



FAMILY EYECARE & CONTACT LENS CENTER LLC

Kirk D. Kvitle, O.D.
Jason M. Kvitle, O.D.
3325 Maine Street
Quincy, Illinois 62301
(217) 231-3937

Welcome to Our Office

Name _____
 Street _____
 City _____ State _____ Zip _____
 Home Phone _____
 Cell Phones _____ Ok to Text Yes No
 Social Security Number _____
 Employer _____
 Employer Phone _____
 Occupation _____
 Hobbies _____
 Email Address _____
 Today's Date _____ Date of Last Exam _____
 Name of Doctor who examined _____
 Date of Birth _____ Age _____ Sex: Male Female
 What is the purpose of your visit today? _____
 Spouse (or parent) name _____
 Spouse (or parent) work phone _____

Vision Insurance: Medicare Medicaid
 VSP Blue Cross
 Flex Plan
 Other _____

How will you settle your account today?
 Check Cash Credit Card Financing

List of other family members (spouse, children, etc.)
 Mark boxes if patients of Family Eyecare Center
 (Dr. K.Kvitle/Dr. J. Kvitle)

Diagnostic Issues

Please list any complaints about wearing glasses or contacts?

- Do you have more than 1 pr. of current Rx Glasses? No Yes
- Is there anything you would like to change about your current eyewear? No Yes
- Do you work on a computer for long periods? No Yes
- If you wear glasses, would you benefit from thinner, lighter lenses? No Yes
- Do you feel the need for sunglasses? No Yes
- Are you interested in a "test drive" of the latest in contact lens design(s)? No Yes
- Laser vision correction is a common choice to reduce or eliminate the need for glasses or contacts. Do you desire information regarding laser vision correction and/or a free evaluation regarding your candidacy? No Yes

Do You Experience...

- Any discomfort with your eyes? No Yes
- Problems with glare or reflection? No Yes
- Sensitivity to light? No Yes
- Headaches? No Yes
- Floater or flashes of light? No Yes

How did you hear about our office?

- Friend or relative. Who? _____
- Another health care practitioner. Who? _____
- Yellow pages. Which directory? _____
- Newspaper advertisement. Which paper? _____
- Radio advertisement. Which station? _____
- Previous patient. Who? _____
- Participating eye care plan. _____
- Other _____

CONSENT FOR TREATMENT

Dr. Kirk Kvitle/Dr. Jason Kvitle are here with authorized to render services, medication and treatment as necessary. I assume full financial responsibility for any bills incurred. Dr. Kirk Kvitle/Dr. Jason Kvitle are participating Medicare providers.

INSURANCE RELEASE

I authorize the release of medical information contained in my medical records to family physicians and/or insurance companies. A photocopy of this authorization shall be as valid as the original. I assume responsibility for any balance above insurance.

MEDICARE LIFETIME CONSENT

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Kirk Kvitle/Dr. Jason Kvitle for any services furnished by that physician. I authorize any holder of medical information about me to release to the Health Care Administrations and its agents any information needed to determine these benefits of the benefits payable to the related services.

LATE/NO SHOW POLICY & MEDICATION REFILLS

It is the policy of Family EyeCare & Contact Lens Center, LLC that if a patient misses more than three (3) appointments in 1 year without calling to cancel, they will be made walk-in only. A patient is considered "LATE" if they are more than 15 minutes late for their scheduled appointment. It is at the discretion of the provider as to whether the patient can still be seen as they will need to reschedule.

PAYMENT FOR SERVICES IS EXPECTED AT THE TIME SERVICES ARE RENDERED. ARRANGEMENTS SHOULD BE MADE FOR EXCEPTIONS. ANY ACCOUNT WITH A BALANCE OVER 90 DAYS WILL BE SENT TO COLLECTIONS UNLESS ARRANGEMENTS HAVE BEEN MADE.

SIGNED: _____

DATE: _____