Please complete the following form prior to your visit.
You can print this form and bring it in to your appointment, email it back to us at patient@drmyeyes.com or you can fax it to 425-453-3711
Thank you!

Name:
DOB:

Imaging/Technology Fee

We highly value current health care technologies that can help us treat, monitor and assist our patients. During your examination we will take images of your eyes that are beyond the standard for a routine eye examination. In most cases, these images allow us to examine the health of your eye without the use of dilating eye drops. These images provide a more accurate documentation of your eye for future reference.

It is our office philosophy that every patient should receive this level of care.

In order to maintain this level of care, we ask for a $10 fee. This charge is not covered by your insurance. If this charge is a concern to you, please leave the area below blank. Otherwise, please sign below to acknowledge this fee. Thank you.

Patient/Guardian Signature: ____ Date: ________________

Notice of Privacy Practices Acknowledgement of Receipt

I acknowledge that I was offered a copy of the Eyecare Center (Bruce A. Beaulaurier, OD, Grant E. Lindberg, OD, Susan Kwong, OD, Angela Ebeler Jones, OD) Notice of Privacy Practices (HIPAA).

Patient/Guardian Signature: ____ Date: _____________

Release to Bill Insurance

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefit to the physician or supplier of services rendered.

Patient/Guardian Signature: ____

Release of Personal Health Information

The following person(s) may receive disclosure of protected health information about me:

____

Please initial if you authorize The Eyecare Center to contact you via text message: _________

(If no authorization, leave spaces blank.)

For Office Use Only:

New glasses? *YES* *(lens only)* *NO* *(needs adjustment)* *Undecided* *Plans to get new contacts* *YES* *NO*

Options: *SV (Dist . Reading Interm.)* *PAL* *Bifocal* *Trifocal* *Office* *Sun*

Follow up appt needed: *Glauc. Workup* *RCE* *Eye Check F/U* *When?_______________*

On File		Scanned	

VSP Eye Health Management ☐ N/A
Conditions: ☐Diabetes ☐Diabetic Retinopathy ☐Hypertension ☐High Cholesterol ☐AMD ☐Glaucoma
Complete if the patient has diabetes or diabetic retinopathy: Dilation performed? ☐Yes ☐No PCP communication completed/planned: ☐Yes ☐No