

## APPOINTMENT CHECKLIST-ADULT STRABISMUS

- Current health insurance information, including ID card
- Photo identification
- Complete registration forms from link provided or download and print forms from our website.  
The check-in time is when the patient presents completed registration forms, not when the patient arrives. Please arrive 20-30 minutes prior to your appointment time if forms need to be completed in the office.
- Referral/Authorization (if required by your insurance)
- List of all medications/supplements you take (including strengths/dosages)
- Pharmacy information (name, address, and phone number)
- Please bring a translator, if necessary.
- Copays and other out of pocket expenses will be collected at check-in. We accept cash, check, and most credit cards.
- Glasses and/or contact lenses (Please bring contact lens boxes with lens information.)
- If relevant, please bring records pertaining to your condition such as relevant MRI/CT results, lab results, etc. If you have had strabismus surgery, please obtain a copy of the operative report from the surgeon and bring it to your appointment.
- Please allow sufficient travel time. If you arrive more than 15 minutes after your scheduled appointment time, you may be asked to reschedule.
- Your initial evaluation may take several hours, please plan accordingly.



**Ideal EyeCare • 6028 S. Fort Apache Road, Suite 101 • Las Vegas, NV 89148**

**THANK YOU FOR CHOOSING IDEAL EYECARE**

Name (Last, First, MI):		Date of Birth:	Age:
SSN:	Gender:	Marital Status:	
Cell Phone:	Email:		
Home Phone:			
Street Address:		Apt/Unit #:	
City, State, Zip Code:			
Race: <input type="checkbox"/> Alaskan <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hawaiian/Pac Islander <input type="checkbox"/> Spanish/Latin <input type="checkbox"/> White <input type="checkbox"/> Other _____			
Ethnicity:	Preferred Language:		
Employer:	Occupation:		
How did you hear about us?			
<input type="checkbox"/> Google/Internet Search <input type="checkbox"/> YouTube ad <input type="checkbox"/> Facebook/Instagram <input type="checkbox"/> Word of Mouth <input type="checkbox"/> Physician referral <input type="checkbox"/> Other _____			
Pharmacy:	Phone #:	Cross Streets:	
Referring Physician:	Phone #:		
Primary Care Physician:	Phone #:		
Emergency Contact:	Phone #:		

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Name:	Insurance Name:
ID #:	ID #:
Group #:	Group #:
Subscriber Name:	Subscriber Name:
Relationship to patient:	Relationship to patient:
Subscriber Date of Birth:	Subscriber Date of Birth:

### HIPAA Approved Contacts

Name	Phone:	Relationship:	Date of Birth:
Name	Phone:	Relationship:	Date of Birth:
Name	Phone:	Relationship:	Date of Birth:

### Patient or Authorized Person's Signature

I understand that even if Ideal EyeCare is contracted with my insurance plan, I am ultimately responsible for payment of both covered and non-covered services performed during the course of my treatment. I understand that any payment collected today is an *estimate* of my total liability and additional monies may still be owed once my insurance plan has processed the claim. I request payment of authorized benefits by my insurance plan be made to Ideal EyeCare for services rendered and request that Ideal EyeCare submit claims for payment for those services on my behalf to my insurance carrier. I authorize the release of any/all medical information to the insurance carrier or its agents to allow for benefit or claim determination. I understand that if Ideal EyeCare does not participate with my insurance plan or if I have elected to receive care outside of my insurance coverage, I am assuming financial responsibility for all services rendered and no claim will be filed to my insurance company on my behalf. I certify that the information provided above is complete and accurate and assume any and all financial liability caused by omissions or inaccuracies.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

*We also offer a multitude of aesthetic services!*

Whether your concerns are fine lines and wrinkles, facial volume loss, body contouring, brown spots or pigment, acne treatment/prevention, and/or tattoo removal, we have advanced solutions available for every skin type.

Yes, I would like more information.

No, thank you. I am not interested.

## MEDICAL HISTORY QUESTIONNAIRE-ADULT

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**Primary Care Doctor:** \_\_\_\_\_ **Referring Doctor/Specialist:** \_\_\_\_\_

**What is the reason for today's visit?** \_\_\_\_\_

**Do you need to renew your Drivers License within the next 90 days?**  Yes  No

**If you wear glasses, what is your preferred type? (Please mark all that apply)**

- Distance only   
  Reading Only   
  Computer Only   
  Bifocals   
  Trifocals  
 Progressives (no line bifocal)   
  Rx Sunglasses   
  Non-Rx Sunglasses

**Do you wear contact lenses?**  Yes  No      **Are you interested in contact lenses?**  Yes  No

Allergies	Reaction	Severity
_____	_____	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
_____	_____	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
_____	_____	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
_____	_____	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe

**Are you currently experiencing any of the following:** (Please mark all that apply and provide detail)

- |  |  |
|--|--|
| <input type="checkbox"/> Abnormal Head Position _____<br><input type="checkbox"/> Blurry/Decreased Vision _____<br><input type="checkbox"/> Double Vision _____<br><input type="checkbox"/> Droopy Eyelid(s) _____<br><input type="checkbox"/> Dry Eyes _____<br><input type="checkbox"/> Eye Injury _____<br><input type="checkbox"/> Eye Pain/Burning _____<br><input type="checkbox"/> Eye Misalignment _____ | <input type="checkbox"/> Flashes/Floaters _____<br><input type="checkbox"/> Glare/Light Sensitivity _____<br><input type="checkbox"/> Growth/Bump in Lid _____<br><input type="checkbox"/> Headaches _____<br><input type="checkbox"/> Itchy Eyes/Eyelids _____<br><input type="checkbox"/> Red Eyes _____<br><input type="checkbox"/> Watery Eyes _____<br><input type="checkbox"/> Other _____<br><input type="checkbox"/> <b>NONE</b> (I am not experiencing any of these symptoms) |
|--|--|

**Past Ocular History:** (Please mark all that apply and provide detail)  **NONE** (I have never had any of these conditions)

- |   |  |
|---|--|
| <input type="checkbox"/> Amblyopia (Lazy Eye) _____<br><input type="checkbox"/> Aphakia _____<br><input type="checkbox"/> Astigmatism _____<br><input type="checkbox"/> Cataracts _____<br><input type="checkbox"/> Diabetic Retinopathy _____<br><input type="checkbox"/> Dry Eyes _____<br><input type="checkbox"/> Glaucoma _____<br><input type="checkbox"/> Hyperopia (Farsightedness) _____ | <input type="checkbox"/> Iritis/Uveitis _____<br><input type="checkbox"/> Keratoconus _____<br><input type="checkbox"/> Macular Degeneration (Dry) _____<br><input type="checkbox"/> Macular Degeneration (Wet) _____<br><input type="checkbox"/> Myopia (Nearsightedness) _____<br><input type="checkbox"/> Optic Neuritis _____<br><input type="checkbox"/> Retinal Detachment _____<br><input type="checkbox"/> Other _____ |
|---|--|

**Past Ocular Surgeries:** (Please mark all that apply and provide detail)

- |   |  |
|---|--|
| <input type="checkbox"/> Blepharoplasty _____<br><input type="checkbox"/> Cataract Surgery _____<br><input type="checkbox"/> Corneal Transplant _____<br><input type="checkbox"/> Foreign Body Removal _____<br><input type="checkbox"/> LASIK/PRK/RK _____<br><input type="checkbox"/> Ptosis Repair _____<br><input type="checkbox"/> Punctal Plugs _____ | <input type="checkbox"/> Retinal Laser _____<br><input type="checkbox"/> RD Repair _____<br><input type="checkbox"/> Strabismus Surgery _____<br><input type="checkbox"/> Glaucoma Surgery _____<br><input type="checkbox"/> Vitrectomy _____<br><input type="checkbox"/> Other _____<br><input type="checkbox"/> <b>NONE</b> (I have never had eye surgery) |
|---|--|

**WOMEN: Are you pregnant or nursing?**  Yes  No

**MEN: Have you ever taken prostate medicines / alpha blockers?**  Yes  No If yes, please mark which medication(s):

- Flomax  
  Tamsulosin  
  Hytrin  
  Cardura  
  Saw Palmetto  
  Doxazosin  
  Terazosin  
  Uroxatral  
  Rapaflo

**Preferred Pharmacy (Name & cross-streets)** \_\_\_\_\_

**Systemic Medications:** (Please list all OTC/supplements/Prescription Medications you take inc dosage/strength)

- Please see Medication List (separate page)   
  **NONE** (I do not take medications (OTC or RX)/vitamins/supplements)

**Ocular Medications:** (Please list **all** OTC/supplements/Rx medications, inc. dosage/strength-or attach a separate page)



**Ocular Significant Illnesses/Conditions:** (Please mark all that apply and provide detail)

- Bell's Palsy \_\_\_\_\_
- Brain Tumor \_\_\_\_\_
- Cancer \_\_\_\_\_
- Chicken Pox/Shingles \_\_\_\_\_
- Diabetes \_\_\_\_\_
  - Type I  Type II  Diet-Controlled  Insulin Use  Oral Medication(s) Use Last Hemoglobin A1C \_\_\_\_\_ Date \_\_\_\_\_
  - Average BSL \_\_\_\_\_ Name of doctor who manages your diabetes (Internist/Endocrinologist) \_\_\_\_\_
- Headaches/Migraines \_\_\_\_\_
- Herpes Simplex \_\_\_\_\_
- Histoplasmosis \_\_\_\_\_
- HIV/AIDS \_\_\_\_\_
- Hypertension \_\_\_\_\_
- Meningitis \_\_\_\_\_
- Myasthenia Gravis \_\_\_\_\_
- Multiple Sclerosis \_\_\_\_\_
- Parkinson's \_\_\_\_\_
- Rheumatoid Arthritis \_\_\_\_\_
- Stroke/TIA \_\_\_\_\_
- Syphilis \_\_\_\_\_
- Thyroid disease \_\_\_\_\_
- Other: \_\_\_\_\_
- NONE** (I have never had any of these conditions)

**Other Past Medical Illnesses** (Please mark all that apply and provide detail)

- Anemia \_\_\_\_\_
- Asthma \_\_\_\_\_
- CHF \_\_\_\_\_
- COPD/Emphysema \_\_\_\_\_
- Depression \_\_\_\_\_
- Eczema \_\_\_\_\_
- Hearing Loss \_\_\_\_\_
- Heart Attack (MI) \_\_\_\_\_
- Irregular Heartbeat (Arrhythmia) \_\_\_\_\_
- Kidney Disease \_\_\_\_\_
- Lung Disease \_\_\_\_\_
- MRSA \_\_\_\_\_
- Osteoarthritis \_\_\_\_\_
- Polymyalgia \_\_\_\_\_
- Psychiatric Disorder \_\_\_\_\_
- Seizure Disorder \_\_\_\_\_
- Skin Cancer \_\_\_\_\_
- Sleep Apnea \_\_\_\_\_
- Other \_\_\_\_\_
- Other \_\_\_\_\_
- NONE** (I have never had any of these conditions)

**Other Systemic Surgeries/Operations:** (Please include dates performed and request separate page if necessary)

- Please see Procedure List (separate page)  **NONE** (I have never had any type of surgery or procedure)

**Family History** (Please mark all that apply and circle which family member)

- Blindness \_\_\_\_\_ Parent / Sibling / Maternal Grandparent / Paternal Grandparent
- Cataracts \_\_\_\_\_ Parent / Sibling / Maternal Grandparent / Paternal Grandparent
- Glaucoma \_\_\_\_\_ Parent / Sibling / Maternal Grandparent / Paternal Grandparent
- Strabismus \_\_\_\_\_ Parent / Sibling / Maternal Grandparent / Paternal Grandparent
- Amblyopia (Lazy Eye) \_\_\_\_\_ Parent / Sibling / Maternal Grandparent / Paternal Grandparent
- Macular Degeneration \_\_\_\_\_ Parent / Sibling / Maternal Grandparent / Paternal Grandparent
- Diabetes \_\_\_\_\_ Parent / Sibling / Maternal Grandparent / Paternal Grandparent
- Cancer \_\_\_\_\_ Parent / Sibling / Maternal Grandparent / Paternal Grandparent
- Heart Disease \_\_\_\_\_ Parent / Sibling / Maternal Grandparent / Paternal Grandparent
- Hypertension \_\_\_\_\_ Parent / Sibling / Maternal Grandparent / Paternal Grandparent

**Unknown Family History**

**Social History:**

- Do you smoke/vape tobacco?  Yes  No If yes, how much and how often? \_\_\_\_\_
- Have you ever smoked tobacco?  Yes  No Do you use other tobacco products?  Yes  No
- Do you drink alcohol?  Yes  No If yes, how much and how often? \_\_\_\_\_
- Do you use recreational drugs?  Yes  No If yes, what substance and how often? \_\_\_\_\_

**Are you bothered by Dry Eyes? Please indicate which symptoms you experience:**

- Burning  Eye Fatigue  Gritty/Sandy sensation  Soreness  Irritation  Watery eyes

**Do you use artificial tears?**  Yes  No **What brand and how often?** \_\_\_\_\_

**Do you use Restasis, Cequa, or Xiidra regularly?**  Yes  No

**Have you received any of these treatments?:**

- Punctal Plugs  LipiFlow  Autologous blood serum drops  IPL (Intense Pulsed Light)  Prokera graft  iLux  BlephEx

I have completed this form as accurately as possible. I understand that providing incorrect information or omitting information can be dangerous to my health and it is my responsibility to inform the office of any changes in my health status.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**REVIEW OF SYSTEMS (Please check any/all symptoms/conditions you *currently* experience)**

<p><b>Ears, Nose, and Throat</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Hearing Impairment</li> <li><input type="checkbox"/> Ringing in Ears</li> <li><input type="checkbox"/> Vertigo</li> <li><input type="checkbox"/> Cold Sores</li> <li><input type="checkbox"/> Dry Mouth</li> <li><input type="checkbox"/> Sinusitis</li> </ul> <p><b>Cardiovascular-Heart</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chest Pain</li> <li><input type="checkbox"/> Dizziness</li> <li><input type="checkbox"/> Fainting Spells</li> <li><input type="checkbox"/> Shortness of Breath</li> <li><input type="checkbox"/> Irregular Heartbeat (arrhythmia)</li> <li><input type="checkbox"/> Atrial Fibrillation</li> <li><input type="checkbox"/> Difficulty Lying Flat</li> <li><input type="checkbox"/> Leg Swelling</li> <li><input type="checkbox"/> Palpitations</li> <li><input type="checkbox"/> Blood Clots (DVT)</li> <li><input type="checkbox"/> High Cholesterol</li> </ul> <p><b>Constitutional</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Fatigue/Weakness</li> <li><input type="checkbox"/> Fever</li> <li><input type="checkbox"/> Weight Gain/Loss</li> </ul> <p><b>Respiratory-Breathing</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cough</li> <li><input type="checkbox"/> Congestion</li> <li><input type="checkbox"/> Wheezing</li> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Shortness of Breath</li> <li><input type="checkbox"/> Emphysema</li> <li><input type="checkbox"/> Tuberculosis</li> <li><input type="checkbox"/> Sleep Apnea             <ul style="list-style-type: none"> <li><input type="checkbox"/> CPAP with Oxygen</li> <li><input type="checkbox"/> CPAP without Oxygen</li> </ul> </li> </ul> <p><b>Gastrointestinal Disease-Stomach</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Acid Reflux/Heartburn</li> <li><input type="checkbox"/> Nausea/Vomiting</li> <li><input type="checkbox"/> Jaundice/Hepatitis</li> <li><input type="checkbox"/> Abdominal Pain</li> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Colitis-Ulcerative</li> <li><input type="checkbox"/> Diverticulitis/Diverticulosis</li> <li><input type="checkbox"/> Gastric Stomach Ulcer</li> <li><input type="checkbox"/> Hiatal Hernia</li> <li><input type="checkbox"/> Irritable Bowel Syndrome (IBS)</li> <li><input type="checkbox"/> Crohn's Disease</li> </ul> <p><b>Genitourinary</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain/Difficulty</li> <li><input type="checkbox"/> Blood in Urine</li> <li><input type="checkbox"/> History of Kidney Stones</li> <li><input type="checkbox"/> History of STD</li> <li><input type="checkbox"/> Discharge</li> <li><input type="checkbox"/> Urinary Incontinence</li> <li><input type="checkbox"/> Chronic Dialysis</li> <li><input type="checkbox"/> Enlarged Prostate</li> <li><input type="checkbox"/> Renal Failure</li> <li><input type="checkbox"/> Uterine Disease</li> </ul>	<p><b>Psychiatric</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Anxiety</li> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Mood Swings</li> <li><input type="checkbox"/> Difficulty Sleeping</li> </ul> <p><b>Endocrine</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Increased thirst</li> <li><input type="checkbox"/> Increased Hunger</li> <li><input type="checkbox"/> Increased Urination</li> <li><input type="checkbox"/> Increased Sweating</li> <li><input type="checkbox"/> Fingernail Changes</li> <li><input type="checkbox"/> Temperature Intolerance</li> </ul> <p><b>Hematologic/Lymphatic (Blood)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Easy Bruising</li> <li><input type="checkbox"/> Gums Bleed Easily</li> <li><input type="checkbox"/> Prolonged Bleeding</li> <li><input type="checkbox"/> Heavy Aspirin Use</li> <li><input type="checkbox"/> Blood Clots</li> <li><input type="checkbox"/> Malignant Hyperthermia</li> <li><input type="checkbox"/> Liver Disease</li> </ul> <p><b>Musculoskeletal (Muscles, joints, &amp; bones)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Stiffness</li> <li><input type="checkbox"/> Arthritis</li> <li><input type="checkbox"/> Joint Pain</li> <li><input type="checkbox"/> Joint Swelling</li> <li><input type="checkbox"/> Back Pain</li> <li><input type="checkbox"/> Weakness</li> <li><input type="checkbox"/> Gout</li> <li><input type="checkbox"/> Osteoporosis</li> <li><input type="checkbox"/> Osteopenia</li> </ul> <p><b>Integumentary (Skin)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Rash</li> <li><input type="checkbox"/> Sores</li> <li><input type="checkbox"/> Lesions</li> <li><input type="checkbox"/> Hives</li> <li><input type="checkbox"/> Eczema</li> <li><input type="checkbox"/> Café-au-lait spots</li> <li><input type="checkbox"/> Psoriasis</li> <li><input type="checkbox"/> Rosacea</li> </ul> <p><b>Neurological</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Seizures</li> <li><input type="checkbox"/> Weakness/Paralysis</li> <li><input type="checkbox"/> Numbness</li> <li><input type="checkbox"/> Tremors</li> <li><input type="checkbox"/> ADHD/ADD</li> <li><input type="checkbox"/> Alzheimer's</li> <li><input type="checkbox"/> Dementia</li> <li><input type="checkbox"/> Cerebral Palsy</li> <li><input type="checkbox"/> Multiple Sclerosis</li> <li><input type="checkbox"/> Muscular Dystrophy</li> <li><input type="checkbox"/> Parkinson's Disease</li> <li><input type="checkbox"/> Fibromyalgia</li> <li><input type="checkbox"/> Mini Strokes (TIA)</li> <li><input type="checkbox"/> Stroke (CVA)</li> <li><input type="checkbox"/> Memory Loss</li> <li><input type="checkbox"/> Hallucinations</li> </ul>	<p><b>Immunologic/Inflammatory</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Hives</li> <li><input type="checkbox"/> Seasonal Allergies</li> <li><input type="checkbox"/> HIV</li> <li><input type="checkbox"/> AIDS</li> <li><input type="checkbox"/> Lupus erythematosus</li> <li><input type="checkbox"/> Myasthenia Gravis</li> <li><input type="checkbox"/> Rheumatoid Arthritis</li> <li><input type="checkbox"/> Sarcoidosis</li> <li><input type="checkbox"/> Celiac Disease</li> <li><input type="checkbox"/> Hepatitis             <ul style="list-style-type: none"> <li><input type="checkbox"/> Type A</li> <li><input type="checkbox"/> Type B</li> <li><input type="checkbox"/> Type C</li> <li><input type="checkbox"/> Type D</li> <li><input type="checkbox"/> Type E</li> <li><input type="checkbox"/> Other: _____</li> </ul> </li> <li><input type="checkbox"/> Guillain-Barre Syndrome</li> <li><input type="checkbox"/> Sjogren's Syndrome</li> <li><input type="checkbox"/> Temporal Arteritis</li> <li><input type="checkbox"/> Ankylosing Spondylitis</li> </ul> <p><b>History of Infectious Disease (Latent)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chicken Pox (Varicella)</li> <li><input type="checkbox"/> Shingles</li> <li><input type="checkbox"/> MRSA</li> <li><input type="checkbox"/> Meningitis</li> <li><input type="checkbox"/> Tuberculosis</li> </ul> <p><b>Genetic Disorders</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chromosomal Abnormality</li> <li><input type="checkbox"/> Syndrome: _____</li> <li><input type="checkbox"/> Retinitis Pigmentosa</li> <li><input type="checkbox"/> Down Syndrome</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p><b>Cancer</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bladder</li> <li><input type="checkbox"/> Breast</li> <li><input type="checkbox"/> Colon</li> <li><input type="checkbox"/> Hodgkin's Lymphoma</li> <li><input type="checkbox"/> Non-Hodgkin's Lymphoma</li> <li><input type="checkbox"/> Prostate</li> <li><input type="checkbox"/> Skin             <ul style="list-style-type: none"> <li><input type="checkbox"/> Basal Cell</li> <li><input type="checkbox"/> Squamous Cell</li> <li><input type="checkbox"/> Melanoma</li> </ul> </li> <li><input type="checkbox"/> Leukemia</li> <li><input type="checkbox"/> Lung</li> <li><input type="checkbox"/> Lymphoma</li> <li><input type="checkbox"/> Ovarian</li> <li><input type="checkbox"/> Thyroid</li> <li><input type="checkbox"/> Uterine</li> <li><input type="checkbox"/> Cervical</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p>Treatment Type:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Surgery: _____</li> <li><input type="checkbox"/> Radiation: _____</li> <li><input type="checkbox"/> Chemotherapy: _____</li> </ul>
---	--	---

## FINANCIAL POLICY

The following information is regarding your account at Ideal EyeCare. Please read these policies carefully and discuss any questions or concerns with our staff. We look forward to providing you and your family with excellent eye care.

- Payment is due at the time services are rendered. This may include co-pays, deductibles, co-insurance, non-covered services, etc. We accept all major credit cards as well as debit cards, cash, and checks.
- It is your responsibility to know your insurance coverage and to provide our office with the most current and accurate information. While our staff is extremely knowledgeable about many insurance plans, coverages change frequently and we cannot be held liable for misquoted benefits or eligibility.
- If your insurance requires a referral, you are responsible for contacting your primary care physician/pediatrician to obtain said referral. It is also your responsibility to verify that a valid referral is on file for all visits.
- The determination of your best corrected vision is called a **refraction**. This is considered a **non-covered service/procedure** by most insurance companies. You will be responsible for the **\$55.00** fee when this service is performed. Strabismus patients are responsible for an additional fee of \$40.00 for a prism refraction (total \$95.00). We will bill this service to your insurance as a courtesy, and if they pay any portion, you will be refunded their payment amount.
- For those patients being followed for strabismus, a sensorimotor examination will be performed at each visit. This service is separate from the office visit and may be considered a diagnostic test by your insurance, resulting in additional out-of-pocket cost to you.
- Telemedicine visits, whether scheduled or requested, will be billed to your insurance company and you may be responsible for out-of-pocket costs such as copays or deductibles.
- We do not participate with any vision plans and you are responsible for all “routine” and/or non-covered services provided to you or your child. This includes myopia management evaluations.
- All “self pay” patients are required to pay in full at the time services are rendered. We offer a 20% prompt-pay discount on all professional services and will provide you with an itemized receipt.
- Our office does **not** accept insurance liens, workers compensation, or attorney liens. Payment is the patient’s responsibility and is due in full at the time of service.
- The parent bringing the child for treatment is responsible for payment, regardless of the terms of any divorce decree or custody arrangement.
- All outstanding balances must be paid in full before scheduling surgery, except in emergent cases.
- All delinquent accounts may be sent to a collection agency and you may be charged any/all applicable collection and attorney fees. Once an account has been transferred to collections, you **and** your immediate family members will be **discharged** from the practice.
- All returned checks are subject to a \$35.00 processing fee and will result in refusal to accept future payments by check.
- Any account credit balance less than \$2.00 will not be issued a refund check.
- We charge a **\$25.00** per page fee for any and all forms that require the doctor’s signature and review. This service will not be billed to your insurance company. Payment is due before the form(s) will be released. A receipt will be provided at the time of payment.
- There is a **\$50.00** per page fee for summary of care letters or other requests requiring a drafted and signed letter from the doctor.
- You will be assessed a **\$50.00 NO SHOW** fee for any appointment that is missed or cancelled within 24 hours of your scheduled appointment. You must pay this amount before you will be allowed to schedule another appointment. We offer reminder notifications by text/phone/email as a courtesy, but it is your responsibility to update your calendar. It is very important that you keep our office updated with your most current information.
- Per NRS 629.021, we charge \$0.60 per page for copies of your medical record, whether provided via paper or electronic access. You may also be assessed applicable postage costs if you prefer to have the records sent via mail. These fees are waived if records are transferred directly to another physician for continued care.

I have read and understand the above information.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

## STRABISMUS QUESTIONNAIRE

Eye misalignment and double vision can occur for many reasons and accurate diagnosis of relies on careful examination, measurements of ocular motility, and a detailed history. As you prepare for your appointment, please take a few minutes to think about your symptoms and how they are affecting your daily activities.

- Do you see double?
  - When did it start?
  - Is it worse when you look up close or when you look far away?
  - Is it constant?
  - Are the images side by side or above one another?
  - Do you close one eye to avoid seeing double?
- Are your eyes misaligned?
  - What direction does your eye turn?
  - When did it start?
  - Is it constant?
  - Is it worse when you look up close or when you look far away?
- Have you undergone any treatment (i.e.-surgery or patching) for this issue?

Please list any activities that are affected by your condition: \_\_\_\_\_

---

---

---

Other information/Notes: \_\_\_\_\_

---

---

---

---

---

---

---