FORRESTER EYE ASSOCIATES

3320 NORTH MAIN STREET ANDERSON, SC 29621
PHONE 864 642 1889
FAX 864 224 1768
WWW.FORRESTEREYE.COM

PATIENT PAPERWORK

_____ _____ _____/_____/_____

PATIENT'S LAST NAME **PATIENT'S FIRST NAME** **PATIENT'S DATE OF BIRTH**

PATIENT'S GENDER:
- ☐ MALE
- ☐ FEMALE

SOCIAL SECURITY # _____-_____-_____

STREET ADDRESS:_____
APT./UNIT:_____ **CITY:**_____
STATE:_____ **ZIP:** _____

MAY WE TEXT YOU REGARDING YOUR APPOINTMENTS?
- ☐ YES
- ☐ NO

_____ _____

HOME PHONE **CELL PHONE**

_____ _____ _____

EMPLOYER OR SCHOOL **OCCUPATION OR GRADE IN SCHOOL** **EMAIL**

PARENT OR GUARDIAN INFORMATION

_____ _____ _____/_____/_____

PARENT OR GUARDIAN'S LAST NAME **PARENT OR GUARDIAN'S FIRST NAME** **DATE OF BIRTH**

RELATION TO PATIENT:_____

❒ **ADDRESS and PHONE IS THE SAME AS THE PATIENT**

GENDER:
- ☐ MALE
- ☐ FEMALE

SOCIAL SECURITY # _____-_____-_____

STREET ADDRESS:_____
APT./UNIT:_____ **CITY:**_____
STATE:_____ **ZIP:** _____

HOME PHONE:_____ **CELL PHONE:** _____

FINANCIAL INFORMATION

WHO IS RESPONSIBLE FOR THIS ACCOUNT:

❒ Myself ❒ Parent or Guardian (must be checked if patient is under 18)

NAME:_____

ARE YOU A SELF PAY PATIENT? ❒ YES ❒ NO

INSURANCE INFORMATION

- ☐ PRIMARY MEMBER OF MEDICAL AND VISION INSURANCE FOR THIS VISIT IS ME.
- ☐ THE PRIMARY MEMBER OF MEDICAL AND VISION INSURANCE USED FOR THIS VISIT IS THE SAME AS THE PARENT AND GUARDIAN INFORMATION ALREADY PROVIDED.

_____ _____ _____/_____/_____

PRIMARY MEMBER'S LAST NAME **PRIMARY MEMBER'S FIRST NAME** **DATE OF BIRTH**

RELATION TO PATIENT:_____

PRIMARY MEMBER'S PATIENT'S GENDER:
- ☐ MALE
- ☐ FEMALE

SOCIAL SECURITY # _____-_____-_____

STREET ADDRESS: _____
APT./UNIT:_____ **CITY:**_____
STATE:_____ **ZIP:** _____

_____ _____ _____ _____ _____

MEDICAL INSURANCE CARRIER **MEDICAL INSURANCE ID #** **PLAN NAME** **GROUP #** **PHONE NUMBER**

_____ _____ _____ _____ _____

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PATIENT PAPERWORK

VISION INSURANCE CARRIER **VISION INSURANCE ID #** **PLAN NAME** **GROUP #** **PHONE NUMBER**

WHAT IS THE REASON FOR TODAY'S EXAM?

_____

_____ _____ _____/_____

DATE OF LAST EXAM **DATE GLASSES WERE MADE** **BRAND OF CONTACT LENSES/SOLUTION USED**

PERSONAL HISTORY

PLEASE SELECT ANY EYE CONDITIONS YOU HAVE NOW OR HAVE BEEN DIAGNOSED IN THE PAST WITH BELOW, PLEASE CHECK ALL THAT APPLY:

- ☐ NONE
- ☐ Dry eye
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Retinal disease
- ☐ Macular degeneration
- ☐ Strabismus
- ☐ Iritis/Uveitis Floaters
- ☐ Flashes of light
- ☐ Double Vision
- ☐ Previous eye injury
- ☐ Herpes

PLEASE LIST ANY EYE INJURY OR SURGERY AND WHEN: _____ _____

MEDICATIONS

- ☐ **I will provide a list to scan into my file**
- ☐ **I do not take medication**
- ☐ **I give permission for you to obtain my medication history from my pharmacy** ***Initial:*** _____

	Medication	Dose/Frequency	Reason for Use
1			
2			
3			
4			
5			

PLEASE LIST ANY ALLERGIES TO MEDICATION HERE:

_____

FAMILY HISTORY

PLEASE SELECT CONDITIONS ON YOUR MOTHER'S SIDE OF THE FAMILY BELOW.

- ☐ NONE
- ☐ Macular degeneration
- ☐ Cataracts
- ☐ Glaucoma
- ☐ RETINAL DISEASE
- ☐ Diabetic

PLEASE SELECT CONDITIONS ON YOUR FATHER'S SIDE OF THE FAMILY BELOW.

- ☐ NONE
- ☐ Macular degeneration
- ☐ Cataracts
- ☐ Glaucoma
- ☐ RETINAL DISEASE
- ☐ Diabetic

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SOCIAL HISTORY

PLEASE CHECK ALL THAT APPLY:

☐ NONE ☐ Smoker ☐ Former smoker ☐ Alcohol ☐ Recreational user

MEDICAL HEALTH HISTORY

_____ _____

PRIMARY MEDICAL DOCTOR'S NAME **PRIMARY MEDICAL DOCTOR'S PHONE NUMBER**

PLEASE CHECK ALL THAT APPLY:

ALLERGIES/IMMUNE:

☐ NONE ☐ Seasonal ☐ Medical ☐ Environmental ☐ Lupus ☐ Sjogren's Syndrome

CARDIOVASCULAR:

☐ NONE ☐ High blood pressure ☐ Heart disease ☐ Congestive heart failure

HEMATOLOGIC/LYMPH:

☐ NONE ☐ Cholesterol ☐ Anemia ☐ HIV

EAR/NOSE/THROAT::

☐ NONE ☐ Hearing loss ☐ Sinus conditions ☐ Vertigo

ENDOCRINE:

☐ NONE ☐ Thyroid dysfunction ☐ Diabetes I ☐ Diabetes II

☐ **PLEASE LIST LAST A1C AND DATE TESTED: _____**

INTEGUMENTARY:

☐ NONE ☐ Eczema ☐ Rosacea ☐ Psoriasis ☐ Shingles

MUSCULAR/SKELETON:

☐ NONE ☐ Arthritis ☐ Fibromyalgia ☐ Muscular dystrophy

NEUROLOGICAL:

☐ NONE ☐ Multiple sclerosis ☐ Epilepsy ☐ Migraines ☐ Stroke ☐ Tumor

PREGNANT/NURSING:

☐ NONE ☐ Nursing ☐ Pregnant

☐ **HOW MANY WEEKS ALONG IF PREGNANT: _____**

PSYCHIATRIC:

☐ NONE ☐ Depression ☐ Anxiety ☐ ADHD

RESPIRATORY:

☐ NONE ☐ Emphysema ☐ COPD ☐ Sleep apnea ☐ Asthma

OTHER CONDITIONS NOT LISTED ABOVE:

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FINANCIAL POLICIES

Eyeglass prescriptions are guaranteed for **60 days** from the date of the exam. Any changes to the prescription occurring after 60 days from the date of the exam will incur an office visit fee of **$30.00.**

You will be provided two copies of your eyeglass prescription at the end of your exam.

Contact Lens Patients Policies: First-time contact lens wearers **must** complete the staff-led contact lens training before the release of trial lenses. All contact lens prescriptions require follow-up care before the release of the prescription. You are responsible for following through with your follow-up appointment. Your contact lens exam fee includes two follow-up care for the following 45 days of the initial exam. Any **changes made after the 45 -day period** will incur an office visit fee of **$35.00.** Any changes made after 3 months will require another exam and fitting.

You will be provided two copies of your contact lens prescription once Dr. Forrester releases you for continued wear.

Forms of Payment: Cash, major credit card, or Care Credit

Co-Pays & Deductibles: All Medicare, Medicaid, and other health plan co-pays, deductibles, and shared costs are payable on the date of service. We verify your benefits to the best of our ability. However, it is ultimately your responsibility to know your coverage.

Medicare: We accept assignments and will file all Medicare claims. At the time of service, you are responsible for 20% of the Medicare allowable fee, plus the deductible and any service charge not covered by Medicare. Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862(a)(I) of the Medicare law. If Medicare denies payment, you agree to be personally and fully responsible for all costs by signing. You also agree that payment of authorized Medicare/Medigap benefits is made payable to Forrester Eye Associates for services rendered by that physician/supplier. Your signature will also authorize any holder of medical information about you to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services. A current copy of the Medicare card is required before treatment, or the patient will be rescheduled when the card can be provided.

Medicaid: A current copy of the Medicaid card or the Medicaid ID number is required before treatment, or the patient will be rescheduled.

Private Ins & Managed Care: If you participate in a plan that we accept, we will be happy to file your insurance claims for you. Otherwise, payment in full is your responsibility. Please note that you are ultimately responsible for payment if your private insurance company denies payment.

Self-Pay: Payment is expected at check-out for all services rendered. You may call our office for an estimate of our fees. If you are unprepared to cover your exam, we recommend exploring Care Credit or rescheduling your appointment.

Non-Covered Services: Several non-covered services are essential for the doctor to properly evaluate and treat you during your eye exam. They include refraction, retinal photography, contact lenses, contact fitting fees, etc. Medicare and most insurance plans do not cover these fees, payable upon check-out. You may choose to defer these or any services.

Service Charges: **Our office only accepts checks through the mail to resolve any balance owed**. We no longer accept checks in the office for services rendered for appointments. Any check returned to our office for non-payment will generate an additional processing fee. If your account is sent to a collection agency, you will incur an administrative fee for that effort, including any court costs.

Drivers Forms: We will be happy to complete a DMV Form for you for a $15.00 fee.

Other Forms: A nominal fee per form will be charged for any additional insurance forms or dictated letters from our doctor. Documents will be ready in 2- 3 business days.

No-Show Charge: Due to the negative impact of missed appointments on our staff, doctors, and other patients, a fee of $25.00 will be charged for a no-show or missed appointment if you have not provided us with at least 24-hour.

I have read and agree to all the above-stated office policies by signing below.

PRINTED NAME:_____

SIGNATURE: _____ **DATE:** _____

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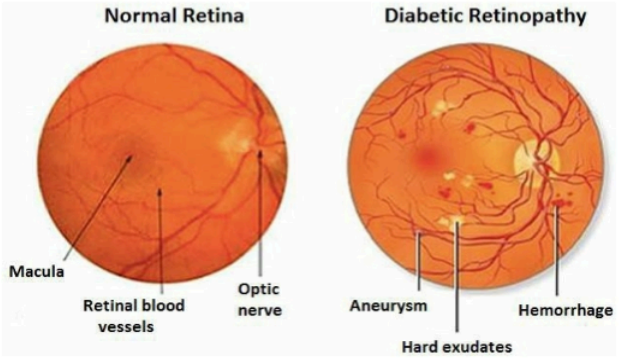
PATIENT PAPERWORK

Retinal Imaging, Visual Field Screening, and Dilation Consent

Retinal Imaging

As part of your eye exam, we recommend a special diagnostic procedure called Retinal Photography. In this procedure, a Retinal Camera is used to take a photograph of the back of the eye (the retina). This is not an X-ray or an ultrasound, nothing will touch your eye, it is simply a highly magnified photograph. Also, with Retinal Photography you may not need to be dilated.

This permanent digital record is very valuable in assessing the health of your eyes presently and in monitoring the health of your eyes over the years. We are able to observe the retina, optic nerve, macula, blood vessels, and arteries of the eyes. It will also serve as an initial reference point with which to compare any changes as we monitor your health in subsequent years.



Your doctor strongly believes retinal photos to be an important part of your comprehensive eye exam. Retinal photos also allow you to see what your eye looks like - just as the doctor sees it.

The fee for this additional part of your eye exam is **$38,** which will be charged every year that photos are taken. Depending on your diagnosis, if there is a medical issue such as diabetes, glaucoma, etc., this procedure may be covered under your medical insurance. Retinal Photography is not covered under most vision plans such as VSP, EyeMed, or Davis Vision. This office will advise you of your coverage.

❒ **Yes, I want to have retinal photos taken of my eye.**

❒ **No, I do not wish to have retinal photos taken**

Visual Field

A critical part of comprehensive eye care is the visual field. We highly recommend this test, which gives a computerized examination of your side (peripheral) vision. Many diseases revealed by a visual field are undetectable in an eye examination and may only be diagnosed with a visual field. Some of the diseases that a visual field may detect are GLAUCOMA, RETINAL DISEASE, BRAIN TUMORS, and many other disorders relating to the eye and brain.

The fee for this test is $19.00. Most insurance will cover this cost.

❒ **Yes, I give consent to have a visual field.**

❒ **No, I decline to have a visual field performed. I understand that this test helps in the detection of many diseases which can cause permanent and irreversible vision loss. I also decline this important part of my eye examination and release all doctors, personnel, and businesses associated with this facility from any liability related to the failure to detect and treat any condition in which the diagnosis would have been aided by this test.**

Dilatation

❒ **Yes, I give consent to have my eyes dilated. We do not guarantee what you can or cannot do (INCLUDING DRIVING) while dilated. So please do not ask if you can drive because everyone is affected differently. There are two main effects from pupil dilation. The first effect for about 2 hours is decreased distance and near vision and the second effect is increased sensitivity to light for about 6 hours.**

❒ **No,I decline to have my eyes dilated, UNLESS IT IS NECESSARY. I understand this is an important part of my eye examination and release all doctors, personnel, and businesses associated with this facility from any liability related to the failure to detect and treat any condition in which the diagnosis would have been aided by this test.**

SIGNATURE: _____ **DATE:** _____

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PATIENT PAPERWORK

CONTACT LENS POLICIES AND PRICING

CONTACT LENS FEES: These fees do not include: • The refraction fee • The cost of a comprehensive eye exam • The cost of the contact lenses	NEW FIT: • Price includes training and follow-ups • A yearly exam that entails problems or changes	ANNUAL CONTACT LENS EXAM: • No issues or changes in lenses.
CONTACT FIT TYPE:		
Spherical Fit	$80.00	$60.00
Low Cylinder Toric Fit	$90.00	$70.00
Specialty Fit • Monovision • Bifocal • Multifocal • High Cylinder Soft Toric (-2.75 or higher)	$100.00	$80.00
WE DO NOT FIT HARD LENSES		

All fit fees include two recheck visits of follow-up care at N/C. Additional follow-up visits are $35.00 each. You have 45 days to return for the follow-up visit to finalize your contact prescription.
You will be provided a copy of your contact lens prescription and access to the prescription via the patient portal once the Doctor has released your for wear and finalized the prescription.

The above fees DO NOT include the cost of the contact lenses.

BY LAW, WE CAN NOT GIVE OUT CONTACT LENS PRESCRIPTIONS UNLESS WE HAVE SEEN THE PATIENT WITHIN THE LAST YEAR.

PAYMENT

Fees for the comprehensive exam, contact lens fitting, or annual contact lens checks are due at the time of service. Full payment is required for all contact lens orders, except trial lenses. If you want your lenses shipped to your home, you must pay in full before the lenses are ordered. When you are picking up from our office, any remaining balance must be paid before the contact lenses are dispensed.
Replacement contact lenses will only be dispensed when the original lenses are returned to our office. We accept cash, VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS. After the initial fit, we will gladly order contact lenses over the phone with a credit card as long as the prescription is valid.

REFUNDS

There will be no refund on opened or marked boxes of lenses or colored lenses because of dissatisfaction with the color.
If you are unhappy, any **UNMARKED, UNOPENED, AND UNEXPIRED boxes of disposable soft contact lenses can be exchanged for up to 6 months from the date of order, EXCEPT some Cooper Vision products. Some Cooper Vision products (including torics) in the same condition can only be exchanged for 3 months from the order date.**

There will be NO refund of the exam, fitting, or annual contact lens check fees.

PLEASE READ COMPLETELY AND KEEP FOR YOUR RECORDS

Advancements in contact lens technology offer the potential of successful contact lens wear to most of our patients. A contact lens is a medical device in contact with the tissues of your eye; therefore, it must fit appropriately to maintain the health of your eyes. A contact lens prescription can only be determined by the careful observation of the lens on the eye and the eye's response to the lens on follow-up visits. Since follow-up care is essential, you must keep all appointments and follow all lens care instructions.

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PATIENT PAPERWORK

THE COMPREHENSIVE EYE EXAM

A complete medical and refractive eye examination is necessary before a patient can be fit with contact lenses. This exam is critical to assure the good health of your eyes and to rule out the possibility of any unsuspected, underlying condition that may prevent contact lens use.

CONTACT LENS FITTING

The goal of contact lens fitting is to find the most appropriate contact lens for each patient's optimal vision and comfort. An enormous variety of types, materials, sizes, and colors are available. We are committed to taking the time and effort to fit your contact lenses properly. Although many patients will need only one fitting session, sometimes this process requires several appointments. In our experience, the extra time, effort, and patience are well merited by both your ultimate satisfaction and the health of your eyes. All patients being fit into contacts for the first time must go through the fitting process. We will not finalize the contact lens prescription until both the patient and the doctor are satisfied with the fit and visual acuity of the contact lens. We will provide one set of trial lenses. If any additional lenses are necessary, there will be a fee of $5.00 to cover the cost of the lens. Any patients who are changing lens brands must also have a new fitting. A contact lens fitting does not have to be performed on the day of the comprehensive or routine eye exam and can be performed in an additional appointment slot within 90 days FROM the initial eye exam.

CONTACT LENS TRAINING SESSION

The patient will be provided with personalized instruction concerning the safe care and usage of contact lenses. The first training will be up to 30 minutes long. If additional time is needed, it will be necessary to schedule a second 30-minute training session at a different time. Upon successful insertion and removal, the patient may begin wearing the contact lenses, and we will schedule the first follow-up appointment. (It is our experience that children learn these new skills more quickly without the parents in the room.)

FOLLOW-UP APPOINTMENTS

Follow-up appointments are necessary to ensure several things:

1. **The contact lenses are fitting and moving well.**
2. **The prescription provides the best possible vision**
3. **The eyes remain healthy.**
4. **There are no problems with insertion or removal.**
5. **The patient understands and complies with the recommended wearing schedule.**

All fit fees include two recheck visits of follow-up care at N/C. Additional follow-up visits are $35.00 each. You have 45 days to return for the follow-up visit to finalize your contact prescription.

ANNUAL CONTACT LENS CHECK

By law, a contact lens prescription is valid for only one year. All patients are required to come in for an annual contact lens exam. This is necessary to assure that the patient's eyes are healthy, and the contact lenses are still fitting well. Contact lens prescriptions cannot be renewed without an annual exam. If we are seeing you for the first time, and you have had a contact lens prescription from another office, we must have a copy of that prescription before your exam in this office. Otherwise, we will consider it a new fit, which we may not have time to complete in your initial visit, and additional costs will apply.

CONTACT LENS CARE GUIDE

- **Always make sure contact lenses are right side out before insertion. The edges should "roll up" at the lens profile. If the edges are flared slightly, the contact may be inside out. An inexpensive magnifier can be very helpful with this evaluation.**
- **Wear lenses for 4 hours on the first day and increase wear by 2 hours each day until a maximum of 12- 14 hours has been reached.**
- **After removing the contacts, clean them properly and place them in the contact lens case, using the new solution daily. Lenses should be stored for at least 4–6 hours for complete disinfection.**
- **Do not allow soft lenses to come in contact with water. Use only solution that is compatible with soft contact lenses.**
- **Do not sleep in contactS.**

Some ADAPTIVE SYMPTOMS are normal for the first couple of weeks. These symptoms include tearing the contact lens upon insertion or removal, mild sensitivity to light, a slight headache, foreign body sensation, dryness, and mild itching. These symptoms should clear up when all-day wear is achieved.
ABNORMAL SYMPTOMS include persistent pain, burning and excessive tearing, redness that does not clear up, hazy vision that remains more than one hour after removal, and abnormal sensitivity to light. If these symptoms occur at any time, you should remove the lenses and call our office. (864-642-1889)
NOTE: Do not sleep in your lenses. Should you fall asleep in your lenses, lubricate them well to loosen them before removal. Once the lens moves freely on the eye, it can be removed. If only minor discomfort or a dry feeling exists, you can resume normal wear in 24 hours. If abnormal symptoms exist, contact our office. (864-642-1889)

CLEANING SOLUTIONS AND REWETTING DROPS

- **There are different cleaning solutions available. We will provide you with the best solution for your needs.**
- **REWETTING drops may be important for lubricating the eye and keeping the contact hydrated. To promote comfort, the lens must be well hydrated. REWETTING solutions also keep debris from building up under the contact lens. Frequency of REWETTING drop use varies from patient to patient. If you do a lot of close work, such as reading or working on a computer, you may experience more dryness because of the reduction in blinking. Certain medications such as antihistamines, diuretics, and birth control pills also contribute to dryness. Do not use an eye drop that is not specified for contact lens use.**

REMEMBER:

Your compliance with the above is of the utmost importance to be successful with contact lens wear and to avoid any unnecessary trauma to the eye. Noncompliance with contact lens care can result in serious eye problems. Please contact Forrester Eye Associates with any questions or concerns about contact lenses at any time.

This consent was signed by: _____

(PRINT NAME PLEASE)

SIGNATURE: _____ **DATE:** _____

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change; if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but we shall honor this agreement if we do. The HIPAA (Health Insurance Portability and Accountability Act of 1996) allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as law allows.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time, and all full disclosures will cease.
- The practice may condition receipt of treatment upon the execution of this consent.

May we phone, email, or text you to confirm appointments?	YES	NO
May we leave a detailed message on your home answering machine or cell phone?	YES	NO
May we discuss your medical condition with a family member?	YES	NO

If YES, please name the members allowed:

_____

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____