# HIPAA compliance policy, dilation drops explained & payment policy

**Patient's Name:** _____

**Guardian's name & relation if a minor:**_____&_____

Acknowledge the "Notice of Privacy Practices" was made available with your **initials here:** _____

Are you followed by another eye doctor?: __No __Yes, name: _____

**Indications for dilation** include but are not limited to: pertinent family/personal medical history, recent injury, abnormal tests results, or lack of preventative care within 3 years. Not having a dilated eye exam when indicated and/or failing to attend a medical office visit may be detrimental to both your health and your vision.

**Dilation is an important part of an eye exam**. It opens the pupil to better evaluate eye health, but it has temporary side effects: Light sensitivity & blurred near vision that may last up to six hours. Please, only drive once comfortable with your vision.

Pupil dilation is not recommended for patients who are pregnant, nursing, or allergic/sensitive to the dilating agents (proparacaine, phenylephrine/hydroxy-amphetamine hydrobromide, & tropicamide).

Primary care physician & pharmacy:

Doctor Name:_____

Practice Name:_____

Office Phone: _____

Office Fax: _____

Pharmacy: _____
(Name and location)
_____

**Initial which best represents your wishes:**

_____ I **don't want** dilation eye drops today. If dilation is indicated, I shall schedule it to be done at a later date.

_____ **Discuss** dilation more with my doctor **if medically indicated**. I understand this may add up to 35 minutes to today's examination.

I authorize and request my insurance company pay directly to the doctor insurance benefits otherwise payable to me for any covered services that can be submitted to my carrier.

I acknowledge that whenever possible, medical insurance will be billed for medical office visits along with any associated procedures and that wellness visits will be billed to vision plans.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

The reason(s) I am here for an eye exam today (check all that apply):

___Yearly Eye Exam ___Eyeglasses ___Contact Lenses ___Medical Office Visit

My signature here confirms the acknowledgements, choices, and authorizations above:

Signature:_____ Date: _____/_____/_____

# Give your eye-care visit some 4-thought

Mark all distances you wear correction: ☐ **Far** ☐ **Reading** ☐ **Computer** ☐ **None**

Grade your vision **with your current vision correction** for each distance:

| | | | |
|---|---|---|---|
| **Far**: | ☐ Acceptable | ☐ May need improvement | ☐ Blurred |
| **Near/Read**: | ☐ Acceptable | ☐ May need improvement | ☐ Blurred |
| **Computer**: | ☐ Acceptable | ☐ May need improvement | ☐ Blurred |

✓ all eye that apply: score:(____)

| How often do you experience: | All the time (4) | Most times (3) | Half the time (2) | Some times (1) | Never (0) |
|---|---|---|---|---|---|
| Itchy eyes? | | | | | |
| Eye redness? | | | | | |
| Watery eyes (tearing)? | | | | | |
| Gritty/sandy sensation? | | | | | |
| Fluctuating vision? | | | | | |

✓ all eye that you're experiencing now:

| | | | |
|---|---|---|---|
| | Discharge | | Bothersome Glare |
| | Burning | | Poor Night Vision |
| | Eyestrain | | Light Sensitivity |
| | Eye pain | | Double Vision |
| | Headache | | Total Vision Loss |
| | Other: _____ | | None of these |

## Select ✓ the iHealth Wellness Package or Retina Photo Only:

### eye iHealth Wellness Package ($68 for all applicable tests)

**The doctor requests the package EVERY 1 TO 3 YEARS & stresses its importance for ALL NEW PATIENTS because it is the best way to asses eye health. It saves you money ($126 value), time (dilate less often), and when compared year to year for change it could save your sight!**

### eye Retina Photo Only ($39 = vision plan copay amount)

**If you decline the above package please opt for the retina photo once a year EVERY YEAR**

**It is the one best way at a wellness visit to check for conditions of the eye that affect the body like high blood pressure, diabetes, high cholesterol, and cancer of the eye (although incidence is rare it can strike at any age, and because of pupil size, children are at greater risk for melanoma than older adults).**

***At any time you may request a test be done a la carte at the retail rate.***

## PERSONAL INFORMATION & DEMOGRAPHICS

Preferred Name: _____ DOB:_____/_____/_____

Street Address: _____ Sex: Male _____ Female____

City/State:_____/_____ Zip Code: _____

Occupation: _____ Hobbies: _____

Preferred Number: _____ ☐ Mobile (text OK) ☐ Home ☐ Work

Email address:_____

Approximate height in feet & inches: _____' & _____" and weight in pounds: _____ lbs

Handedness: ☐ Right ☐ Left Sports you enjoy:_____

Would you like to know if you are a good candidate for vision correction **without** eyeglasses, contact lenses, or eye surgery? ☐ Yes ☐ No

| **Family History:** | **None** | Dad | Mom | Bro | Sis | Son | Daughter |
|---|---|---|---|---|---|---|---|
| Cancer: | | | | | | | |
| Unspecified Diabetes | | | | | | | |
| Type 1 Diabetes: | | | | | | | |
| Type 2 Diabetes: | | | | | | | |
| High Blood Pressure: | | | | | | | |
| Hyperthyroidism: | | | | | | | |
| Hypothyroidism: | | | | | | | |
| Cataract: | | | | | | | |
| Macular Degeneration: | | | | | | | |
| Glaucoma: | | | | | | | |

**Check here if family history is unknown:** ☐

Eye health concerns due to conditions of a grandparent or other distant relative?

☐ No ☐ Yes, details:

_____

_____

_____

_____

_____

_____

**Social History:**

Do you drink alcohol? ☐ No ☐ Socially ☐ >2 drinks/day ☐ >5 drinks/day

Do you use illicit drugs? ☐ No ☐ Yes, details:_____

Are you a current smoker? ☐ No ☐ Yes, how many cigarettes per day?

☐ < 4 cigs ☐ <1pack ☐ 1-2packs ☐ >2packs

If you used to smoke, for many years?_____ & how long ago did you quit?_____

## COMPREHENSIVE REVIEW OF SYSTEMS (PERSONAL HISTORY)

**Constitution:**
__ **None**
__ Developmental Disabilities
__ Cancer
__ Fatigue Syndrome
__ Other: _____

**Ear/Nose/Throat:**
__ **None**
__ Hearing Loss
__ Sinusitis
__ Dry Mouth
__ Laryngitis
__ Other: _____

**Neurological:**
__ **None**
__ Multiple Sclerosis
__ Epilepsy
__ Cerebral Palsy
__ Tumor
__ Stroke/CVA
__ Migraine
__ Autism Spectrum Disorder
__ Other: _____

**Psychiatric:**
__ **None**
__ Depression
__ Attention Deficit
__ Anxiety Disorder
__ Bipolar Disorder
__ Other: _____

**Cardiovascular:**
__ **None**
__ Hypertension (high blood pressure)
__ Stroke/CVA
__ Heart Disease
__ Vascular Disease
__ Congestive Heart Failure
__ Other: _____

**Respiratory:**
__ **None**
__ Current cigarette Smoker
__ Asthma
__ Bronchitis
__ Emphysema
__ Chronic Obstruction
__ Sleep Apnea
__ Other: _____

**Gastrointestinal:**
__ **None**
__Crohn's
__ Colitis
__ Ulcer
__Acid Reflux
__Celiac Disease
__ Other: _____

**Genitourinary:**
__ **None**
__ Kidney Disease
__ Prostate Disease/Cancer
__ Benign Prostatic Hypertrophy
__ Pregnant
__ Nursing
__ Herpes
__ Chlamydia
Other:

**Musculoskeletal:**
__ **None**
__ Arthritis
__ Fibromyalgia
__ Muscular Dystrophy
__ Ankylosing Spondylitis
__ Osteoporosis
__ Gout
__ Other: _____

**Allergies (drug & environmental):**
__ **None**
_____
_____
_____

**Integumentary:**
__ **None**
__ Eczema
__ Rosacea
__ Psoriasis
__ Herpes Simplex/Cold Sores
__ Herpes Zoster/Shingles
__ Other: _____

**Endocrine:**
__ **None**
__ Type 2 Diabetes Mellitus
__ Type 1 Diabetes Mellitus
__ Thyroid Dysfunction
__ Hormonal Dysfunction
__ Other: _____

**Hematologic/Lymphatic:**
__ **None**
__ Anemia
__ Large-volume blood loss
__ Ulcer
__ High Cholesterol
__ Other: _____

**Allergy/Immunology:**
__ **None**
__ Drug Allergies
__ Environmental Allergies
__ Rheumatoid Arthritis
__ Lupus
__ Sjogren's Syndrome
__ Other: _____

**Current Medications:**
__ **None**
_____
_____
_____
_____
_____
_____
_____
_____
_____

**Eyes:**
__ **None**
__ Cataract
__ Glaucoma
__ Macular Degeneration
__ Dry Eye
__ Retinal Detachment
__ Increasing floaters
__ Flashes of light
__ LASIK/PRK/RK Surgery
__ Cataract Extraction
__ Corneal Transplant
__ Strabismus (cross-eye) Surgery