

Dr. Lauren Claborn, OD

Dr. Deborah S Herron, OD

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Welcome to Denison Optical! Thank you for choosing us for your eye care needs. We are delighted to have

you as a patient and appreciate the confidence you have placed in us. Please take a moment to complete the

following information.

PATIENT INFORMATION

Mr. Miss Mrs. Ms. Male Female

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ­­­­­­­­First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Day Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian/Person Responsible\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

**Medical:**

Name of Primary Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Relationship to Insured Self Spouse Child Other

Policy Holder DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vision:**

Name of Primary Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Relationship to Insured Self Spouse Child Other

Policy Holder DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy Holder SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Read**

I assign of all of my medical benefits to the doctors of Denison Optical and authorize said assignee to release all information necessary to secure payment from my insurance company. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company, and that final determination can only be made when the claim is processed. As such, I understand that some fees may not be paid by my insurance and I am will be responsible for all fees that the insurance does not cover. Accounts 90 days-old are subject to collections, and there will be a service charge for any NSF checks. In order to control billing costs and reduce the need to raise our fees, all co-payments, deductibles, and charges for non-covered services, as per my insurance contract, are due at the time services are rendered.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA Notice of Privacy Policies:**

I acknowledge that I have read and/or received Denison Optical’s Notice of Privacy Practices.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health-Related Communications & Reminders by Mobile Telephone Texting & E-Mail:**

I permit Denison Optical to communicate & remind me about my health-related issues & appointments by texting & e-mail.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preference Mail Phone Call Text Email

**HEALTH INFORMATION**

Race: American Indian Or Alaska Native Asian Black Or African America Hispanic Or Latino

Native Hawaiian Or Other Pacific Islander White Declined To Specify

Ethnicity: Hispanic Or Latino Not Hispanic Or Latino Declined To Specify

Preferred Language: English Spanish Other

Do you drink alcohol? Yes No If yes, how much/often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? Yes No If yes, how much/often: Occasional 1/2 pack/day 1 pack/day 1+ pack

**PRIMARY CARE PHYSICIAN/REFERRING PHYSICIAN**

Primary Care Physician and Clinic Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_\_

Referring Physician and Clinic Name ­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Referring Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_

What is the main reason for today's exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When was your last health exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Denison Optical Policies**

**Lab**: Our office is not responsible for any items left over 30 days after the completion of the order. If you choose to use your own frame or lenses, we cannot be responsible for any damage that may occur during the mounting, edging, tinting or dispensing process. If you need an adjustment, and the frame is no longer under warrantee, we cannot be responsible for any breakage or damage that may occur during this process.

**Refund:** We have a no refund, no cancellation policy. All lenses are custom made according to your prescription. We will be glad to work with you on any issues that may occur during the first 60 days. Contact lens cancellations, if and only if approved by lab first, will be subject to a 15% re-stocking fee.

**Payment:** Payment is expected as services are rendered. All glasses and contacts MUST be paid for in full before we can order them. We cannot accept partial payments or checks to hold, unless previous arrangements are made with the Practice Administrator.

**Insurance**: Insurance information must be presented at time of services. No price adjustments will be made after time of service. It is the responsibility of the insured to verify eligibility on all insurance policies prior to their scheduled appointment.

**Warranty/Remake:** Scratch coat and Anti-Reflective warranty is 365 days, unless your insurance has a specific warranty policy. This warranty does not include industrial safety, sports eyewear or mirror coatings. The warranty does not include chips in the lens or breakage. Frame manufacturer defects are covered up to 1 year after purchase with an $8 shipping charge.

**Progressive Non-Adapt Warranty:** The timeframe for non-adapt warranty is 90 days, unless your insurance has a specific non-adapt policy. If you are unable to adapt to the lens, we will provide you new lenses at no charge. No refund on the original purchase will be made. Only 1 non-adapt redo is allowed per patient.

**Notice of Privacy Practices & Denison Optical Policies**

By signing below, I acknowledge that I have reviewed a copy of the “Notice of Privacy Practices” and “Denison Optical Policies”. Signing below signifies that the I agree to the terms and conditions of the agreement stated above.

Patient’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_