Acknowledgement

The Eye Doctor's Office P.A. and Art of Optiks remain committed to the protection of medical and personal health information to our patients and clients as well as protecting their rights under state and federal laws. Provided to you is a copy of our NOTICE OF PRIVACY PRACTICES.

This signature page is simply an acknowledgement that you have been provided with a copy of our NOTICE OF PRIVACY PRACTICES & PATIENT BILL OF RIGHTS.

By signing below you acknowledge that you:

- Have been provided with a copy of our NOTICE OF PRIVACY PRACTICES & PATIENT BILL OF RIGHTS.
- Understand our Privacy Practices and understand your rights as a patient or client of The Eye Doctors P.A. and Art of Optiks.
- Will be informed of any changes made to our Privacy Practices.

Print Patient Name: ______________________________

Signature of Patient: ______________________________

Date of Signature: ______________________________

If personal representative's signature is above, please state relationship to the patient: ______________________________

Office and Financial Policies

Thank you for choosing Art of Optiks as your eye care provider. As one of our patients, we would like to keep you informed of our office and financial policies. We require that you read and sign this document prior to receiving care. We will provide you with a copy of this document for future reference.

Canceled appointments: If you are unable to keep an appointment, please call our office at least 24 hours in advance to reschedule. This allows us time to provide that time slot to another patient. In the event that you have 3 or more cancelations with less than 24 hours notice and/or no show appointments, you will be required to provide a credit card number for future scheduling. A $75 fee for any future last minute reschedules/cancellations or no shows will be billed to your credit card.

Private Pay: If you do not currently have or wish to use insurance benefits to help pay for some or all of your care, payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make arrangements with our Patient Care Coordinator, prior to your appointment. We do offer a 20% prompt pay discount for balances paid in full on the day of service.

Insurance: Please bring your insurance card and driver's license with you to all appointments. With insurance plans where we have agreed to participate as a network provider, your carrier requires that all co-pays are paid at the time of service. In accordance with the Anti-Kickback Statute, our practice is not allowed to waive any co-pay requirements placed on you by your insurance carrier. In the event that you are unable to pay your co-pay on the day of service, there will be a $25 billing fee assessed to your account.

You are responsible for any co-insurance, deductibles, or non-covered services not paid by your insurance for claims filed within the state's required time limitation for submitting healthcare claims. You will receive a statement from our office indicating what your insurance has paid; any balance remaining is due upon receipt of this statement. Accounts 90 days or older are subject to late fees, interest charges, and if necessary, any subsequent collection or attorney fees. There will also be a $31 service fee for all returned checks.

We are only able to bill your vision insurance for routine eye exams. If a medical diagnosis is determined during an exam, we will be billing your medical insurance primarily and your vision insurance secondarily. Any balance remaining will be patient responsibility.

In the event that you provide us with incorrect insurance information, you will ultimately be responsible for the entire balance.

Materials: All co-pays and fees for materials must be paid at the time materials are ordered unless other arrangements are made at the time of service.

I have read the above policies and I understand them. I agree to the aforementioned policies.

Patient Name Printed: ____

Patient Signature: ____ Date: _______________

If personal representative's signature is above, please state relationship to patient:_________________

Art of Optiks
Welcome To Our Office

Welcome to Art of Optiks. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name ______ MI ______ Last Name ______ Preferred Name ______

Street Address ______ City ______ State Zip ______

Social Security Number ______ Date of Birth ______ Home Phone - Include Area Code ______ Day Phone ______

Email Address ______ Guardian ______ , Person Responsible for Account ______

Emergency Contact ______ Emergency Phone ______

How were you referred to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient
☐ Insurance Listing ☐ Drive by ☐ Other ☐ Doctor

Who were you referred by? ______

PRIMARY INSURANCE INFORMATION

Name and Address of Primary Insurance Company ______ City ______ State Zip ______

M ☐ F ☐ Insured's First Name ______ MI ______ Insured's Last Name ______

Insured's Identification Number ______ Group Number ______ Insured's Date of Birth ______

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status ☐ Single ☐ Married ☐ Other

☐ Full Time Student ☐ Part Time Student ☐ Employed

Name

Art of Optiks
PATIENT HISTORY AND INFORMATION

Race

- ☐ American Indian Or Alaska Native
- ☐ Asian
- ☐ Black Or African American
- ☐ Hispanic Or Latino
- ☐ Native Hawaiian Or Other Pacific Islander
- ☐ White
- ☐ Declined To Specify

Other Race

Ethnicity: ○ Hispanic Or Latino ○ Not Hispanic Or Latino ○ Declined To

Preferred Language: ○ English ○ Chinese ○ Dutch; Flemish ○ French ○ German ○ Hindi

Height ft in cm/m ◉ ft in ○ cm ○ m **Weight** ◉ lbs ○ kg

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name

Address of Primary Care Physician City State Zip Phone

REFERRING PHYSICIAN

Referring Physician and Clinic Name

Address of Referring Physician City State Zip Phone

HEALTH HISTORY

What is the main reason for today's exam ? ______ When was your last exam ? ______

When was your last health exam ? ______

Past Illnesses or Injuries: ______

Past Surgeries: ______

Current Medications: ______

Current Eye Drops: ______

Medicines that cause reactions or sensitivities: ______

Specific Allergies: ______

EYE HISTORY

Glaucoma	○ Yes	○ No	Dryness	○ Yes	○ No	Strabismus (Crossed Eyes)	○ Yes	○ No
Cataract	○ Yes	○ No	Excess Tearing/Watering	○ Yes	○ No	Blurred Vision Distance	○ Yes	○ No
Macular Degeneration	○ Yes	○ No	Eye Pain or Soreness	○ Yes	○ No	Blurred Vision Near	○ Yes	○ No
Retinal Detachment	○ Yes	○ No	Foreign Body Sensation	○ Yes	○ No	Distorted Vision (halos)	○ Yes	○ No
Color Blindness	○ Yes	○ No	Infection of Eye or Lid	○ Yes	○ No	Double Vision	○ Yes	○ No
Headaches	○ Yes	○ No	Itching	○ Yes	○ No	Floaters or Spots	○ Yes	○ No
Glare/Light Sensitivity	○ Yes	○ No	Mucous Discharge	○ Yes	○ No	Fluctuating Vision	○ Yes	○ No
Tired Eyes	○ Yes	○ No	Drooping Eyelid	○ Yes	○ No	Loss of Vision	○ Yes	○ No
Amblyopia (Lazy Eye)	○ Yes	○ No	Redness	○ Yes	○ No	Loss of Side Vision	○ Yes	○ No
Burning	○ Yes	○ No	Sandy or Gritty Feeling	○ Yes	○ No			

GENERAL HEALTH CONDITION

Fever	○ Yes	○ No	Respiratory (Asthma)	○ Yes	○ No	Anxiety or Depression	○ Yes	○ No
Weight Loss	○ Yes	○ No	Gastrointestinal	○ Yes	○ No	Thyroid, Diabetes	○ Yes	○ No
Other Symptoms	○ Yes	○ No	Kidney	○ Yes	○ No	Blood/Lymph	○ Yes	○ No
Ears,Nose,Throat	○ Yes	○ No	Muscles,Bones,Joints	○ Yes	○ No	Allergic	○ Yes	○ No
Cardiovascular (high blood pressure etc.)	○ Yes	○ No	Skin	○ Yes	○ No	**Pregnant**	○ Yes	○ No
			Neurological (Multiple Sclerosis)	○ Yes	○ No	**Nursing**	○ Yes	○ No

Name

Art of Optiks

MEDICAL HISTORY QUESTIONAIRE

FAMILY HISTORY

Condition		Condition		Condition	
Amblyopia (Lazy Eye)	○ Yes ○ No	Retinal Detachment	○ Yes ○ No	High Blood Pressure	○ Yes ○ No
Blindness	○ Yes ○ No	Strabismus (Eye Turn)	○ Yes ○ No	Kidney Disease	○ Yes ○ No
Cataract(s)	○ Yes ○ No	Arthritis	○ Yes ○ No	Lupus	○ Yes ○ No
Color Blindness	○ Yes ○ No	Cancer	○ Yes ○ No	Stroke	○ Yes ○ No
Glaucoma	○ Yes ○ No	Diabetes	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Macular Degeneration	○ Yes ○ No	Heart Disease	○ Yes ○ No	Others	○ Yes ○ No

SOCIAL HISTORY

Current Occupation : ______________ Years ________ Employer ______________

SPECTACLE LENS HISTORY

Do you use a computer? ○ Yes ○ No How many hours/day? ______ Distance from Computer? ______

Do you drive? ○ Yes ○ No Mileage to work each way? ______

Do you have glare problems? ○ Yes ○ No

Do you have visual difficulty when driving? ○ Yes ○ No

Do you have problems with night vision? ○ Yes ○ No

Do you currently wear glasses ? ○ Yes ○ No Since ______________

Type of glasses ☐ FullTime ☐ PartTime ☐ Distance ☐ Close

Glasses Owned ☐ SingleVision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Have you had trouble in the past with glasses? ○ Yes ○ No ______________

Do you wear sunglasses? ○ Yes ○ No Are your sun glasses your current prescription ? ○ Yes ○ No

SPECIAL EYEWEAR NEEDS

☐ Computer (special prescriptions, special anti-glare tints or coatings) ☐ Safety Glasses (gardening, woodworking, welding)

☐ Occupational (mechanics, plumbers, pilots) ☐ Sports/Hobbies (racquet sports, motorcycle)

CONTACT LENS HISTORY

If not a contact lens wearer, are you interested in trying contact lenses at this time ? ○ Yes ○ No

Have you ever tried to wear contact lenses? ○ Yes ○ No Reason for stopping? ______________

Do you currently wear contact lenses? ○ Yes ○ No Since ______________

Type and brand of contact lenses ______________ Today's wearing time ? ______

How many hours/day ? ______ How many days/week ? ______

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Lens Comfort	____	____	Distance Vision	____	____	Near Vision	____	____

What Solutions do you use? Cleaner ______________ Disinfectant ______________ Enzyme ______________

SOCIAL HISTORY

Do you use nutritional supplements (vitamins etc.)? ○ Yes ○ No

Do you engage in regular exercise? ○ Yes ○ No

Do you drink alcohol ? If yes, how much/often : ○ No ○ Occasional ○ 1 Per Day ○ 2-3/day ○ 4+/day

Do you smoke ? If yes, how much/often : ○ No ○ Occasional ○ 1/2 pack/day ○ 1 pack/day ○ 1+ pack

Smoking Status ______________

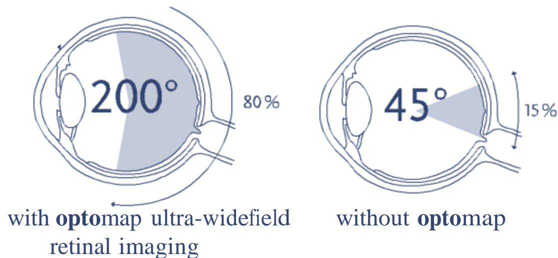
Method of Tobacco Intake : ○ Smoking ○ Chewing

Do you use Illegal Drugs : ○ Yes ○ No

Hobbies/ Interests : ______________

In our continued effort to provide patients with the most advanced eyecare technology available, Art of Optiks is pleased to include the optomap® Retinal exam as an integral part of your eye exam and an option that may eliminate the need for dilation.

Early detection and treatment are essential in preventing conditions that could potentially cause problems or permanent vision loss. In addition to looking for changes in the front of your eye, which could affect overall vision, we also need to look at the retina, inside of the eye, to check that it is healthy and not damaged or showing signs of disease. At every comprehensive eye exam, our doctors want to ensure your entire eye is and remains healthy. Many conditions, such as retinal detachments and retinal holes can be treated successfully if caught early.



with **opto**map ultra-widefield retinal imaging   without **opto**map

The **opto**map® Retinal Exam is fast, easy, comfortable and offers many advantages including:

- Provides an ultra-widefield view of the retina ←
- Is non-invasive
- Allows you to view your retinal image with the doctor during the exam
- Provides an annual, permanent record which gives your doctor comparisons for tracking and diagnosing potential issues.

Your doctor highly recommends the **opto**map® Retinal Exam for all patients. We will perform the **opto**map® Retinal Exam as an enhancement to the general eye exam, and an option instead of dilation for a fee of $39. Insurance does not cover any advanced screening technology beyond the general eye exam.

Please check the appropriate line below and sign at the bottom.

______ I **DO** want to have the **opto**map® Retinal Exam for $39

______ I **DO NOT** want to have the **opto**map® Retinal Exam

PATIENT NAME PRINTED: ____

PATIENT SIGNATURE: ________________________ **DATE: ___________**