CLEARLY EYE CARE
Your Vision. Our Passion.

Name:_____ Date of Birth:_____/_____/_____

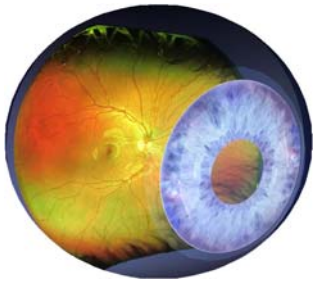
******If your address and insurance have changed, please update with the staff******

FINANCIAL RESPONSIBILITY AGREEMENT REMINDER

All Charges are non-refundable. Payment is due at time of service. Eye care for medical conditions not covered under routine wellness exams. Medical eye visits and contact lens evaluations carry additional charges.
Initial Here_____- I am financially responsible for all charges incurred during eye exams or office visits.

Optomap Retinal Screening

At Clearly Eye Care, we believe that yearly retinal evaluations are critical in early diagnosis and monitoring of your eye health. Therefore, we have acquired the Optomap Retinal Scanner to capture wide angle images of the retina and detect early signs of eye disease without having to dilate the eyes. It is fast, easy and comfortable. This advanced technology is doctor recommended on every patient as part of their yearly exam and carries a $39 charge.



I would like to have the Optomap performed today: NO

Dilation

If you choose not to have retinal imaging performed, or if certain medical conditions are present, you may require dilation. The drops cause light sensitivity and blurry vision for up to 4-6 hours.

I would like to be dilated today: NO

NOTICE OF PRIVACY PRACTICES & 30 DAY INCLUSION PERIOD

1. I have read and understand Clearly Eyecare's Notice of Privacy Practices Form.
2. I also understand that I have 30 days to return to the clinic with any concerns regarding my prescription at no charge. Any visits after the 30-day period may be subject to an additional examination fee due to possible changes in vision.

_____ _____
Patient Signature (or Guardian's Signature) Date

INSURANCE & PAYMENT POLICY

Insurance may cover none or only part of your fees. If we do not accept direct payment from your insurance plan, you will be required to pay our office at the time of service and submit your receipt for reimbursement from your insurance company. If your insurance does not pay as expected, you are ultimately responsible for all charges. We are not responsible if you are not eligible for benefits. We will be happy to assist you with your claims.

_____ _____
Patient Signature (or Guardian's Signature) Date

COVID-19 PANDEMIC ESSENTIAL EYE EXAM AND TREATMENT CONSENT FORM

Patient Name: _____ DOB: _____ Date: _____

Please read and initial next to the following statements to indicate your agreement. If you cannot positively affirm to all these questions, you will be asked to postpone or reschedule your visit to a later date.

_____ I do not currently, nor have I had in the last two weeks, a fever, cough, sore throat, and loss of smell/taste or other cold symptoms.

_____ To the best of my knowledge, I do not have, nor have I been in direct contact with someone who has a confirmed diagnosis of COVID-19 or a presumptive positive COVID-19 test result in the last 30 days.

_____ Neither I, nor anyone living in my immediate household, have traveled outside of the state or country in the last 30 days.

I understand that Clearly Eyecare, its doctors and staff are taking precautions to limit any potential exposure I may have to the COVID-19 virus. I also understand that there is no definitive way to eliminate potential exposure by one hundred percent.

By signing this form below, I agree that I will not hold Clearly Eyecare or any of its doctors and staff personally responsible should I, or someone I come in contact with, become positively or presumptively positive diagnosed with the COVID-19 virus. There are certain inherent risks associated with an eye exam during a pandemic and I assume full responsibility for personal illness that may result and further release and discharge DLV and its doctors and staff for injury, loss or damage arising out of my visit. I understand that COVID-19 infection can lead to illness, disability, or even death and knowingly take the risk of exposure as I deem my eye exam to be essential to the maintenance of my vision.

_____	_____	_____
PRINT LEGAL NAME	SIGNATURE	DATE

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1900 University Blvd. Suite 200, Round Rock, TX 78665

CONTACT LENS PATIENT AGREEMENT

Advancements in contact lens technology offer the potential of successful contact lens wear to most of our patients. A contact lens is a medical device in contact with the tissues of your eye; therefore, it must fit appropriately to maintain the health of your eye's response to the lens on follow-up visits. Since the follow-up care is essential, it is your responsibility to keep all appointments and follow all lens care instructions.

THE COMPREHENSIVE EYE EXAM

Before a person can be fit the contact lenses, a complete medical and refractive eye examination is necessary. This exam is critical to assure the good health of your eyes and to rule out the possibility of any unsuspected, underlying condition that may prevent contact lens use.

CONTACT LENS FITTING

The goal of contact lens fitting is to find the most appropriate contact lens for each patient's optimal vision and comfort. An enormous variety of types, materials, sizes and colors are offered. We are committed to taking the time and effort to fit your contact lenses properly. Although many people will need only on fitting session, sometimes this prove requires several appointments. Everyone being fit into contacts must go through this fitting process. We will not finalize the contact lens prescription until both the individual being fit for contact lenses and the doctor are satisfied with the fit and visual acuity of the contact lens. We will provide one set of trial lenses. **Dispensing of trial contact lenses may only be at the time of the original examination and scheduled follow-up visits when a change is required.** A contact lens trial will not be dispensed at other times. Any patient who is changing lens brands must have a new fitting and there may be an additional fitting charge. Please order your supply of contacts at least one week prior to running out of your contact lenses.

FOLLOW-UP APPOINTMENTS

Follow-up appointments are necessary to assure:

1. The contact lenses are fitting and moving well
2. The prescription is providing the best possible vision
3. The eyes are remaining healthy
4. There are no problems with insertion or removal
5. The patient understand and complies with the recommended wearing schedule
6. **Prescriptions will NOT be written for patients who do not keep follow-up appointments.**

There is no charge for follow-up visits during the first 30 days or the first three follow-up visits, whichever comes first. **All follow up care and office visits after the 30 days period is the responsibility of the patient and are not covered by today's fee. The patient will be assessed a $45.00 refitting fee.**

ANNUAL CONTACT LENS EXAM

By law, a contact lens is only valid for only a year. All patients are required to come in for an annual contact lens exam. This is necessary to assure that the patient's eyes are healthy and the contact lenses are still fitting well. **Contact lens prescriptions cannot be renewed without an annual exam.** Contact lens exams have a **separate charge** that is NOT included in your medical exam.

REFUNDS

There will be NO refund on the exam, fitting and evaluation or annual contact lens examination fee.

Patient/Guardian Signature_____ Date_____

Name (Last, First)_____ Date_____