Name: _____ Date:_____

Do you have any allergies to medication? No ☐ Yes ☐ if yes, please specify_____

List **ALL** medications you take.

_____

_____

List **ALL** injuries, surgeries, and/or hospitalizations you have had and

date:_____

_____

Check any of the following that apply.

☐ Cataracts _____(year of surgery or diagnosis) ☐ Lasik/PRK_____(year of surgery or diagnosis)

☐ Glaucoma ☐ Macular Degeneration ☐ Blindness ☐ Ocular Prosthesis

At the current time are you pregnant No ☐ Yes ☐ how far along are you? _____weeks

Condition	**Me**	**Mother**	**Father**	**Maternal Grandmother**	**Maternal Grandfather**	**Paternal Grandmother**	**Paternal Grandfather**
Diabetes							
Hypertension							
Lupus							
Thyroid Disorder Hypo/Hyper (CIRCLE ONE)							
Blindness							
Heart Disease							
Sjogren's Syndrome							
Glaucoma							
Macular Degeneration							
Retinal Detachment/Disease							
Cancer							
Arthritis							
Multiple Sclerosis							

Elevated Cholesterol							

PATIENT GUIDELINES

(Signature Required Covers Entire Document)

-I understand that if during the course of my examination the doctor determines the need for medical testing & treatment, even though my insurance form states well vision, it will be filed to my medical insurance and I will pay all co-pays, etc.

-I understand that I am financially responsible for all fees, and agree to reimburse any and all fees for services and materials not collected in full should my medical insurance or vision benefit plan deny payment for services or materials rendered.

-I further understand that I agree to pay for any unpaid balances on my account as a result of denial in part or whole from my insurance carrier by denial of medical services, unmet deductibles, non-covered services i.e., refractions, or uncollected fees for prior services.

-If I do not inform you that I have a vision plan or medical insurance before services are rendered, it will be assumed that no coverage exists and I am responsible for all payments.

-I agree this office, NO EXECPTIONS, will not file back claims or refund fees after services are rendered due to lack of notification of a vision benefit plan or medical insurance. It will be my responsibility to file my own claim and seek reimbursement from my insurance carrier.

-I have read and understand the notice of privacy policies and wish to continue care.

Office Policy

Contact Lenses: Due to the expense involved in contact lenses, i.e., Rigid Gas Permeable (RGP), Soft Torics, Specialty Contact Lenses, a 50% deposit is due at the time of ordering.

*If a patient does not receive a contact lens fitting at the time of their exam, the patient must return to the clinic within 60 days.

Eyewear: McKinney Eyeworks has a no refund/no exchange policy, however if the patient is dissatisfied with their vision and or their eyewear, it is the responsibility of the patient to return to the clinic within 30 days after receiving their eyewear. If a patient returns to our office after 30 days, an additional fee for a new refraction will be assessed.

*McKinney Eyeworks is not responsible for the accuracy or the quality of eyeglasses filled from any outside optical. If your eyewear is found to be an improperly-filled Rx from the optical, or deemed to be of inferior quality, a charge of $25 will be assessed to the patient.

There is a $35 charge for cancellation/no show with-out a 24-hour notice

Name_____

Signature_____ Date_____

We take great pride in our patients, thank you for trusting McKinney Eyeworks with your eye care needs!