTACT LENS PRESCRIPTIONS UNLESS WE HAVE SEEN THE PATIENT WITHIN THE LAST YEAR.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PAYMENT**

Fees for the comprehensive exam, contact lens fitting, or annual contact lens checks are **due at the time of service.** The full estimated payment is required for all contact lens orders. Any remaining payment must be paid at the time of pick-up before the contact lenses will be dispensed. Replacement contact lenses will only be dispensed when original lenses are returned to our office in the case of specialty lenses. We accept cash, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS. After the initial fit, we will gladly order contact lenses over the phone with a credit card as long as the prescription is valid.

**REFUNDS**

There will be no refund on custom lenses, opened boxes of lenses, or colored lenses because of dissatisfaction with the color. There will be NO refund of the exam, fitting, instructional class, or annual contact lens check fees.

**CONTACT LENS BENEFIT WITH VISION COVERAGE**

[ ] I wish to use my vision coverage for contact lenses. I am aware that this may be a partial allowance and it includes the initial fit/evaluation and one follow-up visit. I will be responsible for any portion that is not covered by my vision benefit. The benefit does not include the class for the instruction for contact lens insertion/removal and care. If you require additional follow-up visits, there will be a charge as stated above. Once you are fit and use your benefit for contact lenses, you cannot use the benefit for eyeglasses. If you decide you do not want contact lenses after the fit is finalized and the benefit has been submitted to your vision insurance, you will not be eligible for material (eyeglass benefits until your next eligibility (either 12 or 24 month) This is your vision benefit and a contractual agreement with your employe and you vision benefit.

**I have read and understand the Contact Lens Policy, the Contact Lens Fee Policy, and the Contact Lens Care Guide. All of my questions have been answered and I have received copies of the above information. I understand that my compliance with the Contact Lens Care Guide is of the utmost importance in the health of my eyes.**

Parent/Guardian Signature Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hudson Valley Eye Doctor of Optometry**

**SOFT CONTACT LENS CARE GUIDE**

**.** Always make sure contact lenses are right side out before insertion. The edges should “rol up” at the lens profile. If the edges are flared slightly the contact may be inside out. An inexpensive magnifier can be very helpful with this evaluation.

**.**  Wear lenses for 4 hours on the first day and increase wear by 2 hours each day until a maximum of 12-14 hours has been reached.

**.** After removing contacts, clean properly and place in contact lens case, using new solution every day.

Lenses should be stored at least 4-6 hours for complete disinfection. (Depending on care system)

**.** If wearing soft contact lenses that are not disposable, you must use an enzymatic leaner. Johnson & Johnson ULTRAZYME Enzymatic Cleaner once a week. Lenses must soak in the enzymatic cleaner for at least 4 hours for the process to be effective. Rinse lenses thoroughly after this process, then disinfect.

**.** Daily Protein Remover Drops: Blink’s Blink & Clean, Alcon, CLERZ PLUS Lens drops (used while the lenses are in your eyes).

**.**  Do not allow soft lenses to come in contact with water. Use only solution that is compatible with soft contact lenses.

**.** Do not sleep, swim or shower with lenses on. Extended wear lenses are specific lenses approved by the FDA for 24 hour wear.

Some **ADAPTIVE SYMPTOMS** are normal for the first couple of weeks. These symptoms include, tearing upon contact lens insertion or removal, mild sensitivity to light, a slight headache, foreign body sensation, dryness, and mild itching. These symptoms should clear up when all-day wear is achieved.

**ABNORMAL SYMPTOMS** include persistent pain, burning and excessive tearing, redness that does not clear up, hazy vision that remains more than one hour after removal, and abnormal sensitivity to light. If there symptoms occur at any time, you should remove the lenses and call our office (845)565-2020.

NOTE: Do not sleep in your lenses. Should you fall asleep in your lenses, be sure to lubricate them well to loosen them before removal. Once the lens is moving freely on the eye, it can be removed. If you experience abnormal discomfort or a dry feeling, contact or office (845) 565-2020.

**CLEANING SOLUTIONS AND REWETTING DROPS**

**.**  There are different types of cleaning solutions available. We will provide you with the best solution for your needs

**.** Rewetting drops may be important for lubricating the eye and keeping the contact hydrated. To promote comfort and good vision, the lens must be well hydrated. Rewetting solutions also keep debris from building up under the contact lens. Frequency of rewetting drop use varies from patient to patient. If you do a lot of close work, such as reading or working on a computer, tablet, cell phone, you may experience more dryness because of the reduction in blinking. Certain medications such as antihistamines, diuretics, and birth control pills contribute to dryness as well. Do not use an eye drop that is not specified for contact lens use. Do no use disinfecting solution as a rewetting drop.

**REMEMBER**

**Your compliance with the above is the utmost importance to be successful with contact lens wear and to avoid any unnecessary trauma to the eye. Noncompliance with contact lens care can result in serious eye problems. Please contact Hudson Valley Eye Doctor with any question or concerns about contact lenses at any time.**