Community Eye Care

optomap®

ultra-widefield retinal imaging

At Community Eye Care, we are dedicated to providing the highest level of care available. For this reason we offer the **Optomap Retinal Exam** to all of our patients.

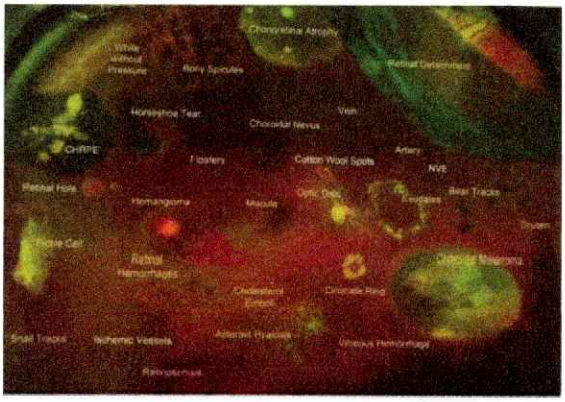
This non-invasive technology allows our doctors to see a high resolution, ultra-wide view of the inner eye, **without the need to dilate your pupils** in most cases. The Optomap Retinal Exam allows for early detection of potentially blinding eye diseases such as glaucoma, macular degeneration, retinal detachment, and even malignant tumors. It also allows for detection of common health conditions such as diabetes, high blood pressure, and high cholesterol, just to name a few.

The Optomap Retinal Exam is an essential part of your comprehensive eye exam. Our Doctors prescribe it for all patients at every annual examination.

As part of your preliminary testing, our doctor's assistant has captured Optomap images for review by the Doctor during your examination today. **The $24.00 Co-Pay for these images is not covered by insurance unless being used to actively follow disease.** Any questions you may have about the Optomap Retinal Exam can be discussed with the Doctor when the images are reviewed during your examination.

We also offer a more in-depth Wellness Package that will give our Doctors even more information on your overall eye health. This package gives our Doctors the ability to **customize** an ongoing plan to ensure your eyes stay healthy. The Wellness package includes Optomap photos along with an additional retinal screening for a **discounted price of $34**.

If you Choose not to accept the prescribed Optomap Imaging, we will be required to dilate your pupils during today's exam.



Signature for Wellness Package Exam:

_____

OR

Signature for Optomap Retinal Exam:

_____

Community Eye Care

We are pleased to welcome you to our practice! Please take a few minutes to fill out this form to the best of your ability. Let us know if you have any questions and we will gladly help you.

***If you have no changes since your last visit, please sign in the bottom right corner.**

Patient Information

Today's Date: _____

Patient's SSN: _____

Patient's Name (last): _____

(first) _____ (MI) _____

Address: _____

City: _____

State: _____ Zip Code: _____

Email: _____

Male Female Birth date: _____

Marital Status

- o Married
- o Widowed
- o Separated
- o Divorced
- o Single
- O Minor

Ethnicity

- o Hispanic or Latino
- o Native Hawaiian/Pacific Islander
- o American Indian or Alaska Native
- o Asian
- o Black or African American
- o White
- o Declined to specify

Other Information

Employer/School: _____

Occupation: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Alternate Phone: _____

Preferred Method of Contact: _____

Name of Spouse or Parents:

_____

Emergency Contact Information

Name: _____

Relationship: _____

Primary Phone: _____

Insurance Information

Name of Insured: _____

DOB of Insured: _____

Insurance Company: _____

Sign below if no information has changed:

_____

Medical and Family History Information- Please list family member when applicable

***If you have no changes since your last visit, please sign at the conclusion of the Medical History.**

	You	Family
Cardio Vascular		
Cardiovascular Disease	___	_____
Coagulation Disorder	___	_____
Congestive Heart Failure (CHF)	___	_____
Elevated Cholesterol	___	_____
Heart Murmur	___	_____
Heart Palpitations	___	_____
High Blood Pressure	___	_____
Heart Attack	___	_____
Stroke	___	_____
Endocrine		
Crohn's Disease	___	_____
Diabetes	___	_____
Gout	___	_____
Hypoglycemia	___	_____
Pituitary Disorder	___	_____
Renal Disease	___	_____
Thyroid Disorder	___	_____
Endophthalmitis	___	_____
Gastrointestinal		
Acid Reflux	___	_____
Cirrhosis	___	_____
Colitis	___	_____
Gall Bladder Disorder	___	_____
Gall Stones	___	_____
Hepatitis (type)_____	___	_____
IBS	___	_____
Jaundice	___	_____
Pancreatitis	___	_____
Ulcer (type)_____	___	_____
Genitourinary		
Amenorrhea	___	_____
Bladder Infection	___	_____
Pregnancy	___	_____
Menopause	___	_____
Ovarian Cysts	___	_____
Pelvic Inflammatory Disease	___	_____
Prostate Disorder	___	_____
STD (Type)_____	___	_____

	You	Family
Hematologic/Lymphatic		
Anemia	___	_____
Hodgkin's Disease	___	_____
Leukemia	___	_____
Sickle Cell Disease	___	_____
Blood Transfusion	___	_____
Head		
Chronic Cough	___	_____
Dry Mouth	___	_____
Headaches	___	_____
Migraines	___	_____
Hearing Loss	___	_____
Sinusitis	___	_____
Immunologic		
AIDS	___	_____
Chicken Pox	___	_____
Diphtheria	___	_____
Herpes	___	_____
Histoplasmosis	___	_____
HIV Positive	___	_____
Lyme Disease	___	_____
Integumentary		
Rosacea	___	_____
Contact Dermatitis	___	_____
Impetigo	___	_____
Lupus	___	_____
Psoriasis	___	_____
Scleroderma	___	_____
Vitiligo	___	_____
Eyes		
Cataracts	___	_____
Macular Degeneration	___	_____
Glaucoma	___	_____

	You	Family
Musculosketal		
Arthritis	___	_____
Rheumatoid Arthritis	___	_____
Down's Syndrome	___	_____
Marfan's Dystrophy	___	_____
Myasthenia Gravis	___	_____
Osteoporosis	___	_____
Scoliosis	___	_____
Respiratory		
Asthma	___	_____
Bronchitis	___	_____
COPD	___	_____
Cystic Fibrosis	___	_____
Emphysema	___	_____
Pneumonia	___	_____
Sarcoidosis	___	_____
Neurological		
Bell's palsy	___	_____
Brain Damage	___	_____
Brain Tumor	___	_____
Cerebral Palsy	___	_____
Dyslexia	___	_____
Encephalitis	___	_____
Epilepsy	___	_____
Horner's Syndrome	___	_____
Mutiple Sclerosis	___	_____
Neuralgia	___	_____
Nystagmus	___	_____
Ophthalmoplegia	___	_____
Parkinson's Disease	___	_____
Seizure Disorder	___	_____
Sturge-Weber Syndrome	___	_____
Tuberous Sclerosis	___	_____
Vertigo	___	_____
Psychiatic		
ADD/ADHD	___	_____
Alcoholism	___	_____
Alzheimer's	___	_____
Anorexia	___	_____
Anxiety Disorder	___	_____
Bulimia	___	_____

	You	Family
Dementia	___	_____
Depression	___	_____
Drug Dependent	___	_____
Insomnia	___	_____
Personality Disorder	___	_____
Schizophrenia	___	_____

List any other medical conditions not listed above:

_____

_____

If you have/had cancer please list the type:

_____

Who is your Primary Care Provider:

_____

List any over the counter (OTC) or Prescription meds:_____

_____

_____

Medication Allergies: _____

_____

Eyedrops: _____

_____

Surgeries: _____

_____

_____

Do you wear glasses or contact lenses? Yes or No

Tobacco Use: Yes No Smokeless Tabacco

If yes, how many packs per day & for how long?

_____

Alcohol Use: Yes No Social Daily

Are you pregnant: Yes No

if yes, how many weeks? _____

In what order were you born?

1 2 3 4 5+

Twin Only Child

Height:_____ Weight: _____

Sign below if no information has changed

_____

Community Eye Care

Consent form For Electronic Delivery of Prescription

I would like my eyeglasses and/or contact lens prescription sent to me electronically via our patient portal.

Yes ☐ No ☐

*If no, please indicate how you would like to receive your prescription.

Email ☐ Print☐

Signed Acknowledgement Form Following Prescription Release

Patient Name: _____

Patient Signature: _____

Date: _____

By choosing our optical for your glasses and/or contact lens purchases we can guarantee you are receiving products that meet our specifications and recommendations. You also receive the benefit of knowing we will be able to assist you in any concerns with your products and any warranty needs. We can be your one-stop shop for all your eyewear and care needs.

You are welcome to have your prescription filled by any optical of your choice, however, if there are any issues with your glasses or contact lenses, we cannot provide assistance. Our doctors make personalized recommendations regarding lens options and measurements; therefore, we cannot guarantee that glasses and/or contacts ordered outside our office meet our recommendations. For any concerns you will have to work with the optical where you purchased your materials.

Included below is important information to review prior to receiving your contact lens prescription.

The Centers for Disease and Prevention (CDC) makes clear, "Contact lenses can provide many benefits, but they are not risk-free -- especially in contact lense wearers don't practice healthy habits and take care of their contact lenses and supplies. If patients seek care quickly, most complications can be easily treated by an eye doctor. However, more serious infections can cause pain and even permanent vision loss, depending on the cause and how long the patient waits to seek treatment."

The CDC recommends the following for contact wearers:

- Schedule a visit with your eye doctor at least once a year
- Take out your contcts and call your eye doctor if you have eye pain, discomfort, redness, or blurry vision
- Understand that eye infections that go untreated can lead to eye damage or even blindness (2)

The Food and Drug Administration (FDA) indicates:

- "To be sure that your eyes remain healthy you should not order lenses with a prescription that has expired or stock up on lenses right before the prescription is about to expire. It's safer to be re-checked by your eye care professional." (3)

(2): https://www.cdc.gof/contactlenses/pdf/Eyewise-doctor-8x11.pdf

(3): https://www.fda.gov/medical-devices/contact-lenses/buying-contact-lenses

Community Eye Care

Notice of Privacy Practices and Payment Policies

Privacy Practices: The law requires that this Community Eye Care practice make every effort to inform you of your rights related to your personal health information. By signing below, I acknowledge that I was given the opportunity to read, have read or had explained to me this Community Eye Care's Notice of Privacy Practice prior to any services offered OR that the Notice of Privacy Practice could not be read due to the emergent nature of the care and will be acquired when possible.

Information Release: By signing below, I authorize this Community Eye Care practice to release my personal health information to the following individuals:

_____ _____

Communication: Community Eye Care may use standard phone, email, and text messaging to communicate with you. These forms of communication are not secure and do not guarantee privacy.

- ❑ By signing below, I authorize the use of these forms of communication to communicate with me.
- ❑ By signing below, I do not authorize the use of these forms of communication to communicate with me and I will provide an alternative method of communication.

Preferred Communication _____

Insurance Authorization: By signing below, I authorize Community Eye Care to release any information; including diagnosis and the records of any treatment or examination rendered to me to my insurance provider. I authorize and request that my insurance company pay Community Eye Care benefits otherwise payable to me. I understand that my insurance company may pay less than the charges submitted. I understand that it is my responsibility to provide the correct insurance and/or payment information. Failure to provide correct information may result in you becoming responsible for the entirety of the costs for services and materials rendered.

Financial Responsibility: By signing below, you understand that due to frequent changes in insurance policies, it is not an easy task for Community Eye Care to correctly interpret the details of each policy. It is recommended that you, as the patient, verify with your insurance

provider if you are unsure of your coverage. Although Community Eye Care makes every effort to remain aware of these changes, it may not always be possible to give you an accurate estimate of your copays.

Your signature provides acknowledgment of your financial responsibility including but not limited to the following circumstances: estimates of your copays do not match the explanation of benefits we receive from your insurance provider, Community Eye Care is out of network with or does not accept payment from your policies, your insurance provider denies payment, or your deductible has not been met. Payment for all services, elective testing, and materials rendered on you or your dependents' behalf is expected on the day of service or order.

Payment Policies: By signing below, you understand that if we are unable to collect all payment due at the time of service/order, we will send you a statement monthly. If we do not receive payment after 90 days a collection fee of 50% will be added to your bill and we will send your account to an outside collection agency. If there are extenuating circumstances, Community Eye Care may have alternative payment options to assist you, please ask us about these if needed.

Signature: If you are signing as a personal patient representative, please indicate your relationship. If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor. I have read and understand this form and I am signing it voluntarily.

Signature of Responsible Party Relationship to Patient Date

Community Eye Care ABN (Advanced Beneficiary Notice)

An ABN is required when:

- Medicare is the insurance provider and materials are purchased.
- Patient's insurance does not cover a specific service or procedure.
- A refraction is performed during a medical appointment. A refraction checks for an updated glasses prescription.
- The patient does not have any medical or vision insurance.

By signing below, you agree to pay any incurred charges that your insurance provider does not pay in full for any services or materials purchased over the next 12 months.

Signature of Responsible Party Relationship to Patient Date