We Thank You For Choosing Our Office To Care For You

Please Print

Miss Mrs. Mr. Dr. (Please Circle)

Minor Married Single Separated Widowed (Please Circle)

Patient's Name: _____Nick Name: _____ Birthdate: _____

Address: _____ City: _____ ST: _____ ZIP: _____

Home Phone #: _____ Cell Phone #_____Business Phone # _____

Primary Language:_____ **Hispanic/Latino Non Hispanic/Latino** (Please Circle One)

Race: Asian African American White Other (Please Circle One)

Email: _____

Employer: _____ Occupation: _____

Student: (Y) _____ (N) _____ Grade: _____ School: _____

Family Physician / Pediatrician Name & Phone:_____

How or by whom were you referred to our Office: _____

Responsible Party

Guarantor / Name of Person responsible for this account: _____

Relationship of Guarantor to Patient: Self Parent Other (Please Circle)
Address (if different from Patient): _____
Name of Employer: _____ Business phone #: _____

Insurance Information

Does Medicare cover you? (Y) (N) Is it your Primary or Secondary Insurance? (Please Circle)

Do you have Vision Insurance Coverage? (Y) (N) (Please circle) Name of Insurance: _____
Name of Policy holder_____ Relationship to Patient_____
Member ID # of Policy holder_____ Date of Birth of policyholder:_____

Do you have Medical Insurance Coverage? (Y) (N) (Please circle) Name of Insurance: _____
Name of Policy holder_____ Relationship to Patient_____
Member ID# of Policy Holder_____ Date of Birth of policyholder:_____

Authorization:

I certify that I have read and understand the information on the front and back of this questionnaire and have answered the questions accurately to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand and agree to be financially responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of Patient (Or parent if minor) (Date)

PLEASE COMPLETE INFORMATION ON BACK

HEALTH HISTORY QUESTIONNAIRE

1. Please describe any problem or concern you have with your eyes.

_____

_____

2. Do you wear …?
( ) Glasses? For Distance ( ) For reading ( )
( ) Contact Lenses? Soft ( ) RGP/Hard ( )

3. Date of last exam _____

4.Date present glasses made_____

5. Please list:
Computer Use _____Hours each day
Hobbies_____
_____
Outdoor activities_____
_____

6. Are you interested in finding out more about LASIK?
( ) Yes ( ) No ( ) Maybe

7. Are you planning on getting new glasses today?
( ) Yes ( ) No ( ) Maybe

8. Are you planning on getting new contact lenses today?

( ) Yes ( ) No ( ) Maybe

9. List all medications and supplements you are taking.
_____
_____
_____
_____
_____
_____

10. List all medications you are allergic to.
_____
_____

Are you pregnant? YES NO (Circle one)
Do you drink alcohol? YES NO
Do you smoke? YES NO

11. Please check any of the problems you have with your vision.
( ) Poor vision ( ) Distance ( ) Near
( ) Blurred vision
( ) Poor night vision ( ) Other-please describe
( ) Double Vision
( ) Halos around lights _____
( ) See flashes of light
( ) Spots before your eyes_____
( ) Headaches
( ) Color Blindness _____
( ) Light sensitive

12. Please check any of the problems you have with your eyes.
( ) Red or bloodshot ( ) Other-please describe
( ) Itching or burning sensation
( ) Tearing _____
( ) Gritty sensation
( ) Discharge _____
( ) Sensitive to light
( ) Pain in eyes _____

13. List any surgeries you've had, include eye injuries?

_____

_____

14. Please indicate if you or any blood relative has had any of the following conditions:

You	or	Relative	
( )		( )	Arthritis
( )		( )	Diabetes
( )		( )	High Blood Pressure
( )		( )	Heart trouble
( )		( )	High Cholesterol
( )		( )	Asthma
( )		( )	Allergies
( )		( )	Skin trouble
( )		( )	Shingles
( )		( )	Cancer / Tumor
( )		( )	Glaucoma
( )		( )	Macular Degeneration
( )		( )	Crossed or lazy eye
( )		( )	Cataracts

Please read and answer all the questions below:

PERIPHERAL VISION TEST

1): Unfortunately, routine eye exams cannot detect many eye diseases such as glaucoma, multiple sclerosis and brain tumors in their early stages. We routinely test patients at their annual exam using the FDT analyzer, a screening visual field analyzer. You may also choose a more sophisticated **Threshold Visual Field** analyzer that will do a more in depth test. It is especially important for those patients with a history of high blood pressure, headaches, migraines, stroke, floaters or high spectacle prescriptions. The FDT procedure only requires 3 minutes and is included in the exam fee, while the Threshold Procedure requires 15 minutes of your time and the fee is **$40.00**. Please understand that while this test is optional for most, it represents preventive health for others.

Yes/No/Discuss I **would like** to have the Threshold Visual Field Test.

RETINAL PHOTOS

3):We take patient education a step further by allowing patients to view the inside of their own eyes. By using **Retinal Photos**, we can provide remarkably clear images of the cornea, retina and other ocular structures. Any patient with vascular disease such as diabetes, hypertension, high cholesterol and glaucoma suspects should add this to their annual health evaluation.
Please note – in most cases you will need to be dilated to get the best image results.

Our fee for this test is **$40.00.** Medical insurance companies will pay for this test only when eye disease exists. We are excited to bring an exceptionally detailed diagnostic test to each of our patients and highly recommend it as an optional addition to your exam today.

Yes/No/Discuss Please perform baseline **Retinal Photo's** today.

Aloma Eye Associates/Dr. Amy Ward

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.

At Aloma Eye Associates, we are required to keep your health information secure and confidential, by law. Also by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We will need to release some or all of your health information, when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

You have the right to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.

You have the right to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.

You have the right to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a report of who we disclose your information to.

If our privacy and security measures or systems are breached in any way, we will notify you.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W., Room 509F, Washington, DC 20201), online (http://www.hhs.gov) or by email (OCRComplaint@hhs.gov). You will not be retaliated against for filing a complaint.

Please contact our Privacy Officer, Cindy Kible, at (407) 671-3100 for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.

Acknowledgment

I have received a copy of the Aloma Eye Associates Notice of Privacy Practices Date _____

Signed _____ Print Name _____

If signing as a parent or guardian, please note the name of the patient _____ _

ALOMA EYE ASSOCIATES
OPTOMETRIC PHYSICIANS

About Your Insurance

There are two types of health insurance that will help pay for your eye care services and products.

You may have both types and Aloma Eye Associates accepts most insurance plans in both categories:

1. Vision plans (such as VSP – Vision Service Plan)
2. Medical insurance (such as Aetna, Blue Cross/Blue Shield, Medicare and others).

- Vision plans only cover routine vision wellness exams, along with eyeglasses and contact lenses. Vision plans do not cover medical eye care (the diagnosis, management or treatment of eye health problems).
- Medical insurance (or health insurance) must be used for medical eye care.
- A vision wellness exam is defined when the only diagnosis is refractive in nature (myopia or astigmatism, for example). A medical eye exam is when the diagnosis is anything other than refractive (glaucoma, cataract, dry eye syndrome, and many others).
- Medical insurance must be used if you have an eye health problem or systemic health problem that has possible ocular complications. This includes medications that have ocular side effects. Your doctor will determine if these conditions apply to you, but some are determined by your case history.
- If you have both types of insurance plans it may be necessary for us to bill some services to one plan and some services to the other. We will follow a procedure called coordination of benefits to do this properly and to minimize your out-of-pocket expense.
- We will bill your vision plan or medical insurance for services if we are a participating provider for that company. If we are not a provider, you may submit your own claim for reimbursement of the fees you pay. We will try to obtain authorization in advance for your insurance benefits so we can tell you what is covered. If some fees are not paid by your insurance, we will bill you for them, such as deductibles, co-pays or non-covered services as allowed by the insurance contract.

Please provide your insurance cards to our staff member so we can make a copy. We need to have your medical insurance card or Medicare card on file in case we should need it in the future for billing your insurance.

I have read and accept these policies.

_____ _____

Patient signature (parent if child) Date