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.

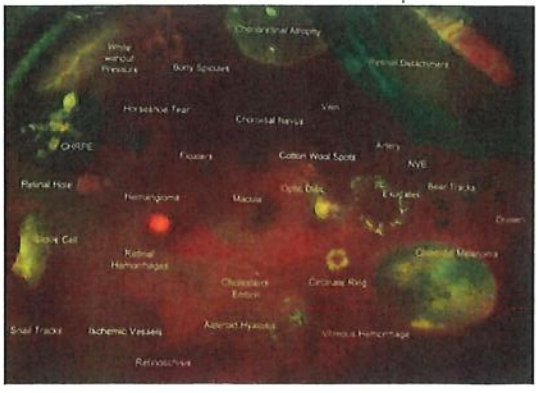
This non-invasive technology allows our doctors to see a high resolution, ultra-wide view of the inner eye, **without the need to dilate your pupils** in most cases. The Optomap Retinal Exam allows for early detection of potentially blinding eye diseases such as glaucoma, macular degeneration, retinal 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 $37.00 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 $42**.

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



Wellness Package Exam: _____

OR

Signature for Optomap Retinal Exam: _____

OR

Signature for Dilation Exam: _____

Patient Name_____

Community Eye Care

Please circle the number that best represents your answer to each question. Your technician will score your answers when you are complete.

Have you experienced any of the following during the last week?	All the time	Most of the time	Half the time	Some of the time	Never
Eyes that are sensitive to light	4	3	2	1	0
Eyes feel gritty	4	3	2	1	0
Painful or sore eyes	4	3	2	1	0
Blurred vision	4	3	2	1	0
Poor vision	4	3	2	1	0

Have problems with your eyes limited you in any of the following in the last week?	All the time	Most of the time	Half the time	Some of the time	Never
Reading	4	3	2	1	0
Driving	4	3	2	1	0
Computer	4	3	2	1	0
Watching Television	4	3	2	1	0

Have your eyes felt uncomfortable in any of the following situations during the last week?	All the time	Most of the time	Half the time	Some of the time	Never
Windy conditions	4	3	2	1	0
Very dry places	4	3	2	1	0
Air-conditioned spaces	4	3	2	1	0

Score_____

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.

_____

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. If our estimates of your copays do not match the explanation of benefits we receive from your insurance provider, your deductible has not been met, or your insurance provider denies payment you acknowledge that you are held responsible for payment of all services, elective testing and materials rendered on you or your dependents' behalf. All amounts are due 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:

- Patient does not have any medical or vision insurance.
- Patient's insurance is out of network with our office.
- Deductible is not or it is unknown if it is met.
- Patient's insurance does not cover a specific service or procedure.
- Community Eye Care does not accept payment from your insurance provider.
- A refraction is performed during a medical appointment. A refraction checks for an updated glasses prescription.
- Medicare is the insurance provider and materials are purchased.

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

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.

Patient Information

Today's Date: _____

Patient's Name: _____

Patient's SSN: _____

Phone: _____

Email: _____

Male Female Birth date: _____

How would you like us to contact you?

Phone Call Text Email

Tobacco Use: Yes No Smokeless

Alcohol Use: No Social Daily

Primary Doctor: _____

Emergency Contact

Name: _____

Relationship: _____

Phone: _____

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

Medical and Family History

Please list the family member(s) when applicable. If you have no changes since your last visit, please sign at the end.

Please List any OTC or Prescription meds:

_____

_____

Please list any medication or other allergies:

_____

Condition	You	Family
Constitutional		
Developmental Disability	____	_____
Cancer	____	_____
Fatigue Syndrome	____	_____
Other: _____	____	_____
ENT		
Hearing Loss	____	_____
Sinusitis	____	_____
Dry Mouth	____	_____
Laryngitis	____	_____
Other: _____	____	_____
Neurological		
Multiple Sclerosis	____	_____
Epilepsy	____	_____
Cerebral Palsy	____	_____
Tumor	____	_____
Migraine	____	_____
Autism	____	_____
Other: _____	____	_____

Condition	You	Family
Psych		
Depression		
ADD/ADHD		
Anxiety Disorder		
Bipolar Disorder		
Other:		
Cardiovascular		
Hypertension		
Stroke/CVA		
Heart Disease		
Vascular Disease		
Congestive Heart Failure		
Other:		
Respiratory		
Smoker		
Asthma		
Bronchitis		
Emphysema		
Chronic Obstruction		
Sleep Apnea		
Other:		
Gastrointestinal		
Crohn's Disease		
Ulcer		
Acid Reflux		
Celiac Disease		
Other:		
Genitourinary		
Kidney Disease		
Prostate Disease/Cancer		
STD-Herpetic/Chlamydia		
Prostate Hypertrophy		
Pregnant		
Nursing		
Other:		

Condition	You	Family
Musculoskeletal		
Arthritis		
Osteoarthritis		
Fibromyalgia		
Muscular Dystrophy		
Ankylosing Spondylitis		
Osteoporosis		
Gout		
Other:		
Integumentary		
Eczema		
Rosacea		
Psoriasis		
Cold Sores		
Shingles		
Other:		
Endocrine		
Diabetes Type 1		
Diabetes Type 2		
Thyroid Dysfunction		
Hormonal Dysfunction		
Other:		
Hematologic/Lymphatic		
Anemia		
Large Volume Blood Loss		
Hypercholesterolemia		
Other:		
Allergy/Immunologic		
Drug Allergies		
Environmental Allergies		
Rheumatoid Arthritis		
Sjogren's Syndrome		
Other:		