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)

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: _____

ALL EYECARE OPTOMETRY
MEDICARE REFRACTION AND OPTOMAP FORM

What is a refraction?

Refraction is a measurement taken by an eye doctor to determine whether or not to prescribe glasses. For the majority of patients, refraction is a critical component of an eye examination.

Will Medicare pay for a refraction?

Even though this is a vital test in the care of your eyes, refraction is a **non-covered** benefit with Medicare. Unfortunately, they do not differentiate between "medical refractions" and refractions performed for the purpose of providing glasses or contact lenses. We are required to charge for this service regardless of whether your insurance company will cover the service as a benefit of your insurance plan. There is a fee of **$45.00** for this test. You will be asked to pay at the time of your visit. **This fee will be charged to you approximately one time per year.** This is a routine charge at all medical, optometric, and surgical ophthalmology and optometry practices.

_____ I understand that refraction is a non-covered service and request an updated prescription and evaluation to properly assess my best corrected vision.

Retinal Examination:

Our Doctors are concerned about retinal diseases such as macular degeneration, glaucoma, retinal detachments, and diabetic retinopathy, all which can lead to partial loss of vision or blindness. Additionally, systemic diseases such as diabetes and high blood pressure can be detected with a retinal examination. Eye exams with retinal evaluations can help you safeguard both your eyesight and general health. The Optomap Digital Retinal Imaging allows us to thoroughly evaluate your internal eye health with dramatically improved precision that includes a depth in the retina not seen with regular dilation. ***The Optomap augments but does not replace a dilated exam by creating a permanent documentation of the interior retina.***

With an annual Optomap, our doctors can track your eye health for concerns, comparison, and treatments. Because Medical and Vision insurances do not pay for *routine* photos, there is a **$35.00** fee for this procedure. *(Please advise staff if you have a history of epilepsy.)*

_____ I elect to have an **Optomap** Digital Retinal Scan of my retina and understand the scan will provide a permanent baseline comparison for my future visits. I understand that based on the doctor's examination, dilation may still be recommended or necessary. I understand there is a **$35.00** fee for this procedure.

OR

_____ I choose to be **dilated** today. I understand that my vision will be slightly blurry after dilation and light sensitive for 3-4 hours.

I understand I am responsible for any fees associated with medical services which may be non-covered benefits. I understand that if there are any additional fees after my insurance is billed, I am responsible for the fees. I understand there may be a late fee of $5.00 if I do not pay my bill within 30 days after receiving my statement.

Print Name: _____ **Signature** _____ **Date:** _____

CONTACT LENS CARE AGREEMENT:

Contact lenses are FDA class I 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? _____

ALL EYECARE OPTOMETRY

PAYMENT POLICY FOR SERVICES RENDERED TO MEDICARE PATIENTS

We thank you for choosing us for your vision exam and 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 answered some of the most frequently asked questions we receive in our clinic in regards to medicare charges and coverages. Please take a moment to look these over to address your concerns and assure your full understanding of the charges that may be incurred for medical services provided to you by our office.

Will Medicare fully cover my vision exam?
There are two parts of annual comprehensive exam. We like to refer to the one portion as the "health" portion of your exam where there are diagnostic tests run as well as a thorough examination by our doctors to assess the health of your eyes. This includes checking for problems such as cataracts, retinal tearing, or glaucoma. Original Medicare fully covers this portion of the exam. The second portion of our exam is the "eyeglass prescription" portion which is called a refraction. This part of the exam is when the doctor checks your vision and gives you a prescription for glasses to help you see. The refraction is not covered by medicare and there is a fee of $40.00 that will be charged at the time of the exam. Contact lens services are not covered by Medicare. Our contact lens fittings begin at $75.00 and contact lens supplies may vary in cost.

What if I need to see the doctor for a medical reason?
Our doctors look forward to providing you with excellent medical care. They are qualified to treat conditions such as glaucoma, diabetic retinopathy, retinal tears, retinal detachment, and other health related problems. Original medicare covers these visits fully. However, there may still be fees such as deductibles or share of costs that Medicare will deem as patient responsibility. The patient is solely responsible for fees of this kind and it is also the responsibility of the patient to send any fee disagreements directly to Medicare.

What if I have a Medicare Supplementary?
Medicare supplement plans are designed to help patients cover the cost of medical services. Some plans will help patients with their share of costs after medicare and some will even help with deductible costs as well. It is the patient's responsibility to provide us with any supplementary coverage otherwise everything will be billed to Medicare only. Often times supplementary plans with only cover share of cost amounts and not Medicare deductibles.

What happens if Medicare 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 Medicare so that the claim will be accepted and paid for. However, if the issue is not resolvable on our end, we will forward all charges to patient responsibility and you will have to contact Medicare to manage the costs.

What is a managed care Medicare Plan?
A managed care or Medicare Advantage plan is managed by a separate insurance entity. These companies can be Cigna, Kaiser Permanente, United Healthcare, and other private companies. Under a managed care plan the private company managing the plan will be the primary coverage and Medicare becomes a supplementary to their coverage.

How will having a managed care Medicare Plan affect my coverage at your office?
We are not providers for most managed care medicare plans. We are happy to attempt to bill Medicare directly and they will route our claim to the proper company that will cover your services. However, these claims are often denied by Medicare. Managed care plans with Kaiser Permanente will not cover your services at our office as they require you to see their providers at local Kaiser Permanente Health Centers. It is the responsibility of the patient to disclose to our office if their coverage is managed care. If fees are incurred due to managed care status and denial of coverage occurs, the patient will be held responsible for all fees associated with rendered services from our office.

What will be my financial responsibility for the medical services I receive?
Medicare often covers most services and the "health" portion of our vision exams. However, there are times when Medicare will not cover all of your service costs. This may be due to an existing deductible, managed care plans or a share of cost.

What is my Medicare deductible?
A Medicare deductible is a designated amount by Medicare that must be paid out of pocket before Medicare begins to cover all or a partial percentage of all services. This amount may vary depending on your specific plan details. Most patients have a yearly deductible of $183.00 (2018 Medicare Deductible). Our claims are sent to Medicare and any deductible amounts still owing are sent back to us as patient responsibility. We do not have a say in how much of your deductible is charged per visit. This amount is designated by Medicare so all disputes must be directed to Medicare.

Why am I paying more for services this year than previous years?
Medicare deductibles are dictated by the administration and are constantly changing. In 2016, the yearly deductible was $166.00 and has risen since 2017 to be $183.00 or more depending on the terms of your coverage.

I've never paid a Medicare deductible before. If I am billed for a deductible after my visit, what would be the reason?
There are details about Medicare coverage that are constantly changing. The terms of your coverage might have changed and while you weren't charged for your deductible previously, under new terms of coverage, you will be charged for a deductible amount. These changes in coverage are determined by the Medicare Administration and not by our office. Your costs also may vary from one office to another depending on if you have supplementary coverage. For example, if you have medi-medi (Medicare with Medi-Cal supplementary coverage) your deductibles may have been covered in the past by Medi-Cal. We are not providers for Medi-Cal and therefore cannot bill them for any services. Therefore, what Medi-Cal once covered will now be owing as patient responsibility because we are not providers under that supplementary plan.

Insurance coverage and terms are the patient's responsibility. We will work diligently in assisting our patients in regards to their plans and cost estimations, however, it is ultimately the responsibility of our patients 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 _____

All Eyecare Optometry SPEED II Questionnaire for Dry Eye Disease

Name: _____ **Gender:** _____ **Date:** _____

Dry eye disease is one of the most frequent reasons patients visit eye doctors. We are concerned that you may be suffering from this condition as well. Please complete the questions below so we can ensure your eye health and comfort. **Select only one answer per question.**

1. Report the **FREQUENCY** of your symptoms using the rating list below:

0 = never **1** = sometimes **2** = often **3** = constant/always

Symptoms	0	1	2	3
Dryness, grittiness, or scratchiness				
Soreness or irritation				
Burning or watering				
Eye fatigue				

2. Report the **SEVERITY** of your symptoms using the rating list below:

0 = no problems
1 = tolerable - not perfect, but not uncomfortable
2 = uncomfortable - irritating, but does not interfere with my day
3 = bothersome - irritating and interferes with my day
4 = intolerable - unable to perform my daily tasks

Symptoms	0	1	2	3	4
Dryness, grittiness, or scratchiness					
Soreness or irritation					
Burning or watering					
Eye fatigue					

3. Please check if you have experienced the previous symptoms (select as many as needed):

❒ Today ❒ In the last 3 days ❒ In the past 3 months ❒ Not applicable

4. Do you use eye drops or an ointment?

❒ No ❒ Yes How often? _____ drop(s) per day / week / month

5. Did you use eye drops today?

❒ No ❒ Yes

6. What is the name of the drops you use? _____

For office use only:
Total SPEED score (frequency + severity) = / 28
❒ No dry eye (0-5) ❒ Mild (5-6) ❒ Moderate (6-10) ❒ Severe (> 10)