Welcome to Visionary Eyeworks

Patient Information

Date: _____/_____/_____

Salutation: ☐Mr. ☐Mrs. ☐Ms. ☐Dr.

Name: _____ Nickname: _____

Suffix: ☐Jr. ☐Sr. ☐II ☐III Credentials: ☐MD ☐OD ☐DO ☐DDS ☐PHD

Address: _____

Apt #: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____ Preferred Communication: ☐Phone ☐Email

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

Gender: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Other

Guardian: _____ Relationship: _____ Phone Number: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

How did you hear about us?

☐Drive by/Signage ☐Advertisement ☐Facebook/Twitter/Instagram ☐Google ☐Yelp
☐Insurance ☐CareCredit ☐Doctor Referral: _____
☐Barter Rewards ☐Friend or Family: _____

Primary Care Physician: _____

Previous Eye Doctor: _____ Last Eye Exam: _____/_____/_____

Employer: _____ Occupation: _____
Sports/Hobbies: _____

Drink: ☐Yes ☐No Smoke: ☐Yes ☐No

Major Injuries/Surgeries: _____

Medications: _____

Allergies: ☐Drug: _____
☐Environmental
☐Latex

Pregnant: ☐Yes ☐No
Nursing: ☐Yes ☐No

Height: _____ Weight: _____

Personal Medical History

Constitutional
☐Developmental Disabilities
☐Cancer
☐Fatigue
☐Trauma
☐Fever
☐Weight loss/gain

Neurologic
☐Multiple Sclerosis
☐Epilepsy
☐Cerebral Palsy
☐Tumor
☐Stroke
☐Migraine
☐Autism

Cardiovascular
☐High Blood Pressure
☐Stroke/CVA
☐Heart Disease
☐Vascular Disease
☐Congestive Heart Failure

Respiratory
☐Asthma
☐Bronchitis
☐Emphysema
☐Chronic Obstruction
☐Sleep Apnea

Ear/Nose/Throat
☐Hearing Loss
☐Sinusitis
☐Dry Mouth
☐Laryngitis

Psychiatric
☐Depression
☐ADD/ADHA
☐Anxiety
☐Bipolar Disorder

Genitourinary
☐Kidney Disease
☐Prostate Disease
☐STD
☐Benign Prostate Hypertrophy

Hematologic/Lymphatic
☐Anemia
☐Ulcer
☐High Cholesterol

Endocrine
☐Type 2 Diabetes Mellitus
☐Type 1 Diabetes Mellitus
☐Thyroid Dysfunction
☐Hormonal Dysfunction

Gastrointestinal
☐Chrohn's
☐Colitis
☐Ulcer
☐Acid Reflux
☐Celiac Disease
☐Osteoporosis

Musculoskeletal
☐Osteoarthritis
☐Arthritis
☐Fibromyalgia
☐Muscular Dystrophy
☐Ankylosing Spondylitis
☐Gout

Integumentary
☐Eczema
☐Rosacea
☐Psoriasis
☐Herpes Simplex
☐Herpes Zoster/Shingles

Allergic/Immune
☐Rheumatoid Arthritis
☐Lupus
☐Sjogren's Syndrome

Ocular/Eye History

☐Glaucoma ☐Cataract ☐Surgery ☐Patching ☐Inflammatory Disorder ☐Nystagmus
☐Strabismus ☐Amblyopia ☐Keratoconus ☐Injury ☐Dry Eye
☐Retinal Degeneration/Hole/Detachment ☐Age-Related Macular Degeneration ☐Other: _____

I wear: ☐Glasses ☐Contact Lenses Contact Brand: _____
How long do you wear your contacts before you throw them away? _____
Do you sleep in your contacts? ☐Yes ☐No
If you could change anything about your contacts what would it be? _____
Rate importance (1-4): _____Health _____Comfort _____Vision _____Cost
Contact Lens Solution: ☐Opti-Free ☐BioTrue ☐Clear Care ☐Renu ☐Generic ☐Other
Eye Drops: _____

Family History

Medical
☐High Blood Pressure
☐Diabetes
☐Cancer
☐Thyroid
☐Other: _____

Ocular
☐Glaucoma
☐Cataract
☐Surgery
☐Patching
☐Strabismus
☐Amblyopia
☐Nystagmus
☐Age-Related Macular Degeneration
☐Inflammatory Disorder
☐Retinal Degeneration/Hole/Detachment
☐Keratoconus
☐Injury
☐Dry Eye
☐Other: _____

Acknowledgment of Receipt of Notice of Privacy Practices

I, patient, have received a copy of this office's Notice of privacy practices.

_____

Print Name

_____

Signature

_____

Date

FOR OFFICE USE

We attempted to obtain written acknowledgment of the receipt of Privacy Practices, but acknowledgment could not be obtained because:

___ Individual refused to sign

___ An emergency situation prevented us from obtaining acknowledgment:

___ Other

Policies & Procedures

Thank you for choosing Visionary Eyeworks as your healthcare provider. We pride ourselves on providing exceptional patient care. We understand that you have options when it comes to choosing your eye care professional. If for any reason you find yourself less than fully satisfied with your glasses, contact lenses or service, please let us know and we will do our best to attend to your concerns.

Insurance Coverage Information

We will submit insurance claims as a courtesy to you. Insurance co-pays and fees for non-covered services are always due at the time of service. Most insurance companies have limitations: some pay a set amount, some pay a percentage and some pay nothing at all. Your insurance policy is a contract between you and your insurance company.

Medical Insurance may cover your exam and other needed services if you are having a problem with your eyes that is related to a ***medical condition***.

Vision Insurance will partially cover your eye exam if you are having problems related to glasses, contact lenses or a "***routine" check-up*** when there are no specific problems.
Initial _____

Eye Wear

If for any reason you are not satisfied with your new glasses we do not provide refunds. However, we will gladly exchange and/or remake your glasses to your satisfaction (additional fees may be required). Payment plan can be discussed at time of purchase.
Initial _____

Providing Your Own Frames

We will be happy to make prescription lenses if you choose to bring in your own frames. In a small percentage of cases, the frame may not hold up during the process of customizing your lenses and may break or get damaged. Please understand that replacement parts may not be available for older and/or discontinued frames. We want to be sure that you understand that if your frame gets damaged we will not be held responsible.
Initial _____

Frame Warranty

If a new frame proves to have a manufacturer's defect, it may be replaced within 365 days of your order. It is up to the manufacturer's discretion as to what is considered defective. If your frame does break, please do not attempt to repair yourself (ie. using any type of glue). This will void your warranty. Please put your glasses in your case and bring it in for us to attempt to repair.
Initial _____

Spectacle Lens Guarantee

If for any reason you are not 100% satisfied with your new glasses, Visionary Eyeworks will remake the order within ninety days into the lens of your choice that is of equal or lesser value (single vision, bifocal, trifocal and progressive) at no additional charge.

Initial _____

Lens Material & Anti-Reflective Warranty

All impact resistance material and anti-reflective coatings are subject to the warranty policies of the coating manufacturers or your insurance company's policies.

Initial _____

Contact Lens Policy/Evaluation and Fitting Fees

When a contact lens prescription is needed, additional services and fees are required that are not part of the routine eye exam. Contact lens prescriptions expire one year from the date of the exam. *The contact lens evaluation fees can range from $75-$120. The price is determined by the complexity and type of the contact lens.* This fee includes all follow up visits related to the current fitting and any trial lenses needed throughout the process.

Unopened boxes of contact lenses may be returned for credit or exchanged if the contact lens prescription is modified by the prescriber. Boxes must be unmarked and in good condition. This policy does not apply when purchasing your contact lenses elsewhere.

Initial _____

Pick Up Policy

Glasses and contact lenses not claimed within ***ninety days*** are subject to forfeit of the deposit and will be returned to the manufacturer**.**

Initial _____

Cancellation Policy

All orders are custom made and involve fixed costs to our practice. Orders cancelled after a deposit is left could be subject to a fee of the total material cost.

Initial _____

Missed Appointments

If you cannot keep your appointment, please inform us at least 24 hours in advance. If we are not notified of your change of plans, then a $75 fee will be assessed.

Initial _____

Thank you for understanding our policies. If you have any questions or concerns, please do not hesitate to ask us.

I have read and understand the above.

_____

Print name of patient/responsible party

_____ _____

Signature of patient/responsible party Date

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Visionary Eyeworks is required by law to maintain the privacy of your health information, to follow the terms of this Notice, and to provide you with this notice of its legal duties and privacy practices with respect to your health information. We will not use or disclose medical information about you without your written authorization, except as described in this Notice. We reserve the right to change our practices and this Notice and to make the new Notice effective for all medical information we maintain. Upon request, we will provide a revised Notice to you.

How Visionary Eyeworks May Use or Disclose Your Health Information

Visionary Eyeworks protects the privacy of your health information. The law permits Visionary Eyeworks to use or disclose your health information for the following purposes:

- *Treatment, Payment, and Regular Health Care Operations* – Information obtained by our office will be used to dispense and provide prescription ophthalmic goods and services to you, bill your insurance carrier if you have third party coverage, and to record and monitor the service provided to you. Information will also be provided to you upon your request.
- *As and When Required by Law* – We may use and disclose your health information to Public Health Officials, Law Enforcement, Health Oversight Activities (for audits, investigations, etc.) Judicial and Administrative, Deceased Person Information, Worker Compensations programs, Food & Drug Administration (FDA for reporting of adverse drug events and quality issues), if there is a serious threat to your health or safety, in times of National Security, if you are in the Military or a Veteran of the armed forces when requested, or if you become an inmate in a correctional facility.
- *Personal Communications* – We may contact you to provide appointment reminders, annual eye examination cards, and other information about treatment alternatives or other health-related benefits and services that may be of interest to you as well as communicate with individuals involved in your care or payment for your care.
- *Disclosure to Our Business Associates* – There are some services provided by us through contracts with business associates. When these services are contracted for, we may disclose health information about you to our business associate so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, we require the business associate to appropriately safeguard the health information.
- *Victims of Abuse, Neglect, or Domestic Violence* – We may disclose your health information to a government authority, such as a social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

Marketing Communications. We must obtain your written authorization prior to using your health information to send you any marketing materials. We may communicate with you about products or services relating to your treatment, care, or alternative treatments, or providers without authorization.

When Visionary Eyeworks May Not Use or Disclose Your Information

Except as described in this Notice of Privacy Practices, Visionary Eyeworks will not use or disclose your health information without your written authorization. If you do authorize Visionary Eyeworks to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If you state law provides additional restrictions upon any of the foregoing uses and discloses, we must follow your state law.

You have the following rights with respect to your health information.

- You have the right to request restrictions on certain uses and disclosures of your health information. To make such a request, you must complete the **Restriction of the Use of Patient Information form** and the request will apply only to the location providing services. Visionary Eyeworks is not required to agree to the restriction that you requested.
- You have the right to inspect and copy your health information as long as the office maintains the health information. Your health information usually will include prescription and billing records. To inspect or copy your health information, you must complete a **Request to Inspect Medical Records form** and submit the request to the location that provided your services. We may charge you a fee for the costs of copying, mailing, or other supplies that are necessary to grant your request. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed.
- You have the right to request that Visionary Eyeworks amend your health information that is incorrect or incomplete. To request an amendment, you must complete a **Request to Amend Medical Records** to the location providing services. Visionary Eyeworks is not required to change your health information and will provide you with information about the procedure for addressing any disagreement with the denial.
- You have a right to receive an accounting of disclosures of your health information we have made after April 14, 2003 for most purposes other than treatment, payment, health care operations, information provided to you, and certain government functions. To request an accounting, you must complete a **Request for Accounting of Disclosure** to the address listed below. You must specify the time period but may not be longer than six years. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time.
- You may request communications of your health information by alternative means or at alternative locations. For example, you may request that we contact you about medical matters only in writing or at a different residence or post office box. To request confidential communication of your health information, you must complete a **Request for Alternative Communication** to the location providing services and will be good for only the location providing services. Your request must state how or when you would like to be contacted. We will accommodate all reasonable requests.

If you would like to exercise one or more of these rights, contact the location that provided you services or submit a written request to your HIPAA Coordinator.

Tennessee Laws - We will not deny you access to your health information. We are prohibited by law from selling your health information.

Dilation

Every comprehensive exam includes an exam of the internal structures of the eye. Dilation provides our doctors an improved and more extensive view of the interior of the eye. The recommended schedule for dilation is dependent on a variety of factors including age and ocular health. In many cases, Digital Retinal Imaging may reduce the need for dilation. In other cases, our doctors may strongly recommend dilation.

Dilation involves the use of medicated eye drops to enlarge the pupil size. The side effects of dilation include: blurry vision and light sensitivity. **These side effects typically last from 4 - 8 hours and often cause difficulty reading, using computers, cell phones and driving.** Also, dilation will increase your exam time by 30 minutes.

☑ *Yes, I would like to have dilation performed today*

☑ *No, I decline dilation*

* PLEASE CHOOSE DILATION ***OR*** RETINAL IMAGING *

Digital Retinal Imaging

Our doctors believe that using the most advanced technology is crucial to maintaining good ocular health and preventing ocular diseases from going undiagnosed. As a result, we utilize Digital Retinal Imaging to produce high definition pictures of your retina, interior blood vessels and optic nerves. These images are vital in helping the doctor assess your risks for serious diseases such as diabetes, glaucoma, macular degeneration and high blood pressure. These conditions can lead to serious health problems including; partial loss of vision and blindness which often develop without warning and progress with no symptoms.

Our doctors recommend Digital Retinal Imaging every 12 months for every patient. These images become a permanent part of your medical file which provide comparisons for tracking and diagnosing potential eye disease. Digital Retinal Imaging often reduces the need for dilation.

Insurance typically **DOES NOT** cover any advanced screening technology beyond the general exam. However, because our doctors highly recommend Digital Retinal Imaging for all patients, **this is available as an enhancement to the general eye exam for a fee of $39**.

☑ *Yes, I would like to have Digital Retinal Imaging performed today*

☑ *No, I decline Digital Retinal Imaging*

Patient Signature: _____ Printed Name: _____

**** In refusing both dilation and retinal imaging, I understand that I am assuming all risks associated with failure to diagnose eye conditions due to lack of information which may have been provided by dilation or retinal imaging.**

Patient Signature: _____ **Printed Name:** _____