

VISION CARE ASSOCIATES (704) 541-0468

Eyewear History

Parent/Guardian: _____

- Glasses
- Bifocals
- Trifocals
- No-line bifocal
- Soft contacts
- Rigid contacts

Name: _____

Social History

Address: _____

- Tobacco use
- Illicit drug use
- Daily alcohol use
- Casual alcohol use
- Non-smoker
- No alcohol use
- No illicit drug use
- HIV
- Hepatitis
- Other...

City, St: _____ Zip: _____

Phone(H): _____ (cell): _____

Birth date: _____ Sex: _____

Family History (parents, grandparents, siblings)

Email: _____

- Blindness
- Glaucoma
- Crossed Eyes
- Color Blind
- Macular Degen.
- Retina Disease
- Retina Detach
- Diabetes
- Heart Disease
- High BP
- Cancer
- Other...

Patient's Occupation: _____

VISION or PRIMARY INSURANCE

Ins Co: _____ #: _____

Medical History (patient only) [check all that apply]

Insured: _____ DOB: _____

- General:** recent fever weight loss
 weight gain pregnant/nursing

Insured's Employer: _____

- Skin:** skin condition eczema rosacea

Relationship to insured: _____

- Neurological:** seizures migraine MS tremor

MEDICAL or SECONDARY INSURANCE Ins

Co: _____ #: _____

- Endocrine:** thyroid disease diabetes

Insured: _____ DOB: _____

- Ear, Nose, Throat, Mouth:** allergies dry mouth deafness
 congestion mouth sores dizziness

Relationship to insured: _____

- Respiratory:** asthma chronic cough emphysema

Date of Last Eye Exam: _____

- Cardiovascular:** heart disease vascular disease
 high BP palpitations

Medical Doctor(s): _____

- Gastrointestinal:** reflux liver disease irritable bowel

- Genitourinary:** kidney disease urinary problems

- Musculoskeletal:** arthritis muscle pain back pain

- Blood/Lymph:** anemia blood disorder cancer

- Psychiatric:** anxiety depression disoriented

- Immunologic:** rheumatoid lupus other autoimmune

- Med Allergies:** penicillin eye drops codeine
 sulfa Novocain other (list)

Other conditions... _____

Eyes:

- Cataracts
- Crossed Eyes
- Lazy Eye
- Dry Eye Syndrome
- Keratoconus
- Stye/Chalazion
- Uveitis/Iritis
- Glaucoma
- Retinal Disease
- Retinal Detach.
- Macular Degen.
- Color Blind
- Eye Injury
- Other...

Current eye symptoms:

- Blurred vision
- Loss of vision
- Distorted vision
- Loss of side vision
- Double vision
- Redness
- Sandy/gritty
- Itching
- Burning
- Excess tearing
- Light sensitive
- Eye pain
- Flashes
- Floaters
- Drooping eyelid
- Other...

Injuries / Surgeries / Hospitalizations:

- Lasik
- Cataract surg.
- Eye muscle surg.
- Eyelid surg.
- Heart surg.
- Other...

FINANCIAL POLICY

Payment is required at the time of service. If we accept your insurance, we will bill it for you. **You are responsible for any copays, coinsurance, deductibles, and charges denied by your insurance. Insurance coverage does not guarantee payment of services in full. CONTACT LENS EVALUATION AND FOLLOW-UP CARE IS CHARGED SEPARATELY FROM YOUR EYE EXAM AND IS NOT OFTEN COVERED BY INSURANCE.**

I understand and agree to this policy.

Signature: _____ Date: _____

ASSIGNMENT OF BENEFITS AND PRIVACY POLICY

Patient Name: _____

Insurance Company: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

I request that payment of authorized/allowable insurance benefits be made either to me or on my behalf to Vision Care Associates, OD, PA for any services furnished me by that provider. **This is a direct assignment of my rights and benefits under this policy.** This payment will not exceed my indebtedness to the provider and I have agreed to pay, in a current manner, any balance of said professional service charges not covered by my insurance benefits. This includes but may not be limited to copayments, coinsurance, deductibles and charges determined by the insurance company to be not covered. I authorize any holder of medical information about me to release to the insurance company and its agents any information needed to determine these benefits or the benefits payable for related services. I also authorize the provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

A photocopy of this Assignment shall be considered as effective as the original.

X _____
Patient Signature Date Signed

HIPAA PRIVACY PRACTICES CONSENT – PLEASE SIGN

As a condition of providing treatment to you, our office must obtain your consent to use and disclose protected health information about you to carry out treatment, payment, and the health care operations of our office. You may revoke this consent at any time by notifying our office in writing, except to the extent that our office has already taken action. You have the right to request our office to restrict the manner in which your protected health information is used or disclosed. Our office is not required to agree to such requested restrictions; however we will do our best to comply with any such requests.

I hereby consent to the use and disclosure of my protected health information by Vision Care Associates, OD, PA, its work force, and its business associates for purposes of treatment, payment, and health care operations. I am aware I can request a copy of Vision Care Associates, OD, PA's HIPAA Compliant "Notice of Privacy Practices" and it will be provided.

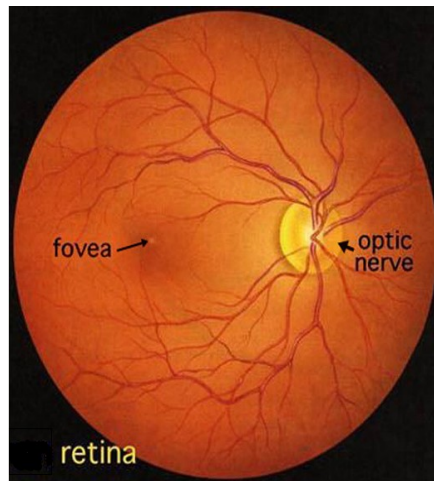
X _____
Patient or Authorized Person's Signature Date Signed

PUPIL DILATION AND DIGITAL RETINAL IMAGING

Our doctors recommend pupil dilation and digital retinal imaging as part of your comprehensive eye examination. Retinal examination through a dilated pupil allows for the inspection of the internal periphery of the eye for the presence of retinal detachments, tumors, and other sight threatening disorders. Side effects of light sensitivity and blur are mild and last only a few hours.

Digital retinal imaging assists your doctor in the early detection of other ocular disorders such as glaucoma, macular degeneration, diabetic retinopathy, and high blood pressure. The advantage of digital imaging is that it provides a permanent record of your retina to be compared to future exams allowing for the earliest possible detection of changes.

Digital imaging can be performed without pupil dilation and provides a more thorough view of the retina than a non-dilated examination if you choose not to have your pupils dilated.



THERE IS NO ADDITIONAL CHARGE FOR DILATION.

The fee for the DIGITAL RETINAL IMAGING is \$35.00.

(Most insurance plans do not cover routine retinal imaging. However, if medical necessity is proven, we will obtain the necessary photographs and file this service through your medical insurance.)

_____ Yes, I wish to have Digital Retinal Imaging (\$35.00)

_____ Yes, I accept pupil dilation (no charge)

RETINAL IMAGING AND DILATION ARE BOTH RECOMMENDED

_____ I decline Digital Retinal Imaging

_____ I decline pupil dilation

Signature

Date