PATIENT INFORMATION

Please print and complete all information

Patient Name: _____
First Middle Last

Mailing address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Security Number: _____

Sex: _____ Race: _____

Single Married Divorced Widow (circle one) E-mail address _____

School or Employer: _____

Position: _____ Work Phone: _____

Family Physician: _____ Phone _____

Who referred you to our office? _____

Parent's or Spouse's Name: _____ Date of Birth _____

Parent/spouse Employer: _____ Phone: _____

Person responsible for payment: _____

Name of person to contact in an emergency situation (someone not in your home):

_____ Phone Number: _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay all copays, deductibles, co-insurance, or any other balance not paid for by your insurance.

I have read and understand the above statement:

X_____ **Date** _____

PLEASE RETURN THIS COMPLETED FORM TO THE RECEPTIONIST ALONG WITH YOUR INSURANCE CARDS AND PHOTO IDENTIFICATION.

THANK YOU
WAGNER FAMILY EYECARE, PC

Wagner Family Eyecare
3285 State Route 257
PO Box 307
Seneca, PA 16346
www.wagnerfamilyeyecare.com

David A. Wagner, OD
Kelly L. Seibert, OD
Makayli B. Kepple, OD
Phone: (814) 677-6636
Fax: (814) 677-9562

Date _____ Name of Patient _____ Date of Birth _____

Please answer all of the following questions about your medical status and history:

1. Have you ever been treated for any medical condition (diabetes, high blood pressure, arthritis, etc.)?
   Yes ___ No ___ If yes, please explain: _____
2. Have you ever had any eye disease (glaucoma, cataract, wandering or lazy eye, retinal detachment, etc.)?
   Yes ___ No ___ If yes, please explain: _____
3. Have you ever had ***any*** surgery?
   Yes ___ No ___ If yes, please provide date and reason _____
   _____
4. Have you ever been hospitalized?
   Yes ___ No ___ If yes, please provide date and reason _____
   _____
5. Do you take any medications or vitamins?
   Yes ___ No ___ If yes, please list: _____
6. Do you take any eye medications?
   Yes ___ No ___ If yes, please list: _____
7. Do you have any food or drug allergies?
   Yes ___ No ___ If yes, please list: _____

REVIEW OF SYSTEMS:	***YES***	***NO***	***PLEASE EXPLAIN***
Do you currently have any of the following conditions?			
Chronic fever, unexpected weight loss/gain, fatigue	___	___	_____
Ear/nose/throat problems (hearing loss, sinus problem, sore throat)	___	___	_____
Heart problems (chest pain, irregular heart beat, etc.)	___	___	_____
Respiratory problems (shortness of breath, wheezing, coughing)	___	___	_____
Gastrointestinal problems (heartburn, abdominal pain, diarrhea, vomiting)	___	___	_____
Urinary problems (pain or discomfort, blood in urine)	___	___	_____
Skin problems (rashes, excessive dryness)	___	___	_____
Musculoskeletal problems (muscle aches, joint pain, swollen joints)	___	___	_____
Neurological problems (numbness, weakness, headaches, paralysis)	___	___	_____
Psychiatric problems (depression, anxiety, panic attacks)	___	___	_____

8. Do any **medical** or **eye diseases** run in your family (diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?Yes ___ No ___ If yes, please explain:
   _____
   _____
9. Do you smoke? If yes, how much? _____ Do you drink alcohol? If yes, how much? _____
   Do you use any illicit or illegal drugs? If yes, what and how often? _____
10. If employed, how many hours per week do you work? _____
11. Does your employment contribute to any stress in your life? Yes ___ No ___

Physician Signature **Date**

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Patient Information

NAME:_____

DATE OF BIRTH:_____

Guarantor

Person who carries the insurance

NAME:_____

DATE OF BIRTH:_____

Primary Insurance Name: _____

I request that payment of authorized benefits be made either to me or on my behalf to **David A. Wagner, O.D.** for any service furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Patient or Parent Signature Date

Supplemental / Secondary Insurance Info.

I request that payment of authorized Supplemental Insurance benefits be made either to me or on my behalf to **David A. Wagner, O.D.** for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to (ins. name)_____ any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Patient or Parent Signature Date

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Complaints:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or Email shown above. If you prefer, you can discuss your complaint in person or by phone.

Changes to This Notice:

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

Notice Revised and Effective: May 3, 2021.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I was offered a copy of Wagner Family Eyecare, PC, Notice of Privacy Practices.

Date _____ Patient Name _____ DOB: _____

Signature _____

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Return Policy for Eyeglasses

All sales of prescription and non-prescription eyeglasses and sunglasses are final. If, however, there are any discrepancies between the doctor's prescription and the actual prescription, any adjustments to the prescription lenses are included once at no charge within 90 days of purchase date. Any prescription changes after 90 days, 50% will be taken off of the new lens price. All orders require a minimum 50% deposit. Adjustments for glasses and minor repairs are provided free of charge for glasses purchased from Wagner Family Eyecare PC.

Frame/Lens Warranty

Most of our eyeglass frames are under manufacturer warranty covering any manufacturing defects for up to one year from the date of purchase. Select frame companies offer longer warranties. This does not include mishandling or abuse. This is a one-time replacement warranty.

Most prescription lenses will have a 1 year scratch coat warranty. This does not imply that the lenses will not scratch. They are scratch resistant not scratch proof. Scratches in the lenses that can be felt with a fingernail or chips caused by abuse are not covered.

Should you need a frame and/or lens replacement that is not covered under the manufacturer's warranty as specified above, Wagner Family Eyecare PC will extend a 50% discount off the retail price to replace a frame and 50% discount off the retail price to replace lenses up to one year of purchase date.

If you add Anti-reflective coating, transition, or UV coating ETC. and decide it is not right for you, the lenses can be remade once within 90 days of the purchase date at no additional cost. However, the original cost(s) of these coating and enhancements are non-refundable.

Non-adapt policy

If you are fit into a progressive (no line bifocal) and cannot properly adapt to this type of lens, Wagner Family Eyecare PC will make your lenses into either a single vision or lined bifocal at no additional cost to you within 90 days. The new lenses should be put into the original frame purchased. If you choose to change frames, new lenses will be 50% off original cost and you will be responsible for the cost of the price difference in the frame. Wagner Family Eyecare PC will not refund the original cost of the progressive lens.

I have read, understood, and shall abide by all aspects of the policies explained to me above.

Name_____

Signature_____

Date_____

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Many of our patients have medical and vision insurance and we want you to understand the difference between the two. This is important because they differ in what they cover, pay, etc.

Vision coverage is designed to determine a prescription for glasses or contacts, and is not equipped to deal with complex medical or eye conditions and/or diseases, and does not include a detailed retinal exam. Therefore, the fee for this service is usually lower.

When a medical condition or diagnosis is present (such as hypertension, diabetes, or eye disease), medical insurers require us to file with your medical insurance. Any copays or deductibles you have for medical specialists or testing will then apply. There are several levels of medical exams with varying fees. Some components of medical exams may not be covered by your insurance; therefore you would be responsible for those fees. Medical fees are usually higher than visual fees. If you do not have medical insurance but require a medical exam, please realize you will pay a higher fee than the normal well-visit exam.

If you have insurance, we HAVE to be able to verify coverage before you are seen. You are responsible for presenting your most recent insurance cards. The only exception to this is an ocular emergency.

Our office does not make these rules. They are defined by the insurance companies. Often we will not know which type of exam you require until we start our testing. We try to take as many insurances as possible, but if we do not take yours, we will give you a printed receipt to file with your insurance company.

By signing below, you state that you understand the above and assign all benefits to us. Whether or not you have insurance, you also understand that you are responsible for your charges.

If you fail to pay your bill in a timely manner, 5% per month finance charges will apply after a 90 day grace period. Should it be necessary to send this account to a collection agency, you will be responsible for all collection fees which may be up to 35% additional fees.

All fees, insurance copays and contact fitting fees (that insurance may not cover) are due at the completion of your exam.

Also, since eye exams are a service, NO refunds are available.

_____ _____
Patient Name Date

_____ _____
Patient/Responsible Party Signature Relationship to Patient

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Personal Representative

The privacy of your health care information is important to us. If you would like to appoint someone that can do the following, please provide their information below.

- Make appointments for health care services.
- Have discussions with health care providers about routine tests and treatments.
- Access to medical information and have discussions with health care providers about routine tests and treatments.

Patient Name: _____

Date of Birth: _____

Name of Patient's Personal Representative: _____

Personal Representative Phone: _____

Name of Patient's Personal Representative: _____

Personal Representative Phone: _____

Name of Patient's Personal Representative: _____

Personal Representative Phone: _____

Patient Signature & Date: _____

If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor.

This form will remain in effect until the patient no longer receives services or notifies us of any changes.