

PATIENT PAPERWORK

PATIENT'S LAST NAME

PATIENT'S FIRST NAME

____/____/____
PATIENT'S DATE OF BIRTH

PATIENT'S GENDER: SOCIAL SECURITY #

☐ MALE

☐ FEMALE

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'S

GENDER: SOCIAL SECURITY #

☐ MALE

☐ FEMALE

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)

ARE YOU A SELF-PAY PATIENT? ☐ YES ☐ NO

INSURANCE INFORMATION

☐ THE 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'S GENDER: SOCIAL SECURITY #

☐ MALE

☐ FEMALE

PRIMARY MEMBER'S

STREET ADDRESS: _____

APT./UNIT: _____ CITY: _____

STATE: _____ ZIP: _____

MEDICAL INSURANCE CARRIER

MEDICAL INSURANCE ID #

PLAN NAME

GROUP #

PHONE NUMBER

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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 WITH IN THE PAST BELOW.

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:** _____

	<u>Medication</u>	<u>Dose/Frequency</u>	<u>Reason for Use</u>
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 after 60 days from the exam date will incur a fee of **\$30**. ***You will be provided two copies of your eyeglass prescription after the exam.**

Forms of Payment: Cash, major credit card, or CareCredit

***WE DO NOT ACCEPT CHECKS**

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. Once the insurance company processes the claim, you may be responsible for any co-pays, co-insurances, deductibles, or non-covered services.

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)(1) 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 its 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.

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.

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.

Forms: We will be happy to complete a DMV form, insurance form, or dictated letters from our doctor for you for a \$15.00 fee.

Medical insurance vs. vision insurance: Our office accepts both MEDICAL insurance and VISION plans. They can be very different in terms of services they cover and do not cover and when it is necessary to file each type.

- Medical insurance will cover any MEDICAL issue that may affect eye health. The visits for treating, monitoring & evaluating these conditions are considered 'medically necessary.' These visits need to be filed with medical insurance.
- Vision plans cover a 'routine' eye exam to determine a glasses prescription and/or screen for eye issues. These plans also may provide coverage for the purchase of glasses and/or contact lenses. Management and evaluation of medical eye conditions are NOT part of 'routine' vision exams.
- Our office will bill each visit based on the reason for the visit, the chief complaint, patient history, the diagnoses made during the visit, and the medical evaluation and treatment that follows the visit. Our doctor will make the final determination as to how a claim will be filed. We will make every effort to file your insurance claims and coordinate benefits between plans, if needed.

****Issues that require filing of medical insurance (even if the visit is a yearly 'routine' exam):**

- New or Sudden Vision Loss
- Flashing lights/floating spots
- Eye pain/redness
- Diabetes
- Glaucoma
- Macular degeneration
- Cataracts
- 'High Risk' Medication use
- Previous Eye Surgery

***PATIENTS WITH THE ABOVE (or similar) ISSUES ARE NOT 'ROUTINE' AND WILL NOT BE FILED TO 'ROUTINE' VISION PLANS**

I have read and understand the above policies. I authorize Forrester Eye Associates to file my insurance by the above guidelines. I am responsible for any CO-PAYMENTS, DEDUCTIBLES, or portions NOT COVERED by my insurance plan(s).

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____

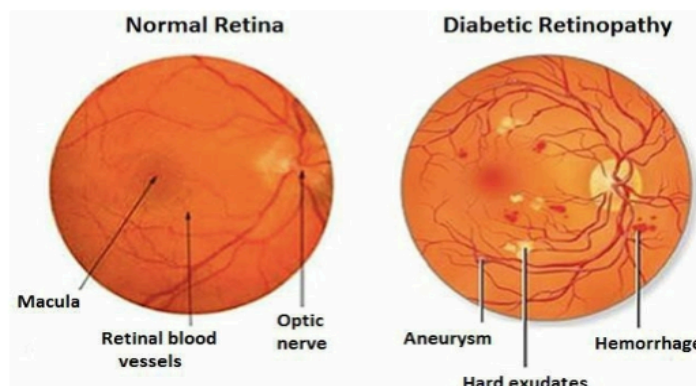
Retinal Imaging, Visual Field Screening, and Dilation Consent

Retinal Imaging

As part of your eye exam, your doctor strongly believes **retinal photography** 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. In this procedure, a retinal camera is used to take a photo of the back of the eye (the retina). Nothing will touch your eye (this is not an X-ray or an ultrasound); it is simply a highly magnified photograph. 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.

The fee for this additional part of your eye exam is **\$39**. Depending on your diagnosis, if there is a medical issue such as diabetes, high blood pressure, glaucoma, etc., this procedure may be covered under your medical insurance. Retinal photography is not covered under most vision plans.



☐ **Yes, I give consent to have retinal photos taken.**

☐ **No, I decline 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**. Depending on your diagnosis, this procedure may be covered under your medical insurance.

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

☐ **No, I decline to have a visual field performed.**

Dilatation

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.

☐ **Yes, I give consent to have my eyes dilated.**

☐ **No, I decline to have my eyes dilated.**

****I understand by declining any of these tests, I'm declining an important part of the exam that could help in the detection of many diseases, which can cause permanent and irreversible vision loss. I understand 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.**

PRINTED NAME: _____

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 call, email, or text you regarding appointments, insurance, and billing? YES NO

*May we leave a detailed message on your 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:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____

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CONTACT LENS POLICIES AND PRICING

CONTACT LENS FIT FEES: These fees do <u>not</u> include:	NEW FIT:	ANNUAL CONTACT FIT:
- The refraction fee - The cost of a comprehensive eye exam - The cost of the contact lenses	- Insertion and removal training - Up to two follow-up visits (additional follow-up visits are \$35.00 each)	- Annual contact lens check - Up to two follow-up visits (additional follow-up visits are \$35.00 each)
Spherical Fit	\$80.00	\$60.00
Toric Fit	\$90.00	\$70.00
Specialty Fit (Multifocal/Monovision)	\$100.00	\$80.00

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. 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 FITTING

By law, a contact lens prescription is valid for one year. Contact lens prescriptions cannot be renewed without an annual exam. The goal of contact lens fitting is to find the most appropriate contact lens for each patient's optimal vision and comfort. Although many patients will need only one fitting session, sometimes this process requires several appointments. 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. You will be provided a copy of your contact lens prescription once the prescription is finalized.

CONTACT LENS TRAINING SESSION

All patients being fit into contacts for the first time must go through the fitting process. The patient will be provided with personalized instruction concerning the safe care and usage of contact lenses. The first training will be up to 45 minutes long. We can schedule a second training session, if needed. Upon successful insertion and removal, the patient may begin wearing the contact lenses, and we will schedule the recheck appointment.

FOLLOW-UP APPOINTMENTS

Be sure to wear the contacts to the contact recheck appointment. Follow-up appointments are necessary to make sure the contact lenses are fitting well, the eyes are healthy, the prescription provides the best possible vision, and there are no problems with insertion and removal. The appointment is also to make sure the patient understands the recommended wearing schedule. You have 45 days to return for the follow-up visit to finalize your contact prescription.

REFUNDS

There will be no refund on opened or marked boxes of lenses or colored lenses because of dissatisfaction with the color. We can only exchange UNMARKED, UNOPENED, AND UNEXPIRED boxes of contact lenses for up to 6 months from the date of order. There will be NO refund of the exam, fitting, or annual contact lens check fees.

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.
- 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 solutions that are compatible with soft contact lenses.
- Do not sleep in contacts. 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.

***ADAPTIVE SYMPTOMS** are normal for the first couple of weeks. These symptoms include 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)

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____