Dr. Tom MacMillan
Dr. Jeremy Anderson
Dr. Lindsay Wood
Dr. Alexis Mears
Dr. Melissa Bogert

Spartanburg VISION

*Our **vision** is to protect **yours***

1200 E. Main Street, Suite 2
Spartanburg, SC 29307
(864) 585-7807
www.spartanburgvision.com

Date: ____ / ____ / ____

Name: Last _____ First _____ M.I. _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home / Mobile Phone: _____ Texting Okay? Y / N Work Phone: _____

Date of Birth: _____ / _____ / _____ Age _____ Male / Female SS#: _____

Marital Status: ☐ Single ☐ Married ☐ Other _____Race: Asian / Black / Hispanic / White / Other _____

Employer: _____ Occupation: _____ Email: _____

How were you referred to our office? _____

Who is the insurance policy holder?

☐ Self ☐ Other: Insured's Name: _____ Insured's DOB: ____ / ____ / ____

Insurance information not required if you provided VISION and MEDICAL cards to receptionist

Name of Primary **Medical** Insurance Carrier: _____ ID #_____

Name of Secondary **Medical** Insurance Carrier: _____ ID # _____

Name of **Vision** Insurance Carrier: _____ ID # _____

✦ *If you have **diabetes**, your exam will be billed to your **medical** insurance. Every diabetic exam requires dilation and a report will be sent to your medical provider. Please note that the specialist copay is typically between $30-$60*

## Eye History

Why did you schedule your visit today? _____

Do you wear glasses? Yes / No / Full-time / Part-time / Distance Only / Near Only

Do you currently wear contacts? Yes / No / Clear / Color Brand _____

Do you want to be fitted for contacts today? Yes / No / Clear / Color

***Please check any of the following that apply***

| | | | |
|---|---|---|---|
| ☐ Blurry vision | ☐ Dryness or irritation | ☐ Itchy Eyes | ☐ Droopy Eyelid(s) |
| ☐ Flashes or floaters | ☐ Eye Pain or Redness | ☐ Headaches | ☐ Double Vision |

***Medication changes since last eye exam***

_____

***Please complete other side***

## Authorization for Release of Information

This form authorizes Spartanburg Vision to release protected information about the patient to the people listed below (e.g. spouse, parent, sibling) by means of phone calls and voice mails/answering machine messages.

I consent to the release of (please check all that apply):

- □ Financial/Billing Information
- □ Medical Care (treatments plans, medications, procedures, appointments, test results, etc.)

_____ _____

Name/Relationship to patient Phone

## Access to your Glasses and Contact Lens Prescriptions

- In an effort to reduce paper waste, we request that you allow us to provide you with a digital copy of your prescriptions through our patient portal.
- In addition to 24/7 access through your patient portal, we are always happy to provide you with a printed copy of your prescription or, if you prefer, we can also send it to you via email.

I agree to receive a digital copy of my prescription via the patient portal ☐ YES ☐ NO _____

(Please Initial)

## Eyeglass Refund & Exchange Policy

We want you to love your new glasses and are committed to making things right if there is an issue. Because prescription lenses are custom-made specifically for you and cannot be reused, full refunds are not available once lenses have been manufactured by the lab.

**Our Promise to You**

- If you are having difficulty adapting to your new lenses purchased at our office, we will gladly provide a **one-time remake at no charge within 30 days** of purchase. If you remain dissatisfied after the lenses have been remade:
  - Lenses may be returned for a 50% refund
  - Frames may be returned if they are in original condition. A $20 re-stocking fee will be applied.
- If you are having difficulty adapting to lenses purchased elsewhere, ask the seller to verify that the lenses have been made correctly. If difficulty persists, we will be happy to re-check your prescription but this may incur a refraction fee.

Your satisfaction matters to us. If you are having trouble with your glasses, please let us know—we will make every reasonable effort to resolve the issue before considering a refund.

_____

(Please Initial)

## Statement of Financial Responsibility and Assignment of Insurance Benefits

I understand that I am financially responsible for all charges not paid by insurance. I authorize the release of information to my insurance company for billing purposes. I hereby authorize payment from my insurance company to Spartanburg Vision.

***We require that a retinal image is taken for every patient. The fee is $10 and is not covered by insurance.***

X _____ _____ _____

Signature of Patient (legal guardian if minor) Print Name Date