Eagle Rock Eyecare: Patient Intake Form

First Name: Middle Name:

Last Name: Suffix:

Date of Birth: Sex:

SSN: Occupation:

Phone: Email:

Address: City:

State: Zip:

Vision Insurance, Policy #, Holder Name & DOB:

Medical Insurance, Policy #, Holder Name & DOB:

Reason for Visit: Last Eye Exam (Mo/Yr):

Wear Glasses? ☐Y ☐N Wear Contacts? ☐Y ☐N

Eye condition(s) or previous eye surgery/injury (include year): ☐None

_____

Medical conditions (include year diagnosed): ☐None

☐T1 Diabetes ☐T2 Diabetes ☐Hypertension ☐High Cholesterol ☐Anemia ☐Other: _____

_____

Medications (prescribed or over-the-counter): ☐No medications

_____

Allergies (medications, environmental, etc.): ☐No known allergies

_____

Family history of glaucoma / macular degeneration / other eye disease & who: ☐Not applicable

_____

Smoke tobacco? ☐Current ☐Former ☐Never **Drink alcohol?** ☐No ☐Yes - frequency: _____

Patient (or Guardian) Signature: _____ **Date:** _____

CONSENT / ASSIGNMENT OF BENEFITS / FINANCIAL RESPONSIBILITY

I consent to examination, diagnosis, and treatment by Eagle Rock Eyecare LLC.

I authorize release of medical information necessary to process insurance claims and assign benefits directly to the provider. I understand I am financially responsible for all charges not covered by insurance.

I acknowledge that co-pays and deductibles are due at check-out. Insurance is a contract between patient and insurer. I understand that my insurance plan may not cover all services, including refractions ($60.00), retinal screenings, contact lens fittings, or materials. Unpaid balances may be sent to collections if not settled in full.

Patient Name: _____

Signature: _____ Date: _____

RETINAL IMAGING AND DILATION: CONSENT OR REFUSAL

Our standard of care involves digital imaging that captures a quick, high-resolution, up-to-200° image of the retina without dilation ($39.00). This screens for retinal tears, detachment, glaucoma, and conditions like diabetes and hypertension. Alternatively, we can offer a dilated exam. Dilation requires an additional 20-30 minutes, and side effects from dilation eye drops include blurry vision and light sensitivity for 4-6 hours. If I decline both, I assume all risks associated with the failure to detect, diagnose, or treat any internal eye problems. Select ONE:

▢ Retinal imaging (no drops) ▢ Dilation (with drops) ▢ Refuse imaging AND dilation

Patient Name: _____

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF VISION PRESCRIPTION RELEASE

I acknowledge that I am provided with a copy of my eyeglass prescription and contact lens prescription (if applicable) after the eye examination.

Patient Name: _____

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: 3/10/2026

Our Commitment to Your Privacy

Eagle Rock Eyecare LLC is committed to protecting the privacy of your protected health information ("PHI"). We are required by law to maintain the privacy of your PHI, provide you with this Notice, and follow the terms of this Notice currently in effect.

How We May Use and Disclose Your Health Information

We may use and disclose your PHI for:

Treatment: To provide and coordinate your eye care.
Payment: To bill and collect payment from you or your insurance.
Healthcare Operations: For quality improvement, staff training, licensing, and auditing.

Other Permitted or Required Disclosures

As required by law, public health activities, health oversight, judicial proceedings, law enforcement, to prevent serious threats, and for workers' compensation.

Uses Requiring Authorization

Marketing, sale of information, or any other use not listed requires your written authorization, which you may revoke.

Your Rights

You have the right to inspect, copy, amend, request restrictions, confidential communications, accounting of disclosures, and a paper copy of this notice.

Our Responsibilities

We will protect your PHI, notify you of breaches, and comply with this Notice.

Complaints

Eagle Rock Eyecare LLC
Address: PO Box 333, West Orange, NJ 07052
Phone: 973-559-7903

You may also complain to the U.S. Department of Health and Human Services.

PATIENT ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and reviewed the Notice of Privacy Practices of Eagle Rock Eyecare LLC.

Patient Name: _____

Signature: _____ Date: ____ / ____ / _____