ALABAMA FAMILY EYE CARE

Mr / Mrs / Ms / Dr / Prof **Full name**:_____ **Preferred name**:_____

Date of Birth: ____/____/_____ **SSN**: _____-_____-_____ **Gender**: M / F **Marital Status**: S / M / D / W

Race: _____ **Ethnicity:** Hispanic / Non-hispanic

Home #:_____ **Work #**:_____ **Cell #**:_____

Address:_____ **City:** _____ **State:**_____ **Zip:**_____

Email:_____ **Preferred Method of Contact**: Home / Cell / Text / Email

Permission to text/email you regarding your account, records, and/or appointments: Yes / No

Who may we thank for referring you? _____ **Occupation**:_____

Hobbies:_____

Health History (circle all that apply):

Constitutional
No
Developmental disabilities
Cancer
Fatigue syndrome
Other

ENT
No
Hearing loss
Sinusitis
Dry mouth
Laryngitis
Other

Neurological
No
Multiple Sclerosis
Epilepsy
Cerebral Palsy
Tumor
Stroke
Migraine
Other

Psychiatric
No
Depression
Attention deficit
Anxiety disorder
Bipolar disorder
Other

Cardiovascular
No
Hypertension
Stroke
Heart disease
Vascular disease
Congestive heart failure
Other

Respiratory
No
Cigarette smoker
Asthma
Bronchitis
Emphysema
Chronic obstruction
Sleep apnea
Other

Gastrointestinal
No
Crohn's
Colitis
Ulcer
Acid reflux
Celiac disease
Other

Genitourinary
No
Kidney disease
Prostate disease/cancer
STD
Prostate hypertrophy
Pregnant
Nursing
Herpes
Chlamydia
Other

Musculoskeletal
No
Osteoarthritis
Arthritis
Fibromyalgia
Muscular Dystrophy
Ankylosing spondylitis
Osteoporosis
Gout
Other

Integumentary
No
Eczema
Rosacea
Psoriasis
Cold sores
Shingles
Other

Endocrine
No
Type 2 Diabetes
Type 1 Diabetes
Thyroid dysfunction
Hormone dysfunction
Other

Hem/Lymph
No
Anemia
Blood loss
Ulcer
High cholesterol
Other

Allergic/Immune
No
Drug allergies
Environmental allergies
Sjogren's Syndrome
Lupus
Rheumatoid arthritis
Other

Tobacco Use (circle one):
Current every day smoker
Current some days smoker
Former smoker
Never smoke

Medications (if extensive, we can make a copy of your list):_____

Patient (or Guardian) Signature _____ **Date:** _____

Digital Wellness Retinal Photography

Wellness retinal photographs provide the doctor with a full digital image of the central retina (the back of the eye) and its structures (the optic nerve, macula, and main blood vessels).

Our doctors recommend these photographs on all patients because there are normal variations in these eye structures from person to person, and it is good to have a record of each individual patient's eye to monitor for gradual changes over time. These are also highly recommended if a patient has a family history of eye disease.

In some patients, these images may detect undiagnosed eye disease. Many eye diseases cause slow structural changes over time. Having a reference image allows your doctor to more accurately identify changes in your eye structures and treat diseases at an earlier stage. It is important that we identify changes early as there are usually no symptoms of damage until significant vision loss has occurred.

If the doctor determines that you need more extensive medical testing, this will be discussed during your exam. Some examples of when additional testing would be necessary include patients with Diabetes, Glaucoma, Macular Degeneration, or abnormal examination findings. These additional tests should be covered by your medical insurance but are subject to your normal medical copay, deductible, or coinsurance.

Because we feel wellness photographs are so important, the fee has been discounted to $30.00.

Initial: _____ I wish to have photographs taken _____ No thank you, not today

Contact Lens Policies

A contact lens fitting or an evaluation of your current lenses are performed in addition to a standard comprehensive eye exam and may require follow-up visits to obtain the best fit. Your contact lens prescription is valid for 1 year. At the end of that year, a new exam and contact lens evaluation will be required to renew your prescription. Our fitting fee provides trial lenses and a 60-day period to ensure a good fit (if more time is required to ensure the best fit, another fitting fee will be necessary).

Fitting Fees (before insurance):

Evaluation of current contact lens prescription: $75
New contact lens fitting fees start at $95

The patient will be responsible for these fees at the time of service.

_____ Yes, I wish to proceed with Contact Lens services at this time, and I understand the contact lens policies stated above.

_____ No, I do not wish to proceed with a Contact Lens service at this time. I understand I will not receive an updated/valid contact lens prescription without a contact lens fitting.

X_____

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Your eye exam today will either be a **ROUTINE EXAM** or a **MEDICAL EXAM**.

A **Routine Exam** is when a patient has **no medical history or problem** that would directly affect the visual system. Our comprehensive routine exam includes a total ocular health assessment, refraction, dilation and a prescription for glasses. **Vision insurance plans** are used for well vision visits.

A **Medical/Problem Focused Exam** is when the doctor identifies the presence of disease or if a patient is experiencing pain, ongoing headaches, dry eyes, or other symptoms indicative of a medical issue. A medical exam is necessary for all glaucoma and diabetic patients as well as any patients with a medical history that directly affects the visual system. **Medical/Health insurance plans** are used for medical exams.

INSURANCE POLICIES

1. If you do not inform us that you have a vision plan or medical insurance before services are rendered, we must assume no coverage exists. **Please provide our office with your current insurance information before arriving to your appointment.**
2. For your convenience, we will attempt to contact your insurance company to verify your benefits at our clinic prior to your initial visit.
3. We will gladly file your vision/medical insurance claim as a courtesy to you.
4. We have no control over your contract with your insurance company.
5. Because insurance policies vary greatly, we can only estimate coverage in good faith. **We at no time guarantee what your insurance will and will not cover.**
6. I agree this office will not back-file claims or refund fees after services are rendered due to lack of notification of vision or medical benefits (with no exceptions).
7. I agree I am responsible to file my own claim if I discover I have vision or medical benefits after services or products are rendered.
8. I understand that I am financially responsible today for all fees. I also agree that I am financially responsible for any and all fees not collected in full on the date of service or should my insurance plan deny payment or apply it to my deductible for services or materials rendered.

Signature of Responsible Party and Consent to Treat: _____

Print name of Responsible Party: _____

Patient Name (Please Print): _____ Date: _____

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ACKNOWLEDGEMENT OF PRIVACY POLICY AND PRACTICES

I understand that in an attempt to protect the privacy of my identifiable health information, Alabama Family Eye Care has established a ***Privacy Notice*** outlining the privacy policies and practices within their office. This information details the use and/or disclosure of information contained in my personal medical/optometric records kept for the purposes of diagnosis, treatment, payment, and health care operations. In accordance with HIPAA regulations, a copy of the ***Alabama Family Eye Care Privacy Notice*** has been made available to me while in the office today. Should I choose to have a personal copy, one will be given to me at no charge.

By signing this, I acknowledge that the ***Alabama Family Eye Care Privacy Notice*** was made available to me. In addition, I authorize all doctors and employees of Alabama Family Eye Care to share any of my related identifiable health information with my referring and family physicians, and with any of the following people:

_____

_____

_____

_____

_____
Printed Name of Patient

_____ _____
Patient (or Guardian) Signature Today's Date