

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

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.

