DR. RENEE´ FUEMMELER AND STAFF WELCOME YOU TO
ACCENT ON VISION EAST
Thank you for choosing us as your eye care provider.
Accent on Vision East, LLC is solely owned and operated by Dr. Renee´ Fuemmeler.

Appointment Date:

PATIENT INFORMATION

Review and complete the following. Please provide the receptionist with your ID.

Name:		
Address:		
Cell Phone: ☐ text ok for exam, order notifications and surveys	Home Phone:	Work Phone:
Email Address: ☐ E-mail ok for exam, order notifications and surveys		
Birthday:	SS# :	
Occupation:	Employer:	

Insured Party

Please provide receptionist with your Medical Insurance Card.

Vision Ins:	Medical Ins:
Ins ID #:	Insurance ID #:
INSURANCE SUBSCRIBER'S INFO:	**INSURANCE SUBSCRIBER'S INFO:**
Name:	Name:
Address:	Address:
DOB:	DOB:
SS#:	SS#:
Employer:	Employer:
Female/Male	Female/Male

Person Financially Responsible for Patient Account

Please review & complete the information below if different from above OR if the pt is under age 18. ☐ Self

Name:	DOB:
Address:	Cell Phone #:
Social Security #:	Work #:
SIGNED:	DATE:

* Most insurance policies pay only a portion of your total charges. If you have any questions about your coverage, please contact your representative. We do not guarantee the accuracy of benefit information given to us by insurance companies. Please understand that financial responsibility for your account is yours, not the responsibility of your insurance company. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits to Accent on Vision East. I understand that I am responsible for any balance my insurance does not pay.
* There will be a $30.00 fee for all returned checks, and balances older than 45 days may be subject to additional collection fees and interest.
* There will be a $25.00 fee for all missed appointments that are not cancelled in advance.
* Payments and all co-payments are due at time of service.

Whom may we thank for referring you to us?____
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For office use only

Date	Scanned	Balance	CL Order Placed	Gl/ Cl Order Placed	InsuranceTo be billed	I n s Billed	Dr. Review	Notes
			Formulary Y N	GL Y N	Y N			
			Non-Form . Y N	CL Y N	Y N			

Section 1

Retinal Health Evaluation Consent

PLEASE INITIAL YOUR CHOICE BELOW:

Dr. Fuemmeler highly recommends that all of our patients receive this test as a part of their comprehensive visual analysis. Vision insurances MAY NOT pay for retinal photo screenings. The charge for routine imaging is $30. Save $10 if combined with visual field testing (*see section 2). If there is a medical diagnosis, your medical insurance may pay for this test. This usually requires a written interpretation/report by the doctor and additional fees will be submitted to your insurance company.

CHOICE #1 DIGITAL RETINAL IMAGING

______I DO want retinal photography performed.

______I DO NOT want retinal photography performed

CHOICE #2 TRADITIONAL DILATED RETINAL EXAM

______I DO want a dilated retinal exam requiring drops.

______I DO NOT want a dilated retinal exam requiring drops

______I would like to RESCHEDULE the appointment for dilation.

CHOICE #3

______I do NOT want a dilated retinal exam or retinal photos and relieve treating optometrist of any liability from failure to diagnose such pathology that would require a retinal evaluation to expose.

Section 2

Visual Fields Testing

PLEASE INITIAL YOUR CHOICE BELOW:

Dr. Fuemmeler highly recommends that all of our patients receive this test as a part of their comprehensive visual analysis. Vision insurances DO NOT pay for visual field screenings. The charge for visual field screening is $20.00. Save $10 if combined with digital retinal imaging (* see section 1). If there is a medical diagnosis, your medical insurance may pay for this test. This usually requires a written interpretation/report by the doctor and additional fees will be submitted to your insurance company.

______I DO want the visual fields screening.

______I would like to RESCHEDULE the appointment for a visual field.

______I do NOT want to have the visual field screening and relieve the treating optometrist of any liability from failure to diagnose such pathology that would require visual field to expose.

Section 3

Acknowledgement of Receipt of Notice of Privacy Practices

We are required to notify you of our Privacy Practices which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print your name here: ____

Signature:____ Date:____

Disclosure:

I agree to involve the following persons in my care for such purposes as:
Picking up glasses, picking up contact lens, setting up and/or verifying appointments, the release of billing statements(i.e. receipts), inquiring about charges and my ocular health.

1. ________________________________ 2.________________________________ 5.________________________________
3. ________________________________ 4.________________________________ 6.________________________________

THIS WILL REMAIN IN EFFECT UNTIL I PROVIDE WRITTEN NOTIFICATION TO ACCENT ON VISION EAST.

Section 4

Contact Lens Policy and Fee Schedule

I have read and understand the contact lens policies. I agree to be fitted with contact lens and will be responsible for the fee incurred.

Print Patient's Name: ____ Date:_______________________________________

Signature of Patient or Guardian (if minor): ____