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North Raleigh Family Eyecare

As a patient of our practice, we would like to offer a warm welcome and our thanks for choosing us to provide your eye health and vision care. In order for us to complete your file, and provide the most beneficial use of your time with us, the doctor has asked you to complete the following tasks and bring the results to your appointment. The doctor needs this information in order to give you the best care possible.

□ **Completed Patient Health Questionnaire**: Since many general health conditions may be associated with visual symptoms and/or eye health problems, this important record (now required by virtually all insurance plans) will allow us to care for you as a "whole person" rather than just a pair of eyes.

□ **Insurance cards:** You must provide all insurance cards at the time of your visit. Even for "routine" visits, if a medical eye condition is discovered we can submit a claim to your health insurance for the medical evaluation portion of your examination.

□ **Eyeglasses:** Please bring your current eyeglasses and sunglasses (even if they seem to be incorrect, broken or not worn often).

□ **Contact Lenses:** If you are getting a contact lens exam, it is best to wear your current contacts to your appointment if possible. Next best is to bring them along in your case. It is very helpful and will save you time if you bring along your cartons or lens packets that indicate the lens series, power, manufacturer, etc. or your written contact lens prescription.

□ **Eye drops, ointments, etc:** Please bring eye drops or ointments with you to review.

□ **Payment**: Payment is due at the time of service unless other arrangements have been made prior to the day of your appointment. We accept cash, checks, money orders, Visa, Mastercard and Discover.

□ **Arrival:** Please arrive promptly at your scheduled appointment time. We request 24 hours notice (but a minimum of 4 hours is required) to reschedule your appointment. If you arrive 15 minutes after your scheduled appointment time, you may be asked to reschedule and then marked as a missed appointment.

CONSENT TO TREAT and HIPAA RELEASE: I voluntarily consent to such care and treatment as prescribed by the doctor as is necessary in his/her medical judgment. I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used in order to: 1. Conduct, plan, direct my treatment & follow-up among staff, involved in that treatment directly & indirectly. 2. Obtain payment from third-party payers, insurance carriers and patient collection activities. 3. Conduct normal healthcare operations such as quality assessment and physician certification.

Our complete Notice of Privacy Practices is available upon request. North Raleigh Family Eyecare, reserves the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. You may request in writing any restrictions on how your private information may be used or disclosed for healthcare operations or payment. NRFE is not required to agree to requested restrictions, although it must abide by such restrictions if an agreement is reached. This consent may be revoked in writing at any time, except to the extent that action has been taken relying on this consent.

INSURANCE and FINANCIAL POLICY: All patients are ultimately responsible for their own bill. Patients who have health care coverage are responsible for providing the office with complete and accurate information regarding their insurance and necessary referrals for office visits. We have made prior arrangements with many insurers and other health plans. We will bill those plans with which we have an agreement and will collect any required copay at the time of service. In the event your health plan determines a service to be "not covered" you will be responsible for the complete charge. In that event, we will bill you and payment is due upon receipt of our statement.

Failure to inform office personnel about your vision plan at the start of your appointment will result in you being billed for charges incurred. North Raleigh Family Eyecare will follow up on unpaid insurance claims. However, your policy is an agreement between you and your insurance company and it is your responsibility to assure that your services are paid in full. Occasionally insurance benefits may be unable to be verified or authorized prior to a patients appointment. Due to different processing & filing requirements of insurance carriers our office will not subsequently file (or refund) for benefits should coverage be identified later.

Full payment for services rendered or materials ordered are expected at the time of service. For your convenience we accept, CASH, CHECK, VISA, DISCOVER and MASTERCARD. Accounts become past due after 90 days. We reserve the right to send the account to a collection & credit-reporting agency, apply a monthly service fee (twenty-dollars) in addition to all collection fees incurred.

Signature:_____ **Print Name:**_____ **Date:**_____.

Patient Health Questionnaire

Please help us by completing this form accurately.

North Raleigh Family Eyecare

Patient: _____

First Name | Middle Name | Last Name | *Occupation

DOB: _____ Age: _____ Primary Care Physician: _____ Date of Last Eye Exam: _____

Do you have any CURRENT ocular complaints which you would like the doctor to know about today? HPI Ocular Complaint

Allergies	Y N	Pain	Y N	Red Eye	Y N	Dry Eye	Y N
Burning	Y N	Eye Fatigue	Y N	Squinting	Y N	Headaches	Y N
Watery	Y N	Double Vision	Y N	Floaters	Y N		

Are you having vision difficulties today? Yes or No If Yes, then please answer questions below. HPI Vision Complaint

WITH Glasses Y N	Right Eye	Left Eye	Both Eyes	Distance	Intermediate Near
WITHOUT Glasses Y N	Right Eye	Left Eye	Both Eyes	Distance	Intermediate Near
WITH Contact Lenses Y N	Right Eye	Left Eye	Both Eyes	Distance	Intermediate Near

HPI Ocular Contacts

Do you currently wear Contact Lenses? Yes* No. (*If Yes then answer questions below.) **Are you interested in contacts today? Y N**

How often do you wear contacts? ( ) Most of the time ( ) On occasion ( ) Would like to wear more ( ) Cannot be worn

How is your vision with contacts? ( ) Satisfactory ( ) Needs Improvement If Y, what distance? ( ) Distance ( )Intermediate ( ) Near

What is the comfort of your contacts? ( ) Comfort OK ( ) Excessive Discomfort When were you first fit in contacts?

Do you experience any of the following? ( ) Dryness ( ) Redness ( ) Burning ( ) Light Sensitivity ( )Lens Movement

Medial Hx | Ocular Hx

Please provide your PERSONAL health and ocular history.

Diabetes	Y N	Cholesterol	Y N	Rosacea	Y N	Glaucoma	Y N	Eye Turn	Y N	Macular Degn	Y N
HIV/AIDS	Y N	Hypertension	Y N	Cancer	Y N	Cataracts	Y N	Dry Eye	Y N	Retinal Detach	Y N
Arthritis	Y N	Auto-Immune	Y N	Parkinson's	Y N	Sjogrens	Y N	Retinopathy	Y N	Color Blind	Y N

Do you wear glasses? Y N If Y: Full time Occasionally Do you smoke? Y N Alcohol Use: Y N

Have you noticed a vision change with your glasses? Y N Pt Hx Female Patients: Are you pregnant? Y N

Spectacles

Do you wear polarized lenses in your sunglasses? Y N **Allergies:**

Do you have glare or night driving problems? Y N

Do you work at a computer? Y N If Y, how many hours? **Medications:**

Are your glasses for: Distance Near Reading Bifocal

Eye Surgery / Injuries **General Surgeries:**

Do you have problems with any of these systems? Review ofSystems

Gastrointestinal Y N	Nerves Y N	Psychological Y N	Eyes Y N
Ears/Nose/Throat Y N	Urinary Y N	Endocrine Y N	Teeth Y N
Cardiovascular Y N	Bones Y N	Blood/Lymph Y N	Skin Y N

Family History Family Ocular - Systemic

Diabetes Y N	Auto-Immune Y N	Glaucoma Y N	Retinal Detachment Y N
HIV / AIDS Y N	Cancer Y N	Cataracts Y N	
Arthritis Y N		Macular Degeneration Y N	

Notes/Add'l Medications:

Sign:_____ **Print:**_____ **Date:**_____

Health Changes: Y N Sign:_____ Print:_____ Date:_____.

Health Changes: Y N Sign:_____ Print:_____ Date:_____.

Health Changes: Y N Sign:_____ Print:_____ Date:_____.

Patient Health Questionnaire

Please help us by completing this form accurately.

North Raleigh Family Eyecare

PUPIL DILATION: Dilation involves instilling eye drops for the purpose of enlarging the pupils of the eyes. This allows a better examination of the eyes' internal structures. Thorough examination of these structures is necessary to rule out various eye diseases or pathology. ***Dilation is recommended for a comprehensive eye examination & when done at that time results in no additional charges. Without dilation I understand my ocular health cannot be thoroughly evaluated.***

Dilation of the pupil causes temporary sensitivity to light and blurring of near vision in most individuals. Blurring of the distance vision may occur as well in individuals with uncorrected farsightedness. You should not operate heavy equipment or drive an automobile unless you are comfortable with your vision. Dark glasses will be provided after your examination to aid with the light sensitivity.

_____ ***YES, I will have my eyes dilated.*** _____ ***NO, I choose not to be dilated.***

RETINAL IMAGING: Retinal imaging is an advanced digital retinal photograph. By taking a digital fundus photo image of the back portion of the eye (the retina), the doctor can detect and monitor ocular health. The screening picture that is produced captures a clear view of the optic nerve, blood vessels, macula and fovea.

Retinal imaging can be a baseline measurement for future comparison. A look at the internal view of the eye can be key in detecting Glaucoma, Macular Deneration, Diabetic retinopathy, High Blood Pressure, High Cholesterol, Retinal detachments and many more eye issues detectable at very early stages. ***Retinal imaging is recommended by North Raleigh Family Eyecare for a comprehensive eye examination and typically is not covered by insurance. The fee is $30***

_____ ***YES, I would like to have retinal imaging.*** _____ ***NO, I will not have retinal imaging.***

CONTACT LENS SERVICES: Insurance companies require that services related to contact lenses are separated from routine eye exams. To cover the extra time and tests performed, as well as any necessary follow-up visits a Contact Lens Fitting Fee is required for all contact lens patients.

Although each insurance is different, the Contact Lens Fitting Fee is generally determined by: 1. Complexity of the fit, including: sphere, astigmatism, monovision, bifocal, multifocal or RGP. 2. New or current contact lens wearer / patient history. 3. Ocular characteristics and health including conjunctiva, cornea and tear film. This fee is determined at the completion of the exam when all of the patient's needs have been assessed.

The Contact Lens Fitting Fee entitles the patient to three (3) follow-up visits within 60 days, specifically to confirm the vision, fit and comfort of the prescription. Each patient is encouraged to use these follow-up visits if necessary, as receipt of the final prescription and /or ordering a supply constitutes final acceptance. Contact Lens Fitting Fees are billable and non-refundable upon initiation of treatment. In accordance with manufacturer guidelines, our office cannot be responsible for opened, defaced or damaged boxes.

EYEWEAR AND LENSES: Proper selection and use of eyewear is critical to your eye safety. No single pair of eyeglasses is best for all situations, so make sure you consider how your eyeglasses will be used before deciding whether to wear dress, safety or sports eyewear. For tasks that require impact protection and children under the age of 18, polycarbonate lenses should be used. Of all materials that spectacle lenses may be fabricated from, polycarbonate lenses are the most impact resistant.

Unless specifically stated, your new eyeglasses are dress eyewear, not safety or athletic spectacles. The type and style of a spectacle frame is an important factor in determining how much protection your eyeglasses will provide. Most frames are fragile and are designed for appearance and NOT for protection.

Your lenses meet or exceed ANSI Z80.1 and FDA requirement 21 CFR Section 801.410 for impact resistance, but they are not unbreakable or shatterproof. If struck with sufficient force, the lenses can break into sharp pieces that can cause serious injury to the eye or blindness. Even if the lenses do not break, the force of impact may cause the lenses or spectacle frame to contact the eye or surrounding area, causing injury. The continued impact resistance of your lenses depends on how well you protect them from physical shocks and abuse. For your own protection, scratched or pitted lenses should be replaced immediately. If your occupation or recreational activities expose you to the risk of flying objects or physical impacts, your eye safety requires special spectacles with safety lenses, side shields, goggles and/or a full-face shield.

We want you to be happy with your eyewear purchase so please let us know within 14 days if you are having any adaption problems. Glasses, contacts and other supplies purchased from our office are non-refundable. We are happy to adjust your glasses, replace nose pads and screws at no charge.

Signature:_____ Print Name:_____ Date:_____.