

# Welcome to our office

Thank you for choosing **Fine Eyewear** for your eye care needs. Please complete this form and if there are any questions please ask one of our staff members for assistance. We will be happy to assist you.

Name \_\_\_\_\_ Date \_\_\_\_\_  
Last First MI  
Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_ Sex: female male  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone # (home) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_  
Email address: \_\_\_\_\_  
Whom may we thank for referring you to our office? \_\_\_\_\_

## Nature of visit: (check all that apply)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> General eye exam | <input type="checkbox"/> First eye exam           | <input type="checkbox"/> Broken/lost eyewear  |
| <input type="checkbox"/> Want new eyewear | <input type="checkbox"/> Want contacts            | <input type="checkbox"/> Distance vision blur |
| <input type="checkbox"/> Near vision blur | <input type="checkbox"/> Double vision            | <input type="checkbox"/> Eyestrain            |
| <input type="checkbox"/> Headaches        | <input type="checkbox"/> Floaters/spots in vision | <input type="checkbox"/> See flashing lights  |
| <input type="checkbox"/> Watery eyes      | <input type="checkbox"/> Temporary loss of vision | <input type="checkbox"/> Burning eyes         |
| <input type="checkbox"/> Red Eyes         | <input type="checkbox"/> Dry eyes                 | <input type="checkbox"/> other _____          |

## INSURANCE INFORMATION

### Medical Insurance Company \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Name of **primary insured**: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Primary birthdate: \_\_\_\_\_ Primary SS #: \_\_\_\_\_  
Primary phone #: \_\_\_\_\_ Name of Primary Employer: \_\_\_\_\_

### Vision Insurance Company \_\_\_\_\_

ID # \_\_\_\_\_  
Name of **primary insured**: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Primary birthdate: \_\_\_\_\_ Primary SS #: \_\_\_\_\_  
Primary phone #: \_\_\_\_\_ Name of Primary Employer: \_\_\_\_\_

## Responsible Party:

There are some important insurance issues that must be recognized **BEFORE** you visit the doctor.

**Vision insurance** plans will usually cover for a basic eye exam minus co-pay. Most vision insurance plans will **NOT** cover for the following contact exam fees: contact lens fitting, follow-ups and/or contact lens materials.

**Medical insurance** plans will usually cover for office visits if you experience headaches, take high risk medications, or have any eye complications, including red eye, itching, dry eyes, redness, etc. They often cover when there is a personal or family history of any vision threatening disease, diabetes, high blood pressure, cholesterol or heart disease.

All vision and medical insurance plans are different. If you are not completely sure of your benefits, please call your insurance company for clarification. I authorize Fine Eyewear to file insurance benefits and have payment assigned to them. I authorize Fine Eyewear to release protected health information to my insurance carrier for the purpose of payment of claims. I have read the above and understand that my vision health insurance **may not** cover for routine eye exam, contact lens exam, red eye, eyeglasses and/or contact lens. **I understand that if my insurance carrier does not pay my claims then I will be held responsible for the balance on my account.**

\_\_\_\_\_  
Patient's or Guardian's Signature

\_\_\_\_\_  
Date

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# Medical History Questionnaire

## Past Ocular History

Date of last eye exam: \_\_\_\_\_ Name of last Eye care physician: \_\_\_\_\_

Have you had any eye diseases?  No  Yes If yes, please list: \_\_\_\_\_

Have you had any eye surgeries?  No  Yes If yes, please list: \_\_\_\_\_

## Medical History

Name of Medical Doctor: \_\_\_\_\_ Doctor's Phone #: \_\_\_\_\_

Last Medical Exam: \_\_\_\_\_

Do you have any **allergies to medications**? \_\_\_\_\_ If yes, please list \_\_\_\_\_

List any previous surgeries: \_\_\_\_\_

Are you pregnant?  yes  no  not sure. Are you nursing?  yes  no

## Social History

Do you use tobacco?  yes  no If yes, type/amount/ how long? \_\_\_\_\_

Do you use alcohol?  yes  no If yes, type/amount/ how long? \_\_\_\_\_

Do you use illicit drugs?  yes  no If yes, type/amount/ how long? \_\_\_\_\_

Have you ever been exposed to or infected with:  Hepatitis  Gonorrhea  Syphilis  HIV

## Review of Systems

Please check/circle if you have any of the following problems: (**List medications** currently using for the applicable problems)

Ears/Nose/Throat: Hearing loss, Sinus problems \_\_\_\_\_

Constitutional: fever, weight loss/gain \_\_\_\_\_

Integumentary (skin): Rashes, Eczema, Rosacea, Lupus \_\_\_\_\_

Neurological: Paralysis, numbness, headaches/migraine, Multiple Sclerosis \_\_\_\_\_

Respiratory: Asthma, short of breath, wheezing, cough \_\_\_\_\_

Cardiovascular: Chest pain, irregular heartbeat, heart disease, High blood pressure, cholesterol \_\_\_\_\_

Digestive: Heartburn, Diarrhea, Reflux \_\_\_\_\_

Musculoskeletal: Rheumatoid Arthritis, Myasthenia Gravis, Osteoporosis \_\_\_\_\_

Blood: Anemia, Sickle Cell, Excessive Bleeding \_\_\_\_\_

Endocrine: Diabetes, Thyroid \_\_\_\_\_

Psychiatric: Depression, Anxiety, Mental illness \_\_\_\_\_

Other: please list \_\_\_\_\_

## Family Health History

If any member of your family (living or deceased) has had any of the following conditions please list the condition and relationship of the person: Diabetes, Heart Disease, Kidney Disease, High Blood Pressure, Lupus, Thyroid Disease, Arthritis, Seizures, Blindness, Glaucoma, Cancer, Crossed Eyes, Cataract, Macular Degeneration, Retinal Detachment or other eye disease. \_\_\_\_\_

**DIGITAL RETINAL IMAGING SCREENING:**

Digital retinal imaging utilizes a high resolution digital camera system to capture a magnified image of the back part (retina) of your eye similar to the miniaturized picture shown here. Dr. Minnick recommends this special diagnostic procedure. It is quick, painless, and nothing will touch your eye.

This digital image will be a permanent record in your file and is invaluable for present and future diagnosis as your eye changes with age. It captures important details concerning the current health of your eye and specific structures such as the retina, optic nerve, macula, and blood vessels. It will also serve as an initial point from which to compare, as we follow your health in subsequent years.



The fee for the retinal image screening is \$30.00. Most insurance do not yet cover retinal image screening.

\_\_\_\_\_ Initial here to request retinal image screening

**COMPUTERIZED VISUAL FIELD SCREENING:**

A sophisticated computerized instrument which provides a more thorough medical analysis of your eyes. Our Humphrey Visual Field Analyzer electronically measures retinal function and sensitivity to light. This measurement can assist us in the early detection of many disorders, including brain tumors, glaucoma, diabetic retinopathy, and retinal detachments. We strongly recommend that all of our patients receive the screening version of this exam. It is especially important for people who have:



- Headaches
- See spots or flashes of light
- History of Diabetes
- History of high blood pressure
- Circulatory problems
- Strong eyeglass prescription

The fee for this screening is \$25.00. Insurance does not cover this test.

\_\_\_\_\_ Initial here to provide your consent for visual field screening

**PUPIL DILATION** uses medicine eye drops to temporarily enlarge pupils. These drops temporarily decrease near focus ability. By enlarging the pupils, Dr. Minnick can examine the inside of your eyes more thoroughly to provide you the very best in eye care. Without pupillary dilation, certain eye diseases and abnormalities can go undetected. The drops can sometimes cause temporary slight stinging for a few seconds, close-up blurry vision and light sensitivity. (Your driving may be affected, great caution is advised.) There is also a rare phenomenon called “Acute Narrow Angle Glaucoma” which is possible in a small group of patients. If you are at risk for this condition, Dr. Minnick will inform you of that risk in advance.

The fee for this service is included in the exam fee. However, if you would like to reschedule for dilation for a **different** day the fee is \$35.

\_\_\_\_\_ Initial here to provide your consent for pupillary dilation

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

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**If you use computer for 2 hours or longer, please check all situations that apply:**

- Laptop
- Monitor Close
- Monitor arms length or further
- Multiple monitors
- Multiple Monitors at different distances

**Please check all that apply:**

- I spend a lot of time outdoors.
- I have trouble seeing at night.
- My job/lifestyle involves both indoor and outdoor activities.
- I am uncomfortable with the weight and thickness of my glasses.
- I find myself moving my glasses up or down to see under different situations.
- I am light sensitive, driving in bright sunlight and glare bothers me.
- I have trouble with close work with:
  - Reading
  - Using my computer
  - Hobbies
- I participate in active or competitive sports. Name of sport: \_\_\_\_\_
- I am an avid golfer
- I am an avid boater/fisherman
- I am an avid cyclist
- My current eyewear doesn't meet my performance needs for work and recreation.
- My current eyewear is great, I'm looking for a new pair to add to my eyewear collection.

**I currently wear: (check all that apply)**

- Eyeglasses
- Contacts
- Non-Rx Sunglasses
- Rx Sunglasses

**Images that I want to convey when I wear my glasses (choose all that apply):**

- Business/serious image for meetings, etc
- Fashion forward with a bold image
- Style but with subtle cues
- Fashion conscience (coordinate with my other accessories: shoes, purse, jewelry)
- Hip/chic image for dinner parties or other social functions
- Different looks, for different occasions, keep people guessing what I'll wear next
- Certain frames or look similar to a particular celebrity or distinguished person
- I would like my glasses to be nearly invisible

**Vitality & Wellness – Supplementation for optimum health and fitness**

Are you currently taking a multi-vitamin or other nutritional supplementation?  Yes  No

Are you interested in learning more about our **pharmaceutical grade supplements**?  Yes  No  
(pharmaceutical\_grade uses purest, highest quality ingredients, undergoes laboratory quality assurance testing and is manufactured for maximum absorption, unlike most on the market today)

If yes, please indicate areas of interest:  anti-oxidants for eye health and protection against free radicals

- multi-vitamins specifically designed for women
- multi-vitamins specifically designed for men
- vitamin and herbal blend specifically designed for insomnia
- natural alternative for weight loss
- herbal/vitamin blend for energy boost
- herbal/vitamin flavored drink for energy boost
- joint and ligament protection



**CONTACT LENS WEARERS AGREEMENT**

I understand that my contact lenses are a medical device and must be used and cared for properly. I understand that contact lenses have a limited useful life span and that I risk eye irritation, infection, possible corneal injury and possible vision loss if I exceed the wearing schedule prescribed by my optometrist. I further understand that contact lenses could potentially cause damage to my eyes and result in vision loss and that there are feasible alternatives such as spectacles available to me.

I understand that I must schedule and return for one progress visit within **ten days** of today in order to evaluate the lens fit and ensure the success of my contact lens wear. The contact lenses may have to be refit until an acceptable fitting is achieved. Following delivery to me of each new pair of contact lenses during this process, I agree to return within ten days for evaluation. **Failure to return for the progress visits within this time will automatically void any and all service agreements, warranties, guarantees, or possibilities of refund. The contact lens prescription is incomplete until the fitting is verified at the progress visit.** My first scheduled visit is \_\_\_\_\_.

**(Please come in for your follow-up visit wearing your contact lenses)**

I understand that any **yearly replacement** contact lenses are warranted against defect for ten days following delivery to me. Beyond this time there is no such warranty or guarantee against any tearing or breakage. **Any opened boxes of disposable lenses, color or custom contact lenses are non-returnable.** There is no warranty for lost contact lenses. Due to their fragile nature, frequent lens replacement is considered normal. **Professional examination and evaluation fees, however, are not refundable under any circumstances.**

I understand that the contact lens examination is specifically for the contact lenses prescribed, to be worn on a \_\_\_\_\_ schedule, and cared for with \_\_\_\_\_ cleaning and disinfecting system. If being fit with **Disposable** contact lenses, I understand that each pair of contacts should be disposed of every \_\_\_\_\_.

If being fit with **Monovision** – one lens for near and one for distance – I understand that my vision will not be as accurate as when both eyes are fitted for distance vision together. With this in mind, I should use caution when driving and during other such potentially dangerous tasks until I adapt and am completely comfortable. I understand that there are alternative available to me that would provide better vision such as spectacles or bifocal contact lenses. \_\_\_\_\_ (Patient’s initials)

I have read and will adhere to the advice, instructions, policies and procedures provided in this agreement as well as the patient instruction pamphlet included in the contact lens cleaning and disinfecting system which I have received today.

\_\_\_\_\_  
Patient’s/ Guardian’s Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dispensing Staff

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## Guide to Successful Contact Lens Wear

### **DO's**

- 1.) Discontinue contact lens wear immediately if you experience any redness or discomfort of the eyes. Remove the contact lenses and call your doctor immediately. Do not continue wearing your contact lenses when it is clear that something is wrong; you will only make things worse and endanger your vision.
- 2.) Always wash your hands with an oil free soap before handling your contact lenses. Proper hygiene is critical in helping prevent eye irritation and/or infections.
- 3.) When sleeping in contact lenses, whether by accident in your daily-wear contacts or routinely in your extended-wear contacts, remember to use artificial tears upon awakening. Also, NEVER remove your lenses immediately after waking up—use the artificial tears, wait 10 minutes, and then gently remove them.
- 4.) If you are new to contact lens wear start with 4 hours the first day and add 2 hours each day until you work up to a full day. If you are in extended-wear contact lenses, please return to see the Doctor after spending your first night in your contacts and then again after the first 3-6 nights.
- 5.) Daily-wear contact lenses are to be worn an average of 10-12 hours per day and are not designed to be slept in.
- 6.) If you are being fit with Toric, Bifocal, or Monovision contact lenses be aware that it is critically important to return for your scheduled progress visit. It is not uncommon for these types of lenses to require at least one refit beyond the first pair in order to achieve a healthy fit and provide acceptable and safe vision. It may take several visits to complete the fitting.
- 7.) Multipurpose solutions such as Renu, Complete, Optifree Express and Opti One are chemically milder than conventional daily cleaners and therefore must be used exactly as each package insert instructs in order to reduce the risk of infection.
- 8.) When using the weekly enzyme tablets, be sure to clean your lenses before and after the enzyme treatment, and remember to wash your contact lens case with soap & water and air-dry it before using it again.
- 9.) Be sure you are comfortable and capable with the insertion, removal, handling and care of your new contact lenses before leaving your doctor's office. Ask for additional instruction if necessary.

### **DON'T'S**

- 10.) Do not continue to wear lenses that are damaged, dirty or torn.
- 11.) Do not over-wear your contact lenses or sleep in your contact lenses (unless approved by your Doctor.) These can result in corneal complications that may result in permanent vision loss.
- 12.) Contacts absorb everything in the environment. This is why you should never swim in your contact lenses. You should also keep this in mind near smoky rooms, chemical labs, etc...
- 13.) Do not use eye medications on the eye while wearing your contact lenses. Always remove your contact lenses first, place the eye medication on the eye, wait 5 minutes, then place the contact lenses back on the eye.
- 14.) Opaque color contact lenses tend to cause "halo" at night for some individuals with pupils that tend to dilate more in low light situations. Be aware and use caution until comfortably adapted to this visual disturbance.
- 15.) Do not alternate or mix solutions. Use only the solutions recommended by your Doctor. Use fresh solution daily. Never use water or any solution not approved for your type of contact lenses.

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY**

We respect our legal obligation to keep health information that might identify you private. We are obligated by law to provide you with notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

**TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**

The most common reasons we would use or disclose your health information is for treatment, payment, or business operations. We routinely use and disclose your medical information within the office on a daily basis. We do not need specific permission to use or disclose your medical information in the following matters, although you have to right to request that we do not.

Examples of how we might use or disclose health information for treatment purposes might include:

Setting up or changing appointments including leaving messages with those at your home or office who may answer the phone or leaving messages on answering machines, voice mails or emails; prescribing glasses, contact lenses, or medications as well as relaying this information to suppliers by phone, fax or other electronic means including initial prescriptions and requests from suppliers for refills; notifying you that your ophthalmic goods are ready, including leaving messages with those at your home or office who may answer the phone, or leaving messages on answering machines, voice mails or emails; referring you to another doctor for care not provided by this office; obtaining copies of health information from doctors you have seen before us; discussing your care with you directly or with family or friends you have inferred or agreed may listen to information about your health; sending you postcards or letters or leaving messages with those at your home who may answer the phone or on answering machines, voice mails or emails reminding you it is time for continued care.

Examples of how we might use or disclose health information for payment purposes might include:

Asking you about your vision or medical insurance plans or other sources of payment; preparing and sending bills to your insurance provider or to you; providing any information required by third party payors in order to insure payment for services rendered to you; collecting unpaid balances either ourselves or through a collection agency, attorney, or district attorney's office.

Examples of how we might use or disclose health information for business operations might include:

Financial or billing audits; internal quality assurance programs; participation in managed care plans; defense of legal matters; business planning; certain research functions; informing you of products or services offered by our office; compliance with local, state, or federal government agencies request for information; oversight activities such as licensing of our doctors; Medicare or Medicaid audits.

**USES AND DISCLOSURES FOR OTHER REASONS NOT NEEDED PERMISSION**

In some other limited situations, the law allows us to use or disclose your medical information without your specific permission. Most of these situations will never apply to you but they could.

- When a state or federal law mandates that certain health information be reported for a specific purpose
- For public health reasons, such as reporting of a contagious disease, investigations or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices
- Disclosures to government or law authorities about victims of suspected abuse, neglect, domestic violence, or when someone is or suspected to be a victim of a crime
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative hearings
- Disclosures to a medical examiner to identify a deceased person or determine cause of death or to funeral directors to aid in burial
- Disclosures to organizations that handle organ or tissue donations
- Uses or disclosures for health related research
- Uses or disclosures to prevent a serious threat to health or safety of an individual or individuals
- Uses or disclosures to aid military purposes or lawful national intelligence activities
- Disclosures of de-identified information
- Disclosures related to a workman's compensation claim
- Disclosures of a "limited data set" for research, public health, or health care operations
- Incidental disclosures that are an unavoidable by-product of permitted uses and disclosures
- Disclosures to business associates who perform health care operations for Fine Eyewear and who commit to respect the privacy of your information
- Unless you object, disclosure of relevant information to family members or friends who are helping you with your care or by their allowed presence cause us to assume you approve their exposure to relevant information about your health

**USES OR DISCLOSURES TO PATIENT REPRESENTATIVES**

It is the policy of Fine Eyewear for our staff to take phone calls from individuals on a patient's behalf requesting information about making or changing an appointment; the status of eyeglasses, contact lenses, or other optical goods ordered by or for the patient. Fine Eyewear staff will also assist individuals on a patient's behalf in the delivery of eyeglasses, contact lenses, or other optical goods. During a telephone or in person contact, every effort will be made to limit the encounter to only the specifics needed to complete the transaction required. No information about the patient's vision or health status may be disclosed without proper patient consent. Fine Eyewear staff and doctors will also infer that if you allow another person in an examination or treatment room with you while testing is performed or discussions held about your vision or health care that you consent to the presence of that individual.

### **OTHER USES AND DISCLOSURES**

We will not make any other uses or disclosures of your health information unless you sign a written *Authorization for Release of Identifying Health Information*. The content of this authorization is determined by federal law. The request for signing an authorization may be initiated by Fine Eyewear or by you as the patient. We will comply with your request if it is applicable to the federal policies regarding authorizations. If we ask you to sign an authorization, you may decline to do so. If you do not sign the authorization, we may not use or disclose the information we intended to use. If you do elect to sign the authorization, you may revoke it at any time. Revocation requests must be made in writing to the Privacy Officer named at the beginning of this Notice.

### **YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

The law gives you many rights regarding your personal health information.

You may ask us to restrict our uses and disclosures for purposes of treatment (except in emergency care), payment, or business operations. This request must be made in writing to Privacy Officer named at the beginning of this Notice. We do not have to agree to your request, but if we agree, must honor the restrictions you ask for.

You may ask us to communicate with you in a confidential manner. Examples might be only contacting you by telephone at your home or using some special email address. We will accommodate these requests if they are reasonable and if you agree to pay any additional cost, if any, incurred in accommodating your request. Requests for special communication requests must be made to the Privacy Officer named at the beginning of this Notice.

You may ask to review or get copies of your health information. There are a very few limited situations in which we may refuse your access to your health information. For the most part we are happy to provide you with the opportunity to either review or obtain a copy of your medical information. All requests for review or copy of medical information must be made in writing to the Privacy Officer named at the beginning of this Notice. While we usually respond to these requests in just a day or so, by law we have fifteen (15) days to respond to your request. We may request an additional thirty (30) day extension in certain situations.

You may ask us to amend or change your health care information if you think it is incorrect or incomplete. If we agree, we will make the amendment to your medical record within thirty (30) days of your written request for change sent to the Privacy Officer named at the beginning of this Notice. We will then send the corrected information to you or any other individual you feel needs a copy of the corrected information. If we do not agree, you will be notified in writing of our decision. You may then write a statement of your position and we will include it in your medical record along with any rebuttal statement we may wish to include.

You may request a list of any non-routine disclosures of your health information that we might have made within the past six (6) years (or a shorter period if you wish). Routine disclosures would include those used your treatment, payment, and business operations of Fine Eyewear. These routine disclosures will not be included in your list of disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you must pay for them in advance at a fee of \$500 per list. We will usually respond to your written request (made to the Privacy Officer named at the beginning of this Notice) within thirty (30) days but we are allowed one thirty (30) day extension if we need the time to complete your request.

You may obtain additional copies of this Notice of Privacy Practices from our business office or online at our website address shown at the beginning of this Notice.

### **CHANGING OUR NOTICE OF PRIVACY PRACTICES**

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change the Notice. We reserve the right to change this Notice at any time. If we change this Notice, the new privacy practices will apply to your existing health information as well as any additional information generated in the future. If we change this Notice, we will post a new Notice in our office and on our website.

### **COMPLAINTS**

If you think that anyone at Fine Eyewear has not respected the privacy of your health information, you are free to complain to the Privacy Officer named at the beginning of this Notice. We are more than happy to try to resolve any concern you may have in writing or by phone. You may also file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you if you make such a complaint.

**ACKNOWLEDGEMENT  
OF  
NOTICE OF PRIVACY PRACTICES**

The law requires that Fine Eyewear make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

**(PLEASE SELECT ONLY ONE OPTION)**

- I have read or had explained to me Fine Eyewear’s Notice of Privacy Practice and agree to continue my care with Fine Eyewear under said terms.
- I was given the opportunity to read Fine Eyewear’s Notice of Privacy Practices and declined but wish to continue my care with Fine Eyewear under the terms of Fine Eyewear’s privacy policies.

**I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.**

\_\_\_\_\_

Patient

\_\_\_\_\_

Date

If you are signing as a personal representative of the patient, please indicate your relationship

\_\_\_\_\_

Representative

\_\_\_\_\_

Relationship to Patient