OPTOMAP

If you are diabetic, please skip this section. The doctor will discuss further options with you during your exam.

I have been presented the benefits of having the OPTOMAP retinal photography.

Check your selection below:

_____ YES, I elect to have the OPTOMAP retinal photography for $39

_____ NO, I would like to have my eyes dilated or discuss further with the doctor

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Notice of Privacy Practices Patient Acknowledgement

I have had the opportunity to receive this practice's Notice of Privacy Practices. The notice provides the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise those rights, and the practice's legal duties with respect to my protected health information. I understand that the practice may change the terms of its Notice of Privacy Practices and that any changes apply retroactively to information created while the current notice is in effect. I understand I can obtain this practice's current Notice of Privacy Practices upon request.

FINANCIAL POLICY

As a courtesy to our patients, we file most vision and medical insurance claims. I understand that I am financially responsible for all charges incurred in the event that my insurance denied payment. I also understand any services not covered by Medicare and other insurers that I am responsible for, payment will be collected at the time of service. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY CLAIM. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN FOR SERVICES RENDERED.

PATIENTS READ AND SIGN AGREEMENT:

1. I have been provided with the Financial Policy

2. I have had the opportunity to receive the Notice of Privacy Practices.

3. I hereby give my consent for Fort Mill Vision Center to evaluate and treat the patient listed below.

4. I understand that my personal health information will be used for treatment, payment and the coordination of health care needs of the patient.

Patient Name (printed): _____Date: _____

Patient or Responsible Party Signature: _____

I give permission to the following persons to access my personal health records from Fort Mill Vision Center:

_____

MEDICAL HISTORY QUESTIONAIRE

Patient Name_____ Today's Date_____
Nickname_____
Address_____ Birthday_____/_____/_____
City/State_____Zip Code_____ Home Phone_____
Social Security Number_____/_____/_____ Daytime Phone_____
Employer_____ Cell Phone_____
Occupation_____ Last Eye Exam_____
Spouse's Name & Birthday_____ Dilated? Y / N
Email Address_____ Hobbies_____
Emergency Contact/Relationship to Contact_____
Emergency Phone Number_____

MEDICAL HISTORY

How is your general health? _____ Are you Pregnant or Nursing? Y / N
Who is your primary healthcare physician/doctor? _____
Do you have problems with any of these systems? (Circle all that apply)

Eyes	Y / N	Gastrointestinal	Y / N	Respiratory	Y / N	Cardiovascular	Y / N
Mental	Y / N	Nervous System	Y / N	Genitourinary	Y / N	Musculoskeletal	Y / N
Skin	Y / N	Ear/Nose/Throat	Y / N	Endocrine	Y / N	Blood/Lymph	Y / N
		Immunologic	Y / N				

Please Explain: _____
Please answer all that apply below:
Diabetes Y / N Type:_____ Date of Diagnosis:_____ Last Hba1c/Blood Glucose:_____
Allergies Y / N Allergic to What:_____ What Happens:_____
Headaches Y / N Other Health Problems:_____
Current Medications (including over the counter):
_____
_____
Have you had any operations: Y / N What Kind:_____ When:_____
Do you use cigarettes/tobacco: Y / N Alcohol: Y / N Other Substances: Y / N
Have you ever been exposed to or infected with any of the following: (please circle all that apply)
Gonorrhea Hepatitis HIV Syphilis
Would you prefer to discuss your social history directly with the doctor: Y / N

FAMILY HISTORY Does anyone in your family have:
High Blood Pressure: Y / N Relation:_____ ____ Diabetes: Y / N Relation: _____
Macular Degeneration: Y / N Relation:_____ Glaucoma: Y / N Relation:_____
Retinal Detachment: Y / N Relation:_____ Cataracts: Y / N Relation:_____
Other Eye Conditions:_____

PERSONAL EYE INFORMATION

Have you had any eye operations: Y / N Describe:_____ Date:_____
Have you had any eye injuries: Y / N Describe:_____ Date:_____
Do you have any of the following: Glaucoma: Y / N Cataracts: Y / N Dry Eyes: Y / N Blurred Vision: Y / N
Any other eye problems:_____
Do you currently wear glasses: Y / N Contact Lenses: Y / N Type of Contacts: _____
Any additional information:_____
Whom may we thank for referring you?_____
Are you planning on selecting new glasses today: Y / N / Only if Necessary
Are you interested in wearing contact lenses: Y / N
Do you want information on LASIK: Y / N

Patient's Authorized Signature

I authorize the release of any medical information necessary to process any third party insurance claims, including Medicare and Medicaid. I am aware that I am responsible for any co-pays or deductibles that are due at the time of visit. I understand that this is not a guarantee of benefits, which cannot be determined until the actual claim is received by the insurance company, and that if the insurance claim is denied I will be responsible for any balances due. If I fail to provide the correct insurance information, I understand that all charges will be my responsibility. It will be my responsibility to contact my insurance company for reimbursement. Should my account become delinquent and is placed with a collection agency, I will be responsible for the collection fees.

Please provide ALL vision AND medical information.

Vision Insurance_____ Member_____

ID # _____ Member's DOB_____

Member's SS #_____

Medical Insurance_____ Member_____

ID # _____ Member's DOB _____

Member's SS #_____

Signature_____ Date_____

(patient/guardian)

Fort Mill Vision Center

Deborah A Long, OD | Adam R Dutson, OD | Allyson T Spratt, OD
1090 Spratt Street, Fort Mill, SC 29715
P: 803-547-5547 F: 803-547-5724

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name:_____ DOB:_____

I request and authorize _____ to release healthcare information, including any prescriptions, of the patient named above to Fort Mill Vision Center.

Patient Signature:_____ Date: _____