Welcome to OptimEyes Optometry
PATIENT HISTORY

Today's Date _____-_____-_____

Name (First) _____ Name(Last)_____ (MI)_____

Birth Date_____-_____-_____ Age_____ Gender ___F ___M Email_____

Address_____ City_____ State_____ Zip Code_____

Home Phone_____ Work Phone_____ Cell Phone_____

Hours on Computer/Day_____ Employment Status_____ Occupation_____

Marital Status ☐Single ☐Married ☐Domestic Partner ☐Other_____

How did you hear about us ☐ Yelp ☐ Google ☐ Friend ☐ Ad/TV Ad ☐ Other_____

INSURANCE INFORMATION:

Vision/Medical Insurance: _____ Social Security #: _____ -_____ - _____

Insurance #:_____ Group #: _____Primary Card Holder: _____

Primary's Birth date: __ - _____ - _____ Employer: _____

VISUAL AND MEDICAL HISTORY:

Reason for today's visit: ☐ Glasses exam ☐ Contact Lens exam ☐ Red Eyes ☐ Other: _____

Glasses currently worn: ☐ Distance Only ☐ Near Only ☐ Bifocal ☐ Comp. Bifocal ☐ Trifocal

Date of last eye exam: _____ Name of Doctor: _____

Are you interested in learning about **Lasik Surgery**? ☐ Yes ☐ No

Date of last medical exam: _____ Name of Doctor: _____

Medications you are currently taking (including over-the-counter): _____

Are you pregnant or planning on becoming pregnant? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No Frequency_____

Please list any drug allergy: _____ Seasonal allergy: ☐ Yes ☐ No

Please check the following that apply to you and/or your immediate family members:

	SELF	FAMILY (*List Relationship*)		SELF	FAMILY
Diabetes	_____	_____	Eye Injury	_____	_____
High Blood Pressure	_____	_____	Floaters/Flashes	_____	_____
Arthritis	_____	_____	Double Vision	_____	_____
Thyroid	_____	_____	Headache	_____	_____
Heart disease	_____	_____	Lazy Eye	_____	_____
Respiratory Problems	_____	_____	Cataract	_____	_____
Kidney Disease	_____	_____	Glaucoma	_____	_____
Cancer	_____	_____	Retinal disease	_____	_____
High Cholesterol	_____	_____	Macular Degeneration	_____	_____
Surgery:_____	_____	_____	Eye Surgery	_____	_____

Do you have: *dry eyes? ☐ Yes ☐ No *itchy eyes? ☐ Yes ☐ No *excess tearing? ☐ Yes ☐ No

Do you skip lines or lose your place when reading? ☐ Yes ☐ No Do you get car sick/motion sickness? ☐ Yes ☐ No

CONTACT LENS INFORMATION:

Do you currently wear contact lenses? ☐ Yes ☐ No If yes, what type? _____

How often do you replace your contact lenses? _____ Do you sleep in your contacts? ☐ Yes ☐ No

Are you interested in contacts you can sleep in up to: **7 days?** ☐ Yes ☐ No **30 days?** ☐ Yes ☐ No

Are you interested in bifocal/multifocal contact lenses? ☐ Yes ☐ No

YOU MUST READ AND SIGN THIS SECTION

Financial Assignment & Release

I, the undersigned, assign directly to OptimEyes Optometry, PLLC and/or Dr. Julie Douangphila all insurance benefits, if any, otherwise payable by me or to me for services rendered.

*I understand that I am financially responsible today for all fees. I also agree that I am financially responsible to reimburse any and all fees for services and materials not collected in full at the date of service or should my insurance or vision plan deny payment for services or materials rendered.

*I further understand that after 60 days from the date of service or claim is filed I agree to pay for any unpaid balances on my account as a result of denial in part or whole from my insurance carrier caused by; unmet deductibles ,non covered materials or professional services, my negligence in fulfilling any paperwork, providing any required information requested of my by my insurance carrier or uncollected fees on service day.

*If you do not inform us that you have a vision plan or medical insurance before services are rendered, we will assume no coverage exists.

*I agree I am responsible to file my own claim if I discover I have vision or medical benefits after services or products are rendered.

* I agree this office with no exceptions will not back file claims, post authorize claims, or refund fees after services are rendered due to lack of notification of vision or medical benefits.

* We will begin your custom glasses order immediately after receipt of payment. All glasses are custom crafted for each patient's unique vision needs. All glasses lenses are tailored to fit the frame which patient selected.

Cancellations on glasses or contacts orders will not be permitted. Patients may not switch frames after their order has been processed. REFUNDS ARE NOT AN OPTION.

To accommodate our patients, we will reschedule your appointment with a 24 hour notice. Please note that there is a $75 fee for cancellations (if no notice is given) and for no shows.

ROUTINE EXAM vs. MEDICAL EXAM

A Routine Exam is when a patient has *no* medical history or problem that would directly affect the vision system. Our comprehensive routine exam includes a 14-point total ocular health assessment, refraction, dilation and a prescription for glasses. Vision Plan insurance is used for **well vision** visits.

A Medical/Problem Focused Exam is when the doctor identifies the presence of disease or if a patient is experiencing pain, ongoing headaches, dry eyes or other symptoms indicative of a medical issue. **A medical exam *is necessary for all glaucoma and diabetic patients* as well as any patient with medical history that directly affects the vision system.** Medical/Health Insurance plans are used for medical exams. If the doctor identifies the presence of disease or you need a problem addressed during your well vision visit, your insurance may require that we reschedule the well vision exam for a different appointment time.

Signature of Responsible Party and Consent to Treat: _____

Patient Name:_____ **Date:** ___-____-_____

ADDITIONAL TESTS *NOT* COVERED BY VISION INSURANCES

1. **EXTENDED DILATION TESTING:**

Binocular Indirect Ophthalmoscopy (BIO) is a technique that provides a thorough view of the retina and vitreous through a dilated pupil in order to evaluate the health of the interior of the eye and to identify structural abnormalities that may be associated with reduced visual acuity thereby aiding in the diagnosis of ocular disease. It allows the doctor a more thorough examination of the retina (back of the eye) and assists in the detection of glaucoma, cataracts, macular degeneration, diabetic and hypertensive changes, retinal holes and detachments, and retinal melanoma (tumors). *Basic dilation is considered a part of a routine eye exam that includes a biomicroscopy exam but does not include a BIO procedure.* Dilating drops enlarge the pupil and are often necessary for farsighted children and adults, and patients with diabetes. The side effects include sensitivity to lights for 4 to 6 hours and trouble focusing up close for 2-3 hours. In most cases you will be able to drive. The American Optometric Association recommends all patients receive an annual dilated examination.

********The fee for this procedure is $35.00.**** *(Basic Dilation is covered by routine vision insurances-BIO procedure not included. Medical insurances covers this test if medically indicated and are subject to insurance benefits.)*

_____ I **DO** consent to having my eyes dilated.

_____ Basic Dilation

_____ Extended Dilation Test

_____ I **DO NOT** wish to have my eyes dilated. I release my doctor from any liability of failure to treat, or diagnose any eye condition due to lack of diagnostic information that could have been obtained by this test.

VISUAL FIELD TESTING:

This screening checks for visual field defects, both in central and peripheral areas. Visual field screening can assist the doctor in early detection of glaucoma, optic nerve disease, visual related neurological diseases, and possible causes of headaches.

********The fee for this procedure is $35.00. Please check one and sign below.****

_____ I **DO** consent to having a visual field performed.

_____ I **DO NOT** wish to have a visual field screening performed. I release my doctor from any liability of failure to treat, or diagnose any eye condition due to lack of diagnostic information that could have been obtained by this test.

FUNDUS CAMERA PHOTOS

The word "fundus" describes the inside or back of the eyeball. A fundus photo would contain an image of the center of the very back inner wall of the eye: the retina. The optic nerve, macula and main retinal blood vessels are common structures seen in a fundus photo. Fundus photography is very useful to document the natural state of the back of the eye in order to give the retinal specialist a future reference to compare with during follow-up visits. It is important to document the findings of most retinal diseases and conditions, especially diabetic eye disease findings, macular degeneration, epi-retinal membranes, macular holes and retinal tears and detachment.

********The fee for this procedure is $40.00. Please check one and sign below.****

_____ I **DO** consent to having fundus photos performed.

_____ I **DO NOT** wish to have fundus photos performed. I release my doctor from any liability of failure to treat, or diagnose any eye condition due to lack of diagnostic information that could have been obtained by this test.

*****We strongly believe in the early detection and treatment of all ocular disease and conditions and strongly recommend all patients to have both procedures performed. **If you choose to have all three tests performed, the courtesy discount for all 3 tests will be $100.00 total. *********

_____ I **DO** wish to have extended dilation, visual field screening, and fundus photos performed. (**The fee for all tests is $100.00).**

Patient Name: _____ Signature:_____

Date: _____-_____-_____

Effective date of notice: 01/01/2016

NOTICE OF PRIVACY PRACTICES

OPTIMEYES OPTOMETRY

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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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). “Health care operations” mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written “authorization form.” The content of an “authorization form” is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it’s your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of OptimEyes Optometry’s Notice of Privacy Practices. Please retain copy for your records.

Patient name (Please Print): _____

Signature_____ **Date** _____