Milano Eyecare Group
Welcome To Our Office

Welcome to Milano Eyecare Group. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

First Name _____ MI _____ Last Name _____ Preferred Name _____

Street/ Mailing Address _____ City _____ State _____ Zip Code _____

Social Security Number _____ Date of Birth _____ Home Phone _____ Day Phone _____

Email Address _____ Guardian _____ Person Responsible for Account _____

Emergency Contact _____ Emergency Phone _____

Patient Status: (circle) Single Married Other

Full Time Student Part Time Student Employed

Employer Name _____ Employer Phone _____

Primary Insurance Information

Primary Insurance Company _____

Insured's First Name _____ MI _____ Insured's Last Name _____

Insured's Identification Number _____ Group Number _____ Insured's Date of Birth _____

Patient Relationship to Insured: Self Spouse Child Other:_____

Secondary Insurance Information

Secondary Insurance Company _____

Insured's First Name _____ MI _____ Insured's Last Name _____

Insured's Identification Number _____ Group Number _____ Insured's Date of Birth _____

Please Read:

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 Milano Eyecare or 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 either to the physician or supplier of services rendered. When possible we will file your insurance for you. Payment from my insurance company is paid directly to Milano Eyecare Group. I understand that I am responsible for any balance my insurance does not pay.

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in the office regardless of insurance. Account balances 90 days old are subject to a 33% collection fee. There will be a $30.00 service charge on all returned checks.

I understand that if I have Medicare, it will be billed as my primary insurance. I understand that billing any secondary insurance may be my responsibility. 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.

There is a 50% refund on all returned materials with Dr. Milano's approval only. However if you have VSP insurance, you will NOT receive a refund due to the reimbursements we receive.

_____ _____

Signature **Date**

Jon G. Milano
Milano Eyecare Group
125 Central Ave-Suite D
Oxford, AL 36203
Telephone: (256)832-2252
Fax: (256)832-2254

Lens and Frame Warranty

Frames we sell to our pateients do have a one time, one year warranty **IF** it is a manufacture's deffect. This does not include theft, accidental loss or damage (i.e. "My dog ate it," "My child broke it in half"). Super Gluing any frame VOIDS the warranty.

Lenses: We offer our patients a Scratch Warranty for their lenses. If you purchase the scratch warranty, and you have scratches on your lenses, we can replace the lenses **one time** throughout the year from the date of purchase. If you choose not to purchase the Scratch Warranty, our lab cannot replace the lens for any reason.

If for any reason, you are unable to adpat to the RX in your new glasses, you will have 60 days from the dispensing day to come back and have them checked. If it it past the 60 days, you will be required to purchase new lenses.

Patient Signature: _____

iWellness Exam

Sight threatening diseases such as glaucoma, macular degeneration, diabetic retinopathy and others often have no outward signs or symptoms, which is why eye exams, including a thorough retinal evaluation, are important to protect vision. In an effort to provide a more thorough eye exam, our practice has incorporated the iWellnessExam™ SD- OCT retinal scan as part of our comprehensive eye exams.

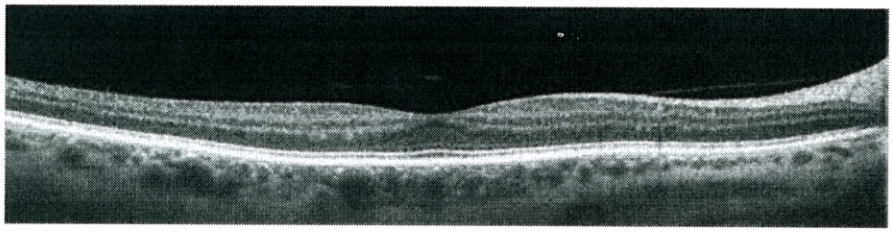
As part of your pre-examination work-up, our technician will perform this test which Dr. Milano will review with you during your examination today. The results of this exam will become a part of your permanent patient record.

The $39 co-pay is typically not covered by your medical or vision insurance unless being used to actively follow disease. This cost will be added into the price of your visit today. Any questions you have about these tests can be discussed during your examination with Dr. Milano.

Patient Signature: _____

*The iWellnessExam is an eligible expense for Flexible Spending Accounts

Normal retinal cross section iWellness OCT



Dieseased retina, visible to iWellness OCT exam often invisible to ophthalmoscopy.