Grand Ledge Optometry, P.C.
11973 Sweetwater Dr, Ste B
Grand Ledge, MI 48837
517-622-2020

Welcome to GRAND LEDGE OPTOMETRY! Please complete the front and back of the *Medical History Questionnaire* as completely as possible, including all medications with their dosage and frequency. Also, we ask that you read and sign our *Statement of Practice Policies, Acknowledgement of Receipt- Notice of Privacy Practices, and Insurance Claim Authorization.* Please bring these forms filled out to your appointment. A copy of our Privacy Practices is posted online or available to you at our office.

MASKS ARE OPTIONAL AT THIS TIME

Please arrive 10-15 minutes early for your first appointment.

Please bring the following items with you the day of your appointment:

- Completed Medical History Questionnaire
- Signed Statement of Practice Policies
- Signed receipt of Privacy Practices and Insurance Claim Form Authorization
- Photo ID
- Vision and medical insurance cards
- Complete list of current medications with dosage and frequency including over the counter medications, if applicable.
- Copay (if required by your insurance company)
- Any glasses, prescription sunglasses or contact lenses that you are currently wearing
- Name, address and phone number of your primary care physican

Payment is due at the time services are rendered. We participate with many major insurance plans. For these plans, copayments, deductibles and coinsurance will be collected at the time of service if amount is known. Payment in full is requested at the time of the visit for patients on insurance plans with which we do not participate, or patients who are self pay. We accept cash, check, American Express, Discover, MasterCard, Visa and Care Credit.

Dilation of the eyes is routinely performed on patients at our office. This process involves instilling drops into the eyes to make the pupil (black opening of eye) larger so that the doctor can perform a more comprehensive health evaluation of your eyes. There is no additional charge for this service. Blurred near vision and light sensitivity are short-term side effects that normally last 2-4 hours. We recommend having sunglasses with you as well as a driver if you have not had this procedure performed in the past.

We look forward to serving your vision needs! Please do not hesitate to call the office at (517) 622-2020 if you have any questions regarding your appointment.

Sincerely,
Dr. Andrew Schmitzer and Staff at GRAND LEDGE OPTOMETRY

Medical History Questionnaire

First Name:_____ Middle Initial:_____ Last Name:_____ Today's Date: _____

Male/Female (circle per birth certificate) Preferred pronoun identified by: He/Him She/Her Them/They Other_____

Mailing Address:_____ Home Phone:_____ Cell:_____

City:_____ State:_____Zip: _____ Work Phone: _____ Prefer: Phone, Text, or Email

Birth Date:_____/_____/_____ Occupation:_____ Email: _____

Social Security # _____-_____-_____ Last Vision Exam: _____/_____/_____ Last Medical Exam: _____/_____/_____

Name of Medical Doctor:_____ Guardian (if applicable): _____

Vision Insurance:_____ Medical Insurance:_____

Cardholder Information: Name_____ Social Security #_____-_____-_____ DOB_____/_____/_____

Referred to our office by: _____

MEDICAL HISTORY

Do you have any allergies to medications? ___ yes ___ no If yes, please list names and reaction if known

_____

List any medications you take (including oral contraceptives, aspirin, over-the-counter medications, and home remedies)

_____

_____

List all major injuries, surgeries, and/or hospitalizations you have had

_____

Currently pregnant? ___ yes ___ no

Currently nursing? ___ yes ___ no

EYE HISTORY

List any eye conditions you have had: crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye infection or injury

_____

Do you wear glasses? ___ yes ___ no

Are you thinking of new glasses today? ___ yes ___ no

Do you wear contact lenses? ___ yes ___ no

Are you thinking of new contact lenses today? ___ yes ___ no

Type of contact lenses:
Check all that apply ___rigid (gas permeable) ___soft ___extended wear (sleep in them) ___toric ___multifocal

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children—living or deceased) for the following conditions:

	YES	NO	Relationship
Blindness	___	___	_____
Cataract	___	___	_____
Glaucoma	___	___	_____
Macular Degeneration	___	___	_____
Retinal Detach or disease	___	___	_____
Lazy Eye/Strabismus	___	___	_____
Diabetes	___	___	_____
High Blood Pressure	___	___	_____
Cancer	___	___	_____
Lupus	___	___	_____
Thyroid disease	___	___	_____
Other _____	___	___	_____

----------PLEASE TURN FORM OVER AND FILL OUT THE OTHER SIDE----------

SOCIAL HISTORY

This information is kept strictly confidential and is required for insurance purposes.

Do you drive? ___ yes ___ no If yes, do you have difficulty when driving? ___ yes ___ no If yes, please describe:

_____

Do you currently or is there any history of tobacco product use? ___ yes ___ no Type/amount/how long? _____

Do you drink alcohol? ___ yes ___ no Type/amount/how long? _____

Do you use illegal drugs? ___ yes ___ no Type/amount/how long? _____

Have you ever been exposed to or infected with ____ Gonorrhea ____ Hepatitis ____ HIV ____ Syphilis

REVIEW OF SYSTEMS

Do you currently or have you had problems in the following areas:

Eyes

Blindness	___ yes ___ no
Blurred Vision	___ yes ___ no
Burning	___ yes ___ no
Chronic Eye Infection	___ yes ___ no
Distorted Vision	___ yes ___ no
Double Vision	___ yes ___ no
Dryness	___ yes ___ no
Eye Injury	___ yes ___ no
Eye Pain or Soreness	___ yes ___ no
Flashes	___ yes ___ no
Floaters	___ yes ___ no
Foreign Body Sensation	___ yes ___ no
Glare/Light Sensitivity	___ yes ___ no
Halos	___ yes ___ no
Itching	___ yes ___ no
Loss of Side Vision	___ yes ___ no
Mucous Discharge	___ yes ___ no
Red eyes	___ yes ___ no
Sandy/Gritty Feeling	___ yes ___ no
Tired Eyes	___ yes ___ no
Watery Eyes	___ yes ___ no

Allergic/Immunologic

Hay Fever	___ yes ___ no
Medicine Allergies	___ yes ___ no

Constitutional

Fever	___ yes ___ no
Weight Loss	___ yes ___ no
Weight Gain	___ yes ___ no

Cardiovascular/Vascular

Heart Pain	___ yes ___ no
High Blood Pressure	___ yes ___ no
Vascular Disease	___ yes ___ no

Ears, Nose, Mouth, Throat

Allergies/Hay Fever	___ yes ___ no
Sinus Congestion	___ yes ___ no
Chronic Cough	___ yes ___ no
Dry Throat/Mouth	___ yes ___ no

Endocrine

Diabetes	___ yes ___ no
Thyroid Problems	___ yes ___ no
Other Glands	___ yes ___ no

Gastrointestinal

Diarrhea	___ yes ___ no
Constipation	___ yes ___ no
Ulcers	___ yes ___ no

Genitourinary

Genitals	___ yes ___ no
Kidney Problems	___ yes ___ no
Bladder Problems	___ yes ___ no

Hematologic/Lymphatic

Anemia	___ yes ___ no
Bleeding Problems	___ yes ___ no

Integumentary

Dry Skin	___ yes ___ no
Other Skin Conditions	___ yes ___ no

Musculoskeletal

Rheumatoid Arthritis	___ yes ___ no
Muscle Pain	___ yes ___ no
Joint Pain	___ yes ___ no

Neurological

Headaches	___ yes ___ no
Migraines	___ yes ___ no
Seizures	___ yes ___ no

Psychiatric

Nervous Disorders	___ yes ___ no
Depression	___ yes ___ no
Compulsive Behavior	___ yes ___ no

Respiratory

Asthma	___ yes ___ no
Shortness of Breath	___ yes ___ no
Emphysema	___ yes ___ no

Please explain if you answered YES to any condition above that needs more detail or if a condition was not listed:

_____

_____

GRAND LEDGE OPTOMETRY

11973 Sweetwater Drive, Suite B Grand Ledge, MI 48837

STATEMENT OF PRACTICE POLICIES

- PAYMENT IS DUE AT THE TIME OF SERVICE

All professional fees are due on the day of service. Office credit or payment plans will not be offered unless given approval prior to your appointment. This applies to all deductibles, copayments, and other collectable fees.

- BILLING YOUR INSURANCE

Please help us ensure billing accuracy and efficiency by informing us at sign-in of **ANY** changes to your insurance information. Any insurance discrepancies that result in non-payment will be billed to the patient. This includes instances in which there are deductible or copayment amounts, lapses in coverage, the patient provides inaccurate or outdated insurance information, or the patient requires or requests non-covered services. If your insurance company does not pay your claim within 90 days of service, the balance will be automatically billed to you. Statements regarding any patient balances are mailed monthly. If you have any questions regarding a balance, please call our office immediately. Failure to pay the amount due before the next billing statement could result in additional finance fees.

VISION INSURANCE **provides coverage only for wellness examinations and material benefits or discounts for contact lenses or eyeglasses. Your** ***MEDICAL INSURANCE*** **provides coverage and will be billed for all visits related to health conditions affecting the eyes, including diabetic evaluations, cataracts, glaucoma, amblyopia (lazy eye), infections, dry eyes, allergies, or any other instance where the reason for examination is not for routine services.** We are happy to provide information regarding your insurance coverage, however, the patient is ultimately responsible for understanding their insurance benefits/coverage, deductibles, and copays.

- ORDERING OF GLASSES AND CONTACT LENSES

We require a minimum **50%** down payment on all orders before they will be manufactured**. Payment in full is required before glasses or contact lenses will be dispensed.** If your order is not picked up within 90 days from the date of order, the down payment will be forfeited and applied to our cost of replacement or return of product.

- RETURNS / EXCHANGES

All of our glasses and contact lenses are custom made or ordered for each individual patient, therefore, all purchases are non-refundable. No cancellations can be accepted once a lab has started making patient eyewear. Exchanges may be made within the first 30 days after purchase on a limited basis. There may be a fee for exchanges, which will be discussed on a case-by-case basis. If you are dissatisfied with your prescription, please notify us immediately. Your happiness is extremely important to us, and we will act quickly to help resolve any issues you may be having. If you first notify our office of trouble with your prescription (adaptation, blurry vision, etc.) more than 30 days after you received your glasses or contact lenses, there may be a fee for prescription checks or modifications and remakes. If there has been an error on our part, we will work to quickly resolve the problem at no cost to you.

- REFUNDS

If there is a need for a refund (i.e. patient accidentally charged incorrectly or insurance overpayment), we reserve the right to issue refunds via check, even if the purchase was made by cash or credit card. Checks will be sent by mail, and you should receive the funds within 1-2 weeks. Credit cards can only be refunded to the same account used for the purchase. If a patient paid via personal check, the check must have cleared before we will issue any refunds. **There will be NO REFUND of professional fees (contact lens fitting fees, examination fees, etc.) if services have already been performed.** No refund will be given for nonadaptation to lenses or remake of items to a less expensive item.

- NO SHOWS

Appointments require 24-hour notice to cancel. All confirmed appointments that are missed without prior notice will incur a $50 no show fee. This fee must be paid before any other services will be performed at our office, including warranties.

By signing below, I am confirming that I have read the above office policies. I understand that if I have any questions or concerns regarding these policies, that I am responsible for contacting a staff member for clarification before services are rendered.

_____	_____	_____
Signature of Patient, Parent, Guardian, or Personal Representative	Date	Please PRINT the name of the Patient, Parent, or Guardian

Grand Ledge Optometry

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I received a copy of GRAND LEDGE OPTOMETRY'S Notice of Privacy Practices.

Patient Name _____

Signature _____ Date _____

Insurance Claim Form Authorization

I hereby authorize GRAND LEDGE OPTOMETRY to release pertinent information about me to file a claim with my insurance company and assign benefits to be paid to GRAND LEDGE OPTOMETRY as indicated on CMS-1500 claim line #12 and #13. I understand I am financially liable for any balance not covered by my insurance or amount that is to be applied toward my annual insurance deductible. A copy of this signature is valid as an original.

Signature:_____ Date:_____