All EyeCare Optometry New Patient Intake Form

Last:____________First:____________MI______
Address:____________________________
____
Tel: (_____)____________Type: Home / Work / Cell
Email:____________________________
Date of Birth:____________Age:_______Sex: M F

Ocular History:

Purpose of today's visit:

- ❑ Annual Visit
- ❑ Blurry Vision
- ❑ Burning
- ❑ Double vision
- ❑ Dryness
- ❑ Flash of light
- ❑ Floaters/spots in vision
- ❑ Grittiness
- ❑ Headaches
- ❑ Infection
- ❑ Itchiness
- ❑ Night vision difficulty
- ❑ Eye pain
- ❑ Tearing
- ❑ Update contact lenses

When was your last eye exam? __________________

Do you wear contact lenses? Y N

Have **you** been diagnosed with the following?

- ❑ None
- ❑ Cataracts
- ❑ Corneal abrasion
- ❑ Dry Eye
- ❑ Eye turn / lazy eye
- ❑ Glaucoma
- ❑ Iritis/uveitis
- ❑ Macular Degeneration
- ❑ Retinal defect/hole/tear
- ❑ Retinal detachment
- ❑ Other eye diseases

Has anyone in your **family** been diagnosed with the following?

- ❑ None
- ❑ Glaucoma
- ❑ Macular degeneration
- ❑ Retinal detachment
- ❑ Other eye diseases

Circle Your Vision Insurance:

VSP EyeMed TriCare None

Medical Insurance Information

Medical Insurance:________________PPO/HMO/IPA
Member ID:________________________
Group ________________________
Policy Holder's Name if different________________
Policy Holder DOB:___/___/___ **SSN:**______________
Relationship to Patient:____________________

Visual Needs Assessment:

Hours of computer usage per day:________________
Hours of outdoor activity per day:________________
Hobbies:________________________
____
How many hours do you read before you experience fatigue?____
Circle if you have: eyestrain neck strain headaches

Who can we thank for your referral to our office?

____

Current Medications and Dose (include OTC and supplements)

____
____
____
____
____

Allergies: ________________________
____

List any prior *eye* surgeries and dates if known (e.g. LASIK):

____
____

Are you pregnant or nursing? Y N
Do you use cigarettes? Y N **If so, how often?**________
Do you drink alcohol? Y N **If so, how often?**________

Medical History:

Have you ever been diagnosed or treated for any of the following health problems? (If yes include diagnosis; otherwise, circle N for No and F for family history)

Condition	Y	N	F
Allergies	Y__________	N	F
Arthritis	Y__________	N	F
Blood/Lymph	Y__________	N	F
Cancer	Y__________	N	F
Cholesterol	Y__________	N	F
Diabetes	Y, Type________	N	F
Digestive/Gastric	Y__________	N	F
Ears/Nose/Throat	Y__________	N	F
Endocrine	Y__________	N	F
Fatigue	Y__________	N	F
Fevers	Y__________	N	F
Heart Disease	Y__________	N	F
High Blood Pressure	Y__________	N	F
Immune	Y__________	N	F
Integumentary (Skin disease)	Y__________	N	F
Kidney	Y__________	N	F
Muscle or Bone	Y__________	N	F
Neurological/Headaches	Y__________	N	F
Psychological	Y__________	N	F
Respiratory	Y__________	N	F
Sinus	Y__________	N	F
Stroke/Seizures	Y__________	N	F
Throat Infections	Y__________	N	F
Thyroid	Y__________	N	F
Unusual Weight Loss/Gain	Y__________	N	F

Notice of Privacy Practices Patient Acknowledgement

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- ✓ A statement that this practice is required by law to maintain the privacy of protected health information.
- ✓ A statement that this practice is required to abide by the terms of the notice currently in effect.
- ✓ Types of uses and disclosures that this practice is permitted to make for each of the following purposes: Treatment, payment and health care operations
- ✓ A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- ✓ A description of uses and disclosures that are prohibited or materially limited by law.
- ✓ A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- ✓ I received notification that the members at All Eyecare Optometry will have access to my claims medication history through an electronic service until I revoke my consent. I understand that my consent can be revoked at any time. Revocation must be made in writing.
- ✓ My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of Health and Human Services (HHS) if I believe my privacy rights have been violated and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information
    - The right to amend protected health information
    - The right to receive an accounting of disclosures of protected health information
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Patient Name: ______________________________ Date of Birth:______________

Signature: ______________________________ Date: ______________

Relationship to patient (if signed by a personal representative of patient):______________________________

Payment Policy:

I hereby assign all medical benefits, including all major medical benefits to which I am entitled including Medicare, private insurance and any other health plans, to All EyeCare Optometry. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment. If my insurance company has not reimbursed All EyeCare within 60 days, I may be billed for any services or products that I have received. I understand that I am responsible for the balances due after billing. I understand that a late fee of $5.00 may be charged if I do not pay my balance within 30 days after receiving my statement.
I certify that my responses on this form are accurate to the best of my knowledge. ***I certify that I understand that there are no refunds or exchanges and that all sales are final unless covered under manufacturer warranty or office warranty programs.***

Signature:______________________________ Date:______________

Eye Wellness Digital Retinal Screening

At All EyeCare Optometry, we are continuously investing in new technologies to detect eye diseases earlier. There are over 200 different conditions that can be detected within the eye, and our mission is to be able to diagnose and treat those conditions, such as glaucoma and macular degeneration, before they can threaten your vision or health.

Our office currently features two technologies:

1) Optomap scan (wide view): (Available in office since 2013)

- Wide angle retinal scan
- Images 85% of retina
- Creates permanent baseline
- Views comparable to dilation

Doctor Recommendation:

1) One baseline for age 8 and above

Indications for annual repeated scans:

1) If dilation is not being performed
2) Medical history of any systemic disease, especially diabetes, high blood pressure, and high cholesterol
3) Family history of glaucoma or macular degeneration

2) Optical coherence tomography (OCT; deep view): (New to office in 2018)

- Cross sectional scan
- Detect diseases on a microscopic level
- Instant, direct imaging of tissue morphology
- No ionizing radiation
- Microscopic resolution of the retinal tissue better than 0.01mm in thickness

Doctor Recommendation:

1) One baseline image for age 18 and above

Indications for annual repeated scans:

1) Age 50 and above
2) Patients with diabetes and/or high blood pressure
3) Patients with autoimmune diseases
4) Concerns for glaucoma
5) Family history of glaucoma or macular degeneration

In our mission to ensure that you maintain optimal eye health, we have brought in technology to help detect glaucoma and retinal diseases earlier. Vision insurances **will not** cover these additional tests.

If you decide to defer taking Optomap or the OCT images, we recommend at minimum annual dilated examinations.

__________ I AGREE TO THE RECOMMENDED **OPTOMAP AND OCT** SCANS ($50).

__________ I **DECLINE** THE SCREENING OPTIONS AND PREFER TO BE **DILATED.**
I understand my vision will be blurry when reading, and I will be light sensitive for 3-4 hours.

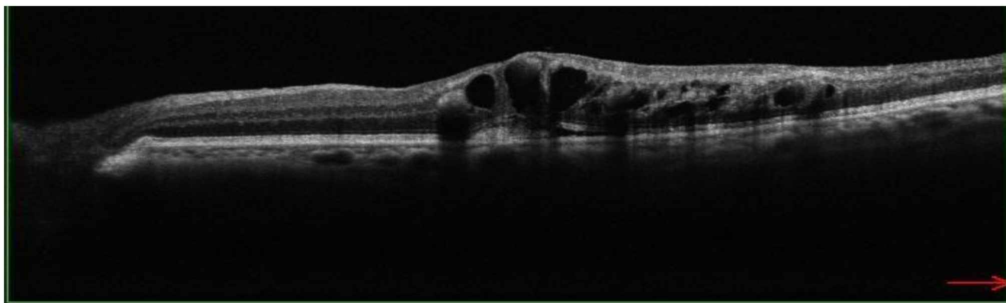
Patient name (please print): ______________________________

Signature: __________________________ Date: ____________

*****PRINTING THIS PAGE IS OPTIONAL*****

Example of an Optomap scan of a patient who has hemorrhaging and swelling from hypertension

Example of an OCT image of a patient who has swelling from hypertension



CONTACT LENS CARE AGREEMENT:

Contact lenses are FDA class 1 medical devices that have the potential for serious complications if not used and fitted properly. For that reason, the standard of care and the requirements of the California State Board of Optometry require an annual examination for renewal of a contact lens prescription. In addition to general eye health assessment, the doctor will assess issues related to contacts such as abnormal blood vessel growth, corneal damage, chronic inflammation, hygiene, discomfort, and poor surface compatibility, in addition to any vision changes. The ***estimated fee*** for these services range ***between $75.00 and $125.00***. These fees will cover any contact lens related follow ups for a 30 day period. If you cannot complete the fitting procedure in the allotted time due to missed follow up appointments, there will be an additional $25.00 charge per visit beyond the global time period. Additional fees for ***training for insertion and removal*** of contact lenses range between ***$40.00 and $60.00*** and apply to all new wearers. **Your insurance copay:** ________

By signing, I acknowledge that I understand the policies regarding the contact lens health evaluation and agree to the associated fees. I understand that these fees are an estimate and are subject to changes based on the doctor's final assessment. I also understand that improper usage of contact lenses as prescribed can lead to vision loss and permanent eye damage. I understand that if an infection is present, I will need to be treated under my medical insurance prior to being refit with contact lenses.

Signature:______________________________________ **Date:**___________________________

CONTACT LENS QUESTIONNAIRE:

Specifications: Brand of Contacts:___________________________ Solution Name:_______________________

Vision:

Can you see distance and near comfortably with your contact lenses? **Yes** **No**

Life Style:

How many days a week do you wear your contact lenses? ____________________days / week

How many hours a day do you wear your contact lenses? ____________________hours / day

If you store your lenses in solution, do you discard your solution every morning? **Yes** **No**

Do you sleep overnight in your contact lenses? **Yes** **No**

If you sleep in your contacts, for how many nights in a row? ____________________nights

Do you swim in your contact lenses? **Yes** **No**

Do you shower in your contact lenses? **Yes** **No**

Comfort:

Do you experience dryness with your contact lenses? **Yes** **No**

Do you have difficulty with seasonal allergies? **Yes** **No**

Contact Lens Health History

Have you had a contact lens related eye infection or complication? **Yes** **No**

If yes, please explain: ______________________________

Have your eyes become contact lens intolerant over the years? **Yes** **No**

Hygiene:

Do you have a backup pair of glasses? **Yes** **No**

Do you rub your contact lenses with solution when cleaning? **Yes** **No**

How often do you change your contact lens case? ______________________________

How often do you change your contact lenses? ______________________________

Please rank from most important to least important so that the doctor can prescribe to enhance your contact lens experience

(1 – Most important, 4- Least important): ____ Convenience ____Comfort ____ Clarity ____ Cost

How can we improve your experience with your contact lenses? ____

PAYMENT POLICY FOR MEDICAL SERVICES

We thank you for choosing us for your medical needs and we are committed to the success of your treatment and care. We understand that medical insurances and their supplementaries may be difficult to understand, so we have compiled some of the most frequently asked questions we receive in our clinic in regards to insurance charges and coverages. Please take a moment to look these over to address your concerns in order to ensure your full understanding of the charges that may be incurred for the medical services provided to you.

What is an HMO and a PPO, and which do you accept at your office?

An HMO is an insurance plan that works with a network of participating providers. Patients with HMO insurances are required to see only participating providers of that plan. Any out of network visits or services will be collected as if the patient has no insurance coverage.

A PPO plan allows the patient to choose any provider they would like. Currently, we are only accepting patients with PPO health plans. If you are a patient with an HMO plan as your primary insurance, it is your responsibility to notify us of this and all charges that result in lack of information will be billed to you directly.

Which plans are you contracted with?

We are providers for the following PPO plans from:

- Adventist Health
- Anthem Blue Cross
- Blue Cross Blue Shield
- Cigna
- Healthscope
- Medicare
- United Health Care

How will my insurance be billed?

We will compile a list of the medical services you received. Each medical service will have a procedure code that will be interpreted by your insurance company. These codes will all be grouped under an invoice for the date of service. Accompanying these procedure codes will be diagnoses codes. The diagnoses codes are for reporting and authorization purposes only, and are not involved in the billing process.

What happens if my insurance denies the claim for my medical visit/services?

We strive to help our patients in the best way we can in dealing with their insurance companies and understanding their coverage. If claims are denied, we will do our best to find a way to bill the insurance company so that the claim will be paid by the company. However, if the issue is not resolvable on our end, we will forward all charges to patient responsibility, and you will have to contact your insurance company to manage the costs.

Are there services that are not covered by insurance?

We try our best to bill as many covered services as we can for our patients. There are, however, some services that insurance companies consider to be "elective." Unfortunately, what we as providers and patients consider "elective" is different from what insurance companies consider to be elective. As a result, we can only bill the services that insurances consider medically necessary. Some services offered at our office that are non-covered services are: Optomap imaging, Meibox photography, Miboflo and Blephex treatments, and some specialty contact lens fittings.

What if I will need to come back for follow up appointments? Will those be covered by my insurance?
All follow up appointments will be billed to your insurance separately. They are not included in initial consultations or examinations. They will be subject to all deductible amounts and copays per your insurance plan.

What will be my financial responsibility for the medical services I receive?
Your financial responsibility will depend on a variety of factors, detailed below:

If you have a…	You are responsible for…
Deductible: an amount designated by your insurance plan that you must pay each year for eligible medical services before your insurance plan kicks in. This means your insurance will not pay for any services until you meet this yearly deductible. The deductible is a constantly fluctuating amount as you pay it off throughout the year.	Payment of the deductible amount that is reported to us by your insurance. Any discrepancy you have with the terms of your deductible must be handled through your insurance as we are not privy to the terms of your insurance coverage and deductible amounts.
Copay: a flat fee that is charged per medical visit/service. Usually, this fee is always in effect even if the deductible has not been met.	Payment of copay amounts for each visit/service. There may be more than one charge per service date if multiple services are performed in a single visit. Please note that we are not primary care providers and **most insurances consider our services to be specialist visits**.
Coinsurance: a percentage of costs that you will be charged after you meet your deductible. Some plans may have a policy with both a copay amount and a co-insurance amount. This is common for plans with lower monthly premiums.	Payment of any and all co-insurance amounts designated as your responsibility per your insurance company.
Out-of-network Charges: charges that are incurred when you visit a specialist or physician that is not "in-network" with your plan. This is common with HMO.	Please check if you have an HMO plan or PPO plan **before** you visit the office. It is your responsibility to report if your insurance coverage is a primary and secondary insurance to our staff. If services are rendered out of network due to a failure in accurate reporting from the patient, then all charges will be charged directly to the patient.

Insurance coverage and terms are the patient's responsibility. We will work diligently to assist our patients to find out about their medical insurance plans and cost estimations, however, it is ultimately the patients' responsibility to contact their insurance companies about any discrepancies of charges and fees. Patients will be responsible for any charges incurred for any medical visit/service charges, deductibles, copayments, and coinsurance amounts designated by their insurance or by our office.

By signing below you are indicating that you have read and understand the information above.

Print Name ________________________ Signature ________________________ Date __________

Relationship to patient if signed by a personal representative: ________________________________