Advanced Eye Care
A Healthy Focus

Welcome to ADVANCED EYECARE. We are honored that you have chosen us as your eye care provider. Our goal is to provide the highest quality care for all our patients in a timely and respectful manner.

We will do our best to provide you with same-day office visits and accept walk-ins for first available slots. You will need to bring your insurance card and a photo ID with you for each appointment. Please let our staff know if you have had any information changes since your last appointment. If you are unable to provide us with your insurance card, your appointment will need to be rescheduled. You will be asked to fill out new registration forms annually, so we may update your information.

You may also go to our website www.advancedicare.com and go to patient registration to fill out/update your information. You may also print and fill out the forms under patient forms to bring to your appointment for a faster check in.

All co-pays and past due balances are expected at time of service unless a prior agreement has been made with our billing department. If applicable, you will be billed for services not covered by your insurance (as stated in your insurance contract).

We ask that you allow plenty of time to get to the office for your appointment. You may be asked to reschedule your appointment if you are more than 15 minutes late. We strive to stay on time. From time to time, emergency arise, and we may need to reschedule your visit. You will have the option to re-schedule on any open day and we will keep you informed if there needs to be any changes.

Please bring a list of all your prescription and over-the-counter medications with you at each visit.

Our office policy for a missed/cancelled appointment is:

- Appointments must be cancelled within 24 hours or a $40 charge will be assessed. The charge must be paid before other services are rendered.
- Two (2) no-show appointments will result in you no longer being added to the schedule and being treated as a walk-in.

We understand that appointments sometime need to be changed, so we ask that you call at least 24 hours in advance if you cannot keep your scheduled appointment.

Providing the highest quality of professional care to our patients is very important to us. Therefore, the following guidelines for dispensing medications in our office have been established:

1. If you are on a medication that requires refill, you will be given ample refills for 30 or 90 days at a time during your office visit.

    a. When you are down to a 30-day supply of medication, we ask that you call and schedule your follow-up office visit in order to be evaluated and have your medications adjusted or refilled. We ask that you allow enough time for us to make an appointment so you're not without your medication.

As a means of ensuring timely communication with our patients, we strongly encourage you to sign up for the Patient Portal, which can provide a quick and easy method for, messaging the office, viewing your eyeglasses or contact prescription, etc. As a new patient, you will receive instructions on how to sign up for the Patient Portal. If you have questions or need assistance, please feel free to speak with a member of our reception team.

Also, if you prefer to text you may text 205-942-7740, and one of our team members will respond. You will need to Consent to the text message to discuss any personal health information.

If you have further questions or need additional information about our services, please feel free to call our office at 205-942-7740 and/or visit our website at www.advancedicare.com.

Welcome to our practice and thank you for choosing ADVANCED EYECARE for all your eye care needs.

Sincerely,

Dr. Alexia C. Vaughn O.D., M.S., M.B.A

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PATIENT INFORMATION FORM

Please enter any blank information so that we can provide the best possible care available.

GENERAL INFORMATION			
LAST NAME:	**FIRST NAME:**		**MIDDLE INTIAL:**
NICKNAME:	**DOB:**		**SEX: MALE/FEMALE**
ADDRESS:			
MAILING ADDRESS:			
EMAIL ADDRESS:			
HOME PHONE:		**CELL PHONE:**	
EMPLOYER/SCHOOL NAME:		**OCCUPATION/GRADE:**	
IF PATIENT IS UNDER THE AGE OF 18 PLEASE ENTER LEGAL GUARDIAN INFORMATION BELOW			
GUARDIAN 1 NAME:	**GUARDIAN 1 DOB:**	**RELATION:**	**PHONE:**
GUARDIAN 2 NAME:	**GUARDIAN 2 DOB:**	**RELATION:**	**PHONE:**
MEDICAL INFORMATION			
PRIMARY CARE DOCTOR NAME:		**LOCATION OF FACILITY:**	
PHARMACY:		**LOCATION:**	
OTHER INFORMATION			
WOULD YOU LIKE TO BE FITTED FOR CONTACTS? OR UPDATE YOUR CONTACT PRESCRIPTION? YES/NO			
HOW DID YOU HEAR ABOUT US?			
PLEASE CIRCLE ONE. **Google Facebook Instagram Twitter ABC FOX NBC CBS Yelp Insurance Radio _____ Friend (IF A PATIENT OF OURS PLEASE ENTER THEIR NAME BELOW)**			

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In order to provide for your eyewear needs better, please fill out this form:

Patient's Name: _____What is your occupation? _____

Does your job require safety protection? Yes No

Do you wear safety protection at home while cutting grass or doing other work around the house? Yes No

Do you use computers, tablets, or smartphones? Yes No

Are your eyes sensitive to sunlight? Yes No

Do you wear sunglasses with 100% UV protection? Yes No Polarized? Yes No

Are you bothered by glare especially at night? Yes No

Which activities do you participate? Golf Fishing/Hunting Reading Skiing Swimming

Cycling Sewing Running/Jogging Basketball Football

Other:_____

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Patient Name:_____ DOB: _____ Today's Date: _____

Have your eyes experienced any of the following during the last week?	All of the time	Most of the time	Half of the time	Some of the time	None of the time
1. Eyes that are sensitive to light? …	4	3	2	1	0
2. Eyes that are gritty? …	4	3	2	1	0
3. Painful or sore eyes? ...	4	3	2	1	0
4. Blurred vision? ...	4	3	2	1	0
5. Poor vision? …	4	3	2	1	0

Have problems with your eyes limited you in performing any of the following in the last week?	All of the time	Most of the time	Half of the time	Some of the time	None of the time
6. Reading? …	4	3	2	1	0
7. Driving at night? …	4	3	2	1	0
8. Working with a computer or bank machine (ATM)	4	3	2	1	0
9. Watching tv? …	4	3	2	1	0

Have your eyes felt uncomfortable during any of the following situations last week?	All of the time	Most of the time	Half of the time	Some of the time	None of the time
10. Windy conditions? …	4	3	2	1	0
11. Places or areas with low humidity (very dry)? …	4	3	2	1	0
12. Areas that are air conditioned? …	4	3	2	1	0

HIPAA Right of Access Form for Family Member/Friend

I, _____, direct my health care and medical services providers and payers to disclose and release eyewear and my protected health information described below to:

Name: Relationship:

_____ _____

Contact information: _____

Name: Relationship:

_____ _____

Contact information: _____

Health Information to be disclosed upon the request of the person named above –

(Check either A or B):

- ☐ **A. Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify): _____ _____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event: _____ unless I revoke it.
- ☐ **I do not give anyone Authorization to my information.**

(NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____

Name of the Individual Giving this Authorization Date of birth

_____ _____

Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524

HIPAA Consent for the Release of Information and Financial Responsibilities:

I consent to the use and disclosure by Vaughn's Family Vision LLC/ DBA Advanced Eye Care and Dr. Alexia C. Vaughn (AEC) any information, e.g. health information concerning my examinations and products, to any part and/or agent, including, but not limited to my employer, medical or optical provider, health plan or plan sponsor ("plan"), as needed for the treatment, the payment of my vision benefit claims, and related customer communications regarding health care services provided by the AEC (e.g. mailings of exam reminder/recall cards or explanations of services/products provided by the AEC).

If I desire to seek third party reimbursement for the services received, I authorize AEC to submit an insurance claim for payment to any third party as identified.

I understand that I am responsible for all charges incurred, including any portion not paid by the third party.

I understand that this consent for release of information is voluntary, and I may revoke my consent at any time by notifying the AEC in writing, except for any disclosure already taken in reliance of my consent to release information; however, AEC is not required to agree to my request. A full copy of our HIPAA is available upon request.

Acknowledgement of Receipt of HIPAA Policy:

AEC is concerned about the privacy of our patients' health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment and will use and disclose your protected health information for treatment, payment and healthcare operations when necessary.

Insurance Policy and Collection Fees to Account Balances:

As a part of our services at this practice we are happy to assist patient in determining the benefits of your individual policy and in collecting your reimbursement of insurance benefits for medical and vision services. To avoid any misunderstandings please read the following statements carefully:

- The Legal obligations of your insurance provider are between you and your provider, not between this practice and your provider.
- When your insurance provider(s) has settled your plan's covered items, you will be notified by a monthly statement if there were any unpaid balances. Unpaid balances can include non-covered items or services, co-pays, deductibles, lapses, ineligibility, or termination coverages. Unpaid balances are the sole responsibility of the patient.
- To keep the cost of the records and collections down, any patient portion amounts on your order will be due at the time of service.
- I authorize the use of this form on all insurance submissions as well as authorizing the release of information to all my insurance companies as well as allowing the doctor to act as my agent to help in obtaining payment from my insurance companies.
- I authorize payment to be made directly to the doctor and permit a copy of this authorization to be used in place of the original.
- Returned checks will incur a fee of $35.
- **I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all costs of collections (33.3%), attorney fees and/or court costs if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other State.**
- **Express Prior Consent to Contact Consumer by Cell Phone: You agree, for us to service your account or to collect monies you may owe, Vaughn's Family Vision LLC/ DBA Advanced Eye Care and/or agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.**
- I/We have read this disclosure and agree that Vaughn's Family Vision LLC / DBA Advanced Eye Care, its employees and/or agents may contact me/us as described above.

Signature _____ Date _____

Eyeglass, Contact Lenses, and Other Materials:

All eyeglasses, contact lenses, and any materials must be paid in full before ordering. **All money paid towards any payment plan is non-refundable.**

Frame Warranty:

All prescription frames are warranted against manufacture's defects for twelve months from the date of purchase. The warranty for frames covers manufacturing defects but not damages induced by the wearer or due to excessive conditions such as heat, moisture, breakage, etc. Patients Own Frame (POF) does not have a warranty. AEC and the Lab used to make the POF glasses will not be responsible for any breakage or damage of the frame during adjusting, repairing, cleaning, or glasses processing. **The warranty replacement fee is $25**.

Prescription Lens Return(s):

If the prescription lenses you ordered are not correct due to lab error or our doctor's error, please return within 30 days of the receipt of the product and they will be remade at no charge. Please note that since prescription lenses are customized and made especially for you, they are **NOT** refundable. Prescription lenses come with a scratch resistant coating which is not scratch proof. There is no warranty on lenses unless you have Crizal brand antiglare which comes with a warranty for scratches for 6 months of date of purchase.

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Contact Lens Return(s):
If you wish to exchange or return contact lens, please return them within 30 days of your receipt of the product. ONLY unopened and unaltered contact lens vials or boxes may be returned or exchanged. Any boxes directly written on and/or marked by the customer will not be refunded or exchanged.

Contact Lens Fits:
Contact lens fitting and evaluation fees are not part of a comprehensive eye exam. These services are separate charges. The charges are as follows: spherical fit $85, toric fit $95, multifocal $105, RGP $200 and up. We cannot guarantee that you will be able to successfully wear contact lenses, and if you are not, the fee for the service is not refundable. Contact lens fits must be completed within 30 days. If not completed within the allotted time period, a refit fee of $50 will be charged. If a contact lens fit is the only service desired, you must have had a comprehensive eye exam within the past 8 months.

Cancelling an Eyeglasses order:
We will allow you to the end of the business day at 5:00 PM central time on the same day order was placed to cancel. Please bear in mind that once an order is placed it is electronically sent to the lab and they start manufacturing your lenses. If the lab has already started, you will not be able to cancel your order. Acceptable methods of cancellation only include speaking directly to an AEC employee.

Clinical Services:
No refund will be made on clinical procedures, services, or prescription lenses. Eyeglasses/contact must be paid in full before it can be dispensed.

Work/School Excuses:
Excuses are only given for patients who have an appointment to see the doctor not for dilation or to pick up materials. Excuses for missed days will only be given if you have a condition that is contagious.

Cancellation Policy:
Appointments must be cancelled within 24 hours, or a $40 charge will be assessed. The charge must be paid before other services are rendered.

Digital Retina Photography with Retinal Imaging (see extra information)
We now offer digital retina photography with retinal imaging as an add-on to your comprehensive eye exam. This technology allows us to take photos of the back of the eye and have documentation so that we can more closely monitor any changes you may have. You should have photography if you have a personal or family history of glaucoma, macular degeneration, other eye diseases, high blood pressure, diabetes, or other diseases that can also affect the eyes. Your insurance company does not cover this advanced testing as part of a comprehensive eye exam. **The fee is $20.** If you would like this test, please check yes or no below:

_____Yes, I want digital photography _____No, I do not want digital photography

I acknowledge that I have received this notice regarding HIPAA and AEC office policies

Name of Patient (print) _____

_____ _____
Signature of patient or authorized representative **Date**

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