revINTAKE

Date: ______________

DEMOGRAPHICS

First Name ______________ Middle Name ______________ Last name ______________

Address ______________________________ Suffix ______________

City ______________ State ______________ Zip Code ______________

Date of Birth ______________ SSN ______________ Sex ○ Male ○ Female

Cell phone ______________ Home phone ______________ Work phone ______________

Preferred contact method ☐ Cell ☐ Home ☐ Work

Email ______________________ Language ______________________

Race ______________________ Ethnicity ______________________

Marital status ○ Single ○ Married ○ Other

Employment status

○ Employed Full Time ○ Employed Part Time ○ Student Full Time ○ Unknown

○ Student Part Time ○ Not Employed ○ Retired ○ None

○ Homemaker ○ Active Military ○ Disabled

What is your driver's license number? ______________________

Who is your employer? ______________________

What is your position/occupation? ______________________

revINTAKE

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Company Name ______________________________

Policy Holder ______________________ Policy Holder Date of Birth ______________

Relationship of Policy Holder ○ Spouse ○ Child ○ Other

Policy Number ______________________________

SECONDARY INSURANCE:

Insurance Company Name ______________________________

Policy Holder ______________________ Policy Holder Date of Birth ______________

Relationship of Policy Holder ○ Spouse ○ Child ○ Other

Policy Number ______________________________

revINTAKE

REASON FOR VISIT

Please tell us why you're coming to see us ______________________

If another provider sent you to us, who? ______________________

EYE HISTORY

When was your last eye exam? ______________________

Who was your previous eye doctor? ______________________

Have you ever had any eye injuries, surgeries for your eyes, or been diagnosed with an eye disease?

- ☐ Negative/No condition
- ☐ Glaucoma suspect
- ☐ Glaucoma
- ☐ Cataract
- ☐ Age related macular degeneration
- ☐ Surgery
- ☐ Patching
- ☐ Inflammatory disorders
- ☐ Strabismus
- ☐ Amblyopia
- ☐ Retinal degeneration
- ☐ Retinal hole
- ☐ Retinal detachment
- ☐ Keratoconus
- ☐ Injury
- ☐ Dry eye
- ☐ Nystagmus
- ☐ Retinal degeneration\ hole\ detachment
- ☐ Other

Do you wear glasses? ○ Yes ○ No

How old are your glasses? ______________________

What don't you like about your current glasses? ______________________

Do you wear contact lenses? ○ Yes ○ No

What brand of contact lenses do you wear? ______________________

What is your contact lens prescription for the right eye? ______________________

What is your contact lens prescription for the left eye? ______________________

What solution(s) do you use to clean your contact lenses? ______________________

Do you sleep in your contact lenses? ○ Yes ○ No

How often do you start a new pair of lenses? ○ Daily ○ Monthly ○ Quarterly ○ Other

What don't you like about your contact lenses? ______________________

revINTAKE

HISTORY OF PRESENT ILLNESS

Are you having any problems with your eyes? ○ Yes ○ No

What problem are you having? ______________________________

Which eye is affected? ______________________________

How would you describe the quality of the problem?

☐ Awareness ☐ Bothersome ☐ Painful

How would you describe the severity of the problem?

○ Mild ○ Moderate ○ Severe

When did the problem begin? ______________________________

Have you ever had this problem before?

○ New Condition ○ Return of Previous Condition ○ Ongoing Condition

Is the problem associated with any of the following conditions?

○ Associated with injury ○ Associated with infection
○ Associated with medical condition ○ Associated with surgery

What have you done to try to make the problem better?

☐ Taking medication ☐ Taking drops ☐ Treated by another provider

Are any symptoms associated with the problem?

☐ Burning ☐ Loss of vision
☐ Tearing ☐ Headache
☐ Mattering ☐ Photophobia
☐ Flashes ☐ Diplopia
☐ Floaters ☐ Red
☐ Loss of sharpness ☐ Itching

revINTAKE

REVIEW OF SYSTEMS

Allergy/Immunology
- ☐ Drug Allergies
- ☐ Environmental Allergies
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Sjogren's Syndrome
- ☐ Other
- ☐ Negative

Hematology/Lymphatic
- ☐ Anemia
- ☐ Large Volume Blood Loss
- ☐ Ulcer
- ☐ Hypercholesteremia
- ☐ Other
- ☐ Negative

Cardiovascular
- ☐ Hypertension
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congestive Heart Failure
- ☐ Stroke/CVA
- ☐ Other
- ☐ Negative

Psychological
- ☐ Depression
- ☐ Attention Deficit
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Other
- ☐ Negative

Gastrointestinal
- ☐ Crohns
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflux
- ☐ Celiac Disease
- ☐ Other
- ☐ Negative

Neurological
- ☐ Multiple Sclerosis
- ☐ Cerebral Palsy
- ☐ Tumors
- ☐ Stroke/CVA
- ☐ Migraines
- ☐ Autism Spectrum Disorder
- ☐ Epilepsy
- ☐ Other
- ☐ Negative

Ear, Nose & Throat
- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis
- ☐ Other
- ☐ Negative

Integumentary (SKIN)
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Herpest Simplex/ Cold Sores
- ☐ Herpes Zoster/ Shingles
- ☐ Other
- ☐ Negative

Genitourinary
- ☐ Kidney Disease
- ☐ Prostate Disease
- ☐ STD-herpetic/chlamydia
- ☐ Benign Prostate Hypertrophy
- ☐ Pregnant
- ☐ Nursing
- ☐ Herpes
- ☐ Chlamydia
- ☐ Other
- ☐ Negative

Musculoskeletal
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Other
- ☐ Negative

Constitution
(e.g. fever, Weight loss, etc)
- ☐ Developmental Disabilities
- ☐ Cancer
- ☐ Fatigue Syndrome
- ☐ Other
- ☐ Negative

Respiratory
- ☐ Cigarette Smoker
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Obstruction
- ☐ Sleep Apnea
- ☐ Other
- ☐ Negative

Endocrine
- ☐ Type 2 Diabetes Mellitus
- ☐ Type 1 Diabetes Mellitus
- ☐ Thyroid dysfunction
- ☐ Hormonal Dysfunction
- ☐ Other
- ☐ Negative

Comments:

revINTAKE

MEDICATIONS

Do you take any prescription or non-prescription medications? ○ Yes ○ No

What is the name of the medication? How often do you take this medication?

Please feel free to share any information about your medications here

What pharmacy do you use? ______

ALLERGIES

Are you allergic to any medications? ○ Yes ○ No

What medication(s) are you allergic to? How severe is your allergy?

Do you have any other allergies? ○ Yes ○ No

What medication(s) are you allergic to? How severe is your allergy?

revINTAKE

PAST, FAMILY AND SOCIAL HISTORY

Who is your primary care physician? ____________________

DIABETES HISTORY

Do you have diabetes? ○ Yes ○ No

How long have you had diabetes? ____________________

What physician is treating your diabetes? ____________________

How frequently do you see your physician for diabetes care? ____________________

What was your last hemoglobin A1c reading? ____________________

FAMILY MEDICAL HISTORY

Does anyone in your family have any of the following medical conditions?

☐ None ☐ Hypertension ☐ Diabetes ☐ Cancer ☐ Thyroid ☐ Other

Does anyone in your family have any of the following eye conditions?

☐ None ☐ Severe Myopia ☐ Macular Degeneration ☐ Cataract ☐ Nystagmus
☐ Glaucoma suspect ☐ Severe Hyperopia ☐ Amblyopia ☐ Dry eye
☐ Glaucoma ☐ Strabismus ☐ Retinal Detachment ☐ Other

SOCIAL HISTORY

Do you drink alcohol? ○ Yes ○ No ○ Unknown

How often do you drink alcohol? ____________________

Do you use tobacco products? ○ Yes ○ No ○ Unknown

What tobacco product do you use?

☐ Cigarettes ☐ Cigars ☐ Pipes ☐ Smokeless tobacco ☐ Other ☐ No preference

How often do you use tobacco products? ____________________

Do you currently or have you ever smoked tobacco products?

☐ Smoker Current status unknown ☐ Never smoker ☐ Former smoker
☐ Current every day smoker ☐ Heavy toboacco smoker ☐ Light tobacco smoker
☐ Current some day smoker ☐ Unknown if ever smoked

Do you have any hobbies? ____________________

Vision Professionals

Financial Policy

Financial Policy and Third Party Policy:

There are two types of insurance that will help pay for your eye care services and products. You may have both

1. Vision care plans (such as VSP, EyeMed and Humana Vision)
   - Vision care plans only cover routine vision exams along with eyeglasses and/or contact lenses. They do not cover diagnosis, management or treatment of medical eye conditions.

2. Medical insurance (such as Aetna, Anthem, Cigna, Medical Mutual, Medicare and UHC)
   - Medical insurance must be used if you have any medical eye problem (dry eye, cataracts, glaucoma, floaters) or a systemic health problem that has ocular complications (diabetes, Hypertension, etc.). Your doctor will determine if these conditions apply to you.
   - If you have both types of insurance plans we will coordinate benefits for medical and vision to minimize your out-of-pocket expense.
   - We will bill your insurance plan for services if we are a participating provider for that plan. If some fees are not paid by your plan, we will bill you for any non-covered services. A doctor will discuss any non-covered services prior to administration.

Payments: Payment and/or co-payments for services are due in full on the day of service. Payment and/or co-payments for materials (frames, lenses, contact lenses, etc.) are due in full on the day the order is placed.

Returned Checks:

There is a fee of $35.00 for any checks returned by the bank.

Waiver of Confidentiality:

We will release your medical information in order to process third party claims on your behalf. If your account is submitted to an attorney, collections agency, court litigation occurs, or if you're past due status is reported to a credit reporting agency, prior medical treatment becomes a matter of public record.

I have read the above statement and agree to the content. In addition, I give my permission to Vision Professionals to provide any necessary Optometric services for myself and for any of my dependents. I understand that I will be financially responsible for non-covered services. In the course of my visit. I acknowledge the fact that my eye care provider will bill my insurance according to my eye care needs and diagnosis.

Patients Name:______________________________ Parent with Child:__________________________________

Signature:____________________________________ Date:______________________

Vision Professionals | Notice of Privacy Practices

Effective 12/31/2019

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. You can get an electronic or paper copy of your medical record:

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information. We may charge a reasonable, cost-based fee.

ASK US TO CORRECT YOUR MEDICAL RECORD

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days

REQUEST CONFIDENTIAL COMMUNICATIONS

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

ASK US TO LIMIT WHAT WE USE OR SHARE

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

GET A LIST OF THOSE WITH WHOM WE'VE SHARED INFORMATION

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

GET A COPY OF THIS PRIVACY NOTICE

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

CHOOSE SOMEONE TO ACT FOR YOU

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

FILE A COMPLAINT IF YOU FEEL YOUR RIGHTS ARE VIOLATED

- You can complain if you feel we have violated your rights by contacting us at 614-880-2020.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

HOW DO WE TYPICALLY USE OR SHARE YOUR HEALTH INFORMATION?

We typically use or share your health information in the following ways:

TREAT YOU

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

RUN OUR ORGANIZATION

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

BILL FOR YOUR SERVICES

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

HELP WITH PUBLIC HEALTH AND SAFETY ISSUES

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

DO RESEARCH

We can use or share your information for health research.

COMPLY WITH THE LAW

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

RESPOND TO ORGAN AND TISSUE DONATION REQUESTS

We can share health information about you with organ procurement organizations.

WORK WITH A MEDICAL EXAMINER OR FUNERAL DIRECTOR

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

ADDRESS WORKERS' COMPENSATION, LAW ENFORCEMENT, AND OTHER GOVERNMENT REQUESTS

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

RESPOND TO LAWSUITS AND LEGAL ACTIONS

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

FOR MORE INFORMATION SEE:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Patient Name:______________________________

Signature:_________________________________

Date:____________________

Notice of Privacy Practices
This notice describes how your personal health record information may be used or disclosed and how you may gain access to this information. Full copies are available by request in the office or available on our website. Please sign indicating that you have been made aware of our Notice of Privacy Practices regarding HIPAA policies and offered a copy for your personal records.

Contact Lens Prescription Acknowledgement
If you are having a contact lens evaluation performed at this exam, we will provide you with a copy of your prescription at the end of the contact lens evaluation process. You may also request this prescription to be e-mailed to you.
By agree this online form you acknowledge that you were provided with a copy of your contact lens prescription at the completion of your contact lens evaluation.

Financial Responsibility Agreement

- I am financially responsible for all charges incurred during eye exams or office visits to Vision Professionals
- **All charges are non-refundable. Payment is due at time of service.**
- **If my insurance is billed and does not pay for ANY reason, I am responsible for full payment of remaining charges.**
- Routine exams for eyeglasses include one follow up appointment within 60 days of the initial examination. Any visits outside of the 60 days WILL INCUR an office visit charge.
- Certain Contact lens evaluations including toric, monovision, multifocal, and first-time wearers carry an additional fee. Contact lens evaluations cover up to 2 follow-up visits and these must be completed within 60 days of the initial contact lens evaluation. Any visits outside of the 60 days WILL INCUR an office visit charge.
- Routine eye exams do not cover eye disease treatment or monitoring. Medical visits for red-eyes, dry eye/allergy treatment, foreign body removal (including contact lens and eyelash removal), and other medical services will be billed their corresponding office visit charges.

Patient Name: ______________________________

Patient Signature: ____________________ Date ____________