Griffin & Reed Eye Care

ABOUT YOUR CHARGES & YOUR PRIVACY

At Griffin & Reed Eye Care, we are a **medical office** dedicated to the health of your eyes. As part of your comprehensive eye care, we also offer vision services, including prescriptions for glasses and contact lenses.

Please note:

Vision services are **typically not covered by medical insurance**. A separate **vision insurance plan** may cover some or all of the fees listed below.

Fees not covered by Medical Insurance Plans

- Prescription for Glasses $45.00
- Retinal Screening Image $39.00
- New Prescription for Contacts $145.00 (see fitting agreement
- Current Prescription for Contacts $95.00 for more details)

Comprehensive Eye Exam Fees

New Patients	$175.00
Current Patients	$155.00

Payment & Insurance Information

These fees are **due at the time of service.** Once the services have been performed, the above fees are not refundable. As a courtesy, we are happy to bill your insurance company of your behalf. To bill your insurance, you must provide: Current insurance card(s), billing address, Group and ID numbers, etc.

If your insurance company does not cover or denies payment for services provided, **you are responsible for the full balance of the fees listed above**. You will be asked to sign below prior to your exam to acknowledge your understanding and acceptance of financial responsibility.

Limits on Use and Release of Protected Information

At Griffin & Reed Eye Care; we are required by law to:

- Maintain the privacy and security of your protected health information (PHI)
- Provide you with this notice of our legal duties and privacy practices
- Notify you promptly if a breach occurs that may compromise your information

How We May Use and Disclose Your Information:

We may use and disclose your protected health information (PHI) to provide, coordinate, and manage your healthcare treatment, including communication with other healthcare providers involved in your care. Your information may also be used for payment purposes, such as billing your insurance, verifying coverage, and collecting payment for services rendered. In addition, we may use your information for healthcare operations, including quality improvement, staff training, and general administrative functions necessary to operate our practice. We will only use or disclose your information as permitted by law, and any uses beyond these purposes—such as marketing or the use of photos and testimonials—will require additional written authorization.

Permitted Disclosures without patient consent:

- Oversite of the health care system, including quality assurance activities.
- Public Health Issues
- Research generally limited to when a waiver of authorization is independently provided by a privacy board or Institutional Review Board.
- Judicial or administrative proceedings
- Certain Law Enforcement activities
- Emergencies and serious threats to health and safety

I have read and understand the information above. I give my consent to use my protected information as stated above and I understand I will be held responsible for any services, not covered by my insurance.

_____	_____	_____
Patient's Name (Please Print)	Patient's Signature	Date

GRIFFIN & REED EYE CARE

"Keeping your world in focus"

WELCOME TO OUR OFFICE

(Please Print)

Name_____

Street_____

City_____State___Zip_____

Home Phone _____

Wk Phone _____Cell_____

Date of Birth _____/_____/_____ Age_____ M / F

Single Married Divorced Drivers Lic# _____

SSN:_____

E-mail address _____

Employer _____

Parent's Name if not 18 _____

Emergency Contact _____

Relation_____Phone #_____

Vision Insurance Information

Insurance_____

Subscriber Name_____

Subscriber SS# ID#_____

Subscriber Date of Birth _____/_____/_____

Are you Subscriber Spouse Dependant ☐ Partner

Primary Major Medical Insurance

Insurance_____

ID#_____Group#_____

Subscriber Name_____

Subscriber Date of Birth _____/_____/_____

Are you Subscriber Spouse Dependant ☐ Partner

Secondary Major Medical Insurance

Insurance_____

ID#_____Group# _____

Subscriber Name_____

Subscriber Date of Birth _____/_____/_____

Are you Subscriber Spouse Dependant ☐

Please Update Your Medical History

(please circle if you have ever had the following)

Allergies: Seasonal Allergies Contact Lens Solution Eye Drop Allergies

Allergies to Medications: Y / N

List_____

Primary Care Physician:_____

Current Medications:_____

_____

Respiratory Problems: Shortness of Breath Wheezing Coughing Asthma Emphysema

Heart: Chest Pain Angina Irreg or Fast Heart Beat High Cholesterol

Blood: High Blood Pressure HIV Aids

Nervous System: Hearing Problems Migraine Headaches Dizziness Stroke Paralysis Alzheimer

Endocrine: Diabetes Thyroid Problem

EYE HISTORY

FOR YOU OR ANY BLOOD RELATIVES

S=Self. M=Mother, F=Father, B=Brother ,S=Sister

- Cataract S M F B S _____
- Glaucoma S M F B S _____
- Lazy/Crossed eyes S M F B S _____
- Diabetes S M F B S _____
- Night Blindness S M F B S _____
- Retinal or macular Degeneration S M F B S _____

List Any Eye Surgeries_____

Contact Lenses

Have you ever worn Contact Lenses? Yes No

Do you wear them now? Yes No

Hobbies or Sports you participate in..

Aerobics	Computers	Mt Climbing	Tennis
Baseball	Dancing	Music	Track
Basketball	Fishing	Reading	VllyBll
Bicycling	Football	Scuba/Snrkl	Wtr Spts
Boating	Gardening	Skiing	Writing
Bowling	Golf	Soccer	
Camping	Hunting	Swim	

How did you hear of our office?

Internet Friend or Family member

Radio Station _____ Other_____