Welcome to Advanced Vision Center!

Please fill out this form as completely as possible and return it to the desk.

Name _____

Address _____ Apt #_____

City _____ State _____ Zip Code _____

Date of Birth _____ SSN _____

Gender _____ Preferred Pronouns _____

Race _____ Ethnicity _____

Phone _____ Cell / Home / Work Email _____

Primary Care Physician _____

Emergency Contact _____ Phone _____

Medical History

Medications	Ocular History
Allergies	Injuries/Surgeries

Family Medical/Ocular History

(Note relation to yourself in the box, example: Mother, Paternal Grandfather etc.)

Cancer _____

Diabetes Mellitus Type 1/Type 2 _____

Hypertension _____

Coronary Heart Disease _____

Thyroid Disorder _____

Cataract _____

Macular Degeneration _____

Glaucoma _____

Retinal Detachment _____

Other _____

Review Of Systems

Vision loss
- ❑ Blurry Vision
- ❑ Double vision
- ❑ Dryness
- ❑ Redness
- ❑ Mucous Discharge
- ❑ Itching
- ❑ Burning
- ❑ Excess Watering
- ❑ Light sensitivity
- ❑ Eye pain/Soreness
- ❑ Styes
- ❑ Flashes
- ❑ Floating spots
- ❑ Tired eyes

Constitution
- ❑ Cancer

ENT
- ❑ Hearing Loss
- ❑ Sinusitis
- ❑ Dry Mouth

Neurological
- ❑ Multiple Sclerosis
- ❑ Migraine

Psychiatric
- ❑ Depression
- ❑ ADHD
- ❑ Anxiety
- ❑ Bipolar

Cardiovascular
- ❑ Hypertension
- ❑ Stroke/CVA
- ❑ Heart Disease
- ❑ Vascular Disease
- ❑ Congestive Heart Failure

Respiratory
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Sleep Apnea

Gastrointestinal
- ❑ Crohn's
- ❑ Ulcerative Colitis
- ❑ Acid Reflux
- ❑ Celiac Disease

Musculoskeletal
- ❑ Arthritis
- ❑ Fibromyalgia
- ❑ Gout

Genitourinary
- ❑ Kidney Disease
- ❑ Herpes
- ❑ Chlamydia

Integumentary
- ❑ Eczema
- ❑ Rosacea
- ❑ Psoriasis

Endocrine
- ❑ Type 2 Diabetes Mellitus
- ❑ Type 1 Diabetes Mellitus
- ❑ Thyroid dysfunction

Hematologic/Lymphatic
- ❑ Anemia
- ❑ Ulcer
- ❑ Hypercholesterolemia

Allergy/Immune
- ❑ Environmental Allergies
- ❑ Lupus
- ❑ Sjogren's syndrome

OTHER:

Height: _____(feet/inches) Weight:_____(lbs)

Social History

Do you drive? YES / NO (please circle one)

Do you Use Tobacco? YES / NO (please circle one)

If yes, Type/Amount/How Long? _____

Are you currently pregnant or nursing? YES / NO (please circle one if applicable)

Hobbies _____

Patient Care Information

Name: _____

What brings you in today? _____

Do you currently wear glasses or contacts? _____

Is there anything you dislike about your glasses or contacts? _____

What is your profession? _____

How many hours a day do you spend on the computer or other electronic device? _____

How do you protect your eyes from sun damage? _____

Do you notice the glare and halos around car headlights at night? _____

Is there anything you wish the Doctor to know about before your eye exam?

_____

*for office use only below this point

Insurance: _____ Exam Co-Pay $_____CL Fit $_____ Optos YES / NO

Optomap Retinal Imaging Consent

Thank you for choosing our office for your eyecare needs.

We have an advanced computerized instrument (Optomap) which performs a quick and painless digital scan of inside your eyes (the retina) and allows Dr. Katz and Dr. Mark to more thoroughly evaluate your eyes for potential disorders which could lead to loss of vision. We are one of only a few facilities in the area that have this technology.

The digital image will be stored in the computer and remain available for comparison at future exams. This allows our doctors to observe even the smallest amount of change from your previous evaluation. The doctor will review and discuss these images with you today as a part of your examination.

Dr. Katz and Dr. Mark highly recommend that patients choose to have this procedure at every yearly examination. In most cases if you do the retinal scan and imaging, then a dilated exam is not necessary.

This technology was originally designed for use on children. We now find it is beneficial for anybody, especially over the age of 40. Also if you have a personal history or family history of systemic diseases such as high blood pressure, high cholesterol, heart disease, melanoma, or diabetes; or of eye diseases such as floaters, macular degeneration, retinal problems or retinal detachment.

The usual fee for this procedure is $120; When done in conjunction with your annual eye examination the fee is reduced to $40. Although insurance does not cover this preventive technology, it is the best method for assuring the long term health of your eyes.

Please Check one:

_____ I DO want this advanced procedure and I will pay $40 today.

_____ I DO NOT want this procedure at this time and understand that I may be dilated.

Signature: _____ **Date:** _____

Patient or guardian, if applicable

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please read it carefully. The privacy of your health information is important to us.

Our Legal Duty: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We will use and communicate your health information only for the purpose of providing your treatment, obtaining payments and conducting health care operations.

USES AND DISCLOSURES OF HEALTHCARE INFORMATION

To Provide Treatment: We will use and disclose your health information within our office to provide you with the best healthcare possible. This may include business office, staff, assistants, opticians, physician assistants, nurses, and physicians. In addition, we may share our health information with referring physicians, laboratories, pharmacies, and other health care personnel providing you treatment, including contact lens and frame companies.

To Obtain Payment: We may use and disclose your health information to obtain payment for services, materials, and treatment you received in our office. We may do this with insurance forms filed for you by mail or sent electronically.

Healthcare Operations: Your health information may be used during performance evaluation of our staff, training programs for students, interns, associates, and business and/or clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing, or credentialing activities.

Appointment Reminders: Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time to contact us for an appointment. Additionally, we may contact you for follow up on your care and inform you of treatment options or services that may interest you or a family member. These may include postcards, folding cards, letters, telephone calls, voice mails, or emails.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we believe a patient is a victim of abuse, neglect or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.

Public Health and National Security: We may disclose to Federal Officials or military authorities your health information required for lawful intelligence, counterintelligence, and other national security activities.

Law Enforcement: As permitted or required by State or Federal Law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime in order to report a crime.

Family, Friends, and Caregivers: We may disclose your health information to a family member, friends, care giver, or other person who you tell us will be helping you with your home hygiene, treatment, medications, or payment. In case of an emergency, where you are unable to tell us what you want we will use our very professional judgement when sharing your health information. We will also use professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, materials, or other similar forms of health information.

To Coroners, Funeral Directors, and Medical Examiners: We may be required by law to provide information about your health to coroners, funeral directors, and medical examiners for the purpose of determining a cause of death and preparing for a funeral.

Required by Law: We may use or disclose your health information when required to do so by law.

Your Authorization: Other than stated above or where Federal,State or Local Law requires us, we will not disclose your health information without your written authorization. You may revoke your authorization in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect.

Patient Financial Responsibility Policy

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

INSURANCE COVERAGE

Your insurance policy is a contract between you and your insurance. As a courtesy, we will file your claim. However, the patient is required to provide us with the most correct and updated information about their insurance, and will be responsible for any charges incurred if the information provided is not correct or updated.

APPOINTMENTS

24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee of $25 may then be added to your account.

REFERRALS

If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If your plan requires a referral and you do not obtain one, you will be held responsible for the visit charges in full at the time of service.

CO-PAYMENTS

By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service and we subsequently send you a statement, an administrative fee of $20 may be added to your account.

OUT-OF-NETWORK PLANS

You will be responsible for any balance your plan indicates as due on their explanation of benefits form. All patients will be responsible for their co-insurance and deductible. If we do not 'participate' with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office.

Private Insurance Authorization for Assignment of Benefits/Information Release: *I, the undersigned, understand that i am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.*

SELF-PAY PATIENTS

Payment is expected at the time of service unless financial arrangements have been made prior to your visit.

DELINQUENCY POLICY

A payment is DELINQUENT after 30 days from the payment due date. A notice will be sent by regular mail requesting payment. A delinquent fee of $25 is charged for each delinquent payment.

BOUNCED CHECK FEE

A bounced check fee is charged for each returned check. The amount of the bounced check fee will be the amount that fully recovers the bank's fees.

MEDICARE

We will submit claims to Medicare. The patient is responsible for the deductible and the 20% coinsurance, which can be billed to a secondary insurance if you have one. Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to All Eye Care, PC, Advanced Vision Center for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.

Print Name _____

Sign Name _____ **Date**_____

PATIENT RIGHTS:

Access: You have the right to look or get copies of your health information, with limited exceptions (you must make a request in writing to obtain access to your health information). If you request copies, we may charge you a fee for each page and per hour for staff time to locate, duplicate and assemble your copy and postage if you request the copies to be mailed to you.

Documentation of Health Information: You have the right to ask us for a description of how and where your health information will be used by our office for any reason other than for treatment, payment or health care operations and certain other activities. Our documentation procedures will enable us to provide information from April 14,2002 and forward. Please let us know in writing the time period for which you are interested. Your request must be limited to no more than 6 years at a time. We may charge you a reasonable fee for your request.

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to an alternative location (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location. We will make every effort to honor your reasonable request for confidential communications.

Amendments: You have the right to ask us to amend your health information. In order to standardize our process, please submit your request in writing and describe the reason for the change. Your request may be denied under certain circumstances.

Request a Paper Copy of this Notice: You have the right to obtain a copy of this Notice of Privacy Practices from our office at any time.

Complaints: If you think that we have not properly respected the Privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office of Civil Rights. We support your right to the privacy of your health information. If you want more information, please contact our office.

Acknowledgement of Receipt of Notice of Privacy Practices

I, the patient, have read and understand the Notice of Privacy Practices.

Print Name _____

Sign Name _____

Date_____