

730 NORTH OPTOMETRY

Appointment Date: _____

Patient's Name: _____ Date of Birth: _____

Patient Status: (please circle) **New** or **Established**

Home Address: _____ City/State: _____ Zip Code: _____

Primary Phone Number: (please circle) **Cell** **Home** **Work** _____

Secondary Phone Number: (please circle) **Cell** **Home** **Work** _____

Email Address: _____ Gender: (please circle) **Male** or **Female**

Profession/Hobbies: _____

Race: (please check which one applies to you)

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Hispanic
- Other _____
- Unknown
- Decline to answer

Pharmacy Name: _____ Phone Number: _____

Address: _____

Personal Medical History

Do you have a history of the following conditions/diseases?

Constitutional

- Developmental Disabilities
- Cancer
- Fatigue Syndrome
- Other
- None

Ear Nose Throat

- Hearing Loss
- Sinusitis
- Dry Mouth
- Laryngitis
- Other
- None

Neurological

- Multiple Sclerosis
- Epilepsy
- Cerebral Palsy
- Tumor
- Stroke/CVA
- Migraine
- Autism
- Concussion
- Other
- None

Psychiatric

- Depression
- Attention Deficit
- Anxiety Disorder
- Bipolar Disorder
- Other
- None

Cardiovascular

- Hypertension
- Stroke/CVA
- Heart Disease
- Vascular Disease
- Congestive Heart Failure
- Other
- None

Respiratory

- Cigarette Smoker
- Asthma
- Bronchitis
- Emphysema
- Chronic Obstruction
- Sleep Apnea
- Other
- None

Gastrointestinal (GI)

- Crohn's Disease
- Colitis
- Ulcer
- Acid Reflux
- Celiac Disease
- Other
- None

Genitourinary (GU)

- Kidney Disease
- Prostate Disease (Cancer)
- STD _____
- Benign Prostate Hypertrophy
- Pregnant (Currently)
- Nursing (Currently)
- Herpes
- Other
- None

Musculoskeletal

- Rheumatoid Arthritis
- Osteoarthritis
- Fibromyalgia
- Muscular Dystrophy
- Ankylosing Spondylitis
- Osteoporosis
- Gout
- Other
- None

Integumentary

- Eczema
- Rosacea
- Psoriasis
- Cold Sores
- Shingles
- Other
- None

Endocrine

- Type I Diabetes
- Type II Diabetes
- Thyroid Dysfunction
- Hypothyroidism
- Hyperthyroidism
- Hormonal Dysfunction
- Other
- None

Hematologic/Lymphatic

- Anemia
- Large-volume blood loss
- Ulcer
- Hypercholesterolemia
- Other
- None

Allergic/Immune

- Drug Allergies
- Environmental Allergies
- Rheumatoid Arthritis
- Lupus
- Sjorgren's Syndrome
- Other
- None

Environmental Allergies

- Nuts
- Shellfish
- Bee stings
- Animal Dander
- Dust
- Hayfever
- Latex**
- Ragweed
- Dairy
- None

If you selected "Other" to any of the above, please

specify:

Personal Medical History

Medications: Are you *currently* taking over-the-counter (OTC) or prescription medications? Please list with dosage

Drug Allergies:

Please list all

Personal Social History

Alcohol Use:

- Yes; Amount/Often: _____
- No

Tobacco Use:

- Current Every Day Smoker
- Current Some Day Smoker
- Former Smoker (smoked more than 100 cigarettes in a lifetime)
- Never smoker (smoked 100 or less cigarettes in a lifetime)

Do you have a history of the following eye conditions?

Personal History-Ocular

- Glaucoma
- Glaucoma Suspect
- Cataract
- Age-related Macular Degeneration
- Patching
- Inflammatory Disorder
- Strabismus
- Amblyopia
- Retinal Degeneration
- Retinal Hole
- Retinal Detachment
- Keratoconus
- Injury
- Dry Eye
- Nystagmus
- None
- Other:

Eye Concerns

- Redness
- Burning
- Itching
- Tearing
- Discharge
- Blurred Vision
- Eye Strain
- Eye Pain
- Severe Sensitivity to light
- Headache
- Poor Night Vision
- Bothersome Night Glare
- Double Vision
- Total Loss of Vision
- None
- Other, Please list any additional eye concerns:

Family Medical History

Family History-Medical

Father/Mother/Brother/Sister/Son/Daughter

- Cancer _____
- Type I Diabetes _____
- Type II Diabetes _____
- Hypertension _____
- Hyperthyroidism _____
- Hypothyroidism _____
- Other _____
- None

Family History-Ocular

Father/Mother/Brother/Sister/Son/Daughter

- Cataract _____
- Degenerate disorder of macula _____
- Glaucoma _____
- Glaucoma Suspect _____
- Amblyopia _____
- Severe Myopia _____
- Severe Hyperopia _____
- Strabismus _____
- Retinal Detachment _____
- Dry Eye _____
- Nystagmus _____
- Other _____
- None

Contacts Lenses

Do you wear contact lenses?

- Yes
- No

If yes, what brand? _____

Right eye power: _____

Left eye power: _____

How old are your contacts? _____

Average daily wear time: _____

Average replacement period: _____

Do you sleep in your contacts?

- Yes
- No



ACKNOWLEDGEMENT OF RECEIPT OF H.I.P.A.A. PRACTICES

I acknowledge that I reviewed a copy of 730 North Optometry's Notice of Privacy Practices

Signature: _____ Date: _____

Patient Printed Name: _____

Financial and Office Policies

Thank you for choosing our practice for your eye care. It is important to us that you are aware of our office policies prior to your visit. Kindly review the following and sign below.

- ❖ Professional fees are due at the time of service. Orders for contacts lenses require one of the three options: payment in full at time of order, payment in full if it is a year supply, or payment in full at time of pick up. Eyeglasses orders require either payment in full or a 50% deposit before order is sent to lab.
- ❖ In regards to your insurance, we will gladly help you interpret your benefits, however, you are solely responsible for knowing your benefits for any service or product not covered by your insurance. **Tip:** Have us obtain and review your insurance benefits with you prior to your appointment so there are no surprises the day of your visit.
- ❖ Most major medical plans do not provide coverage for materials. We cannot directly submit materials to your major medical insurance, but we will gladly help you by providing all the necessary codes and documents for private reimbursement.
- ❖ Recalls and appointment confirmations will be done through an automated service using home, mobile, work number(s) and/or email address that you provide us.
- ❖ Missed appointments will incur in a **\$35.00 charge** to your account if the office is not notified 24 hours prior to the scheduled appointment time. **Note:** *Please be advised that your appointment may need to be rescheduled if you arrive more than 10 minutes late.*

I agree to the policies of 730 North Optometry.

Patient signature: _____

Notifier: 730 North Optometry

Patient Name: _____

Advance Beneficiary Notice of Noncoverage (ABN)

Note: If your insurance company does not pay for your visit today, you will be responsible for payment. Insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need.

We expect that your medical insurance may not pay for the following:

- **Refraction**-some medical insurances do not cover refraction because it is considered to be routine vision care. Cost: \$45.00
- **Contact Lens Exam**-some medical insurances do not cover most contact lens exams because it is considered to be routine vision care. Cost: \$50.00-\$175.00
- **Optos Retinal Photographs**-photographs will not be covered unless there is a specific medical diagnosis. Cost: 39.00

Please choose an option below:

- **Option 1.** (Initial)_____ I want my insurance company billed for an official decision on payment for my visit today. After which, an Explanation of Benefits (EOB) will be sent to me. I understand that if my insurance does not pay, I am responsible for payment, but I may appeal to my insurance according to their respective appeal policies.
- **Option 2.** (Initial)_____ I do not want my insurance billed for my visit today. I agree to pay my bill now, as I am responsible for payment. I cannot appeal if insurance is not billed.

This notice gives our opinion, not an official insurance decision. Signing below means that you have received, and understand this notice, and will comply with the selected option above.

Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY. Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice).

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we must carry out in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

when a state or federal law mandates that certain health information be reported for a specific purpose; for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices; disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence; uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws; disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies; disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else; disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations; uses or disclosures for health related research; uses and disclosures to prevent a serious threat to health or safety; uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service; disclosures of de-identified information; disclosures relating to worker's compensation programs; disclosures of a "limited data set" for research, public health, or health care operations; incidental disclosures that are an unavoidable by-product of permitted uses or disclosures; disclosures to "business associates" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA; [specify other uses and disclosures affected by state law].

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for health care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION

The following are some specific uses and disclosures we may not make of your health information without your authorization:

Marketing activities. We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent to such payment.

Sale of health information. We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.

Psychotherapy notes. Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization.

You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.

We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.

We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

730 North Eye Exam Information

(Please review and save for your own records)

Concussion Baseline Screenings: We provide free concussion baseline screenings for children age 5-18 years old. This screening tests visual tracking ability, which becomes reduced in the event of a concussion. This screening is only valid for 1 year. If you decide to have the screening test done, you may need to schedule an appointment with the vision therapist on another day to complete the test. If your child suffers head trauma, call the office the SAME DAY to repeat the screening test and have a neurological visual examination with the Doctor. Charges will apply for this follow-up evaluation. Please notify the staff if you wish to have your child complete a concussion screening.

Optos Retinal Photographs: In order to evaluate the health of the eyes, a retinal exam is necessary. We provide Optos Retinal Photographs in our office as an alternative to pupil dilation. The photographs only take a few seconds to complete, and there are no lasting side effects. The charge for Optos is \$19 for your first visit, and \$39 for each subsequent visit. These charges are not covered by insurance.

Pupil Dilation: Pupil dilation is another way the Doctor can evaluate the health of the eyes. This involves instilling drops which dilate the pupil, and cause blurred vision at near and/or distance, and sensitivity to light for 4-6 hours. This service is covered under vision insurance plans.

Tonometry/Pressure Test: The Doctor will check the pressures in your eyes to determine if there is risk for Glaucoma, a disease which can cause blindness. This involves instilling a numbing drop into the eyes. The eyes may sting when the drop is instilled, and remain numb for 10 minutes. There are no lasting side effects from this eye drop.

Pediatric Developmental History

Required for all school-aged children

Child's name: _____ DOB: _____

Today's Date: _____

Mother's first and last name: _____ Mother's age at time of birth: _____

Father's first and last name: _____ Father's age at time of birth: _____

Length of pregnancy: _____ weeks Birth weight: _____

Were there any complications before, during or immediately following birth? Yes No

If yes, please explain: _____

Check any of the following milestones which you believe developed late or are still delayed?

Gross Motor Fine Motor Speech Language Personal/Social

Describe any serious illnesses or accidents: _____

Does your child have food allergies? _____

Has your child ever had a concussion? Yes No If so, please explain: _____

Visual History

Please check those that apply:

Eye teaming/focus

- Words move or flicker when reading
- Eyestrain when reading or writing
- Blurred vision at near or far
- Poor attention for near tasks
- Words/letters overlap
- Headaches with near tasks
- Exaggerated paper rotation
- Double vision
- Holds book too close to face
- Burning/tearing/redness with near tasks
- Rubs eyes with near tasks
- Difficulty copying from the whiteboard
- Misalignment of numbers in columns
- Poor posture with writing
- Avoids reading/near work
- Turns/tilts head while reading
- Covers one eye while reading

Tracking/Visual Motor

- Moves head excessively when reading
- Skips lines when reading
- Omits words when reading
- Reads words out of order
- Loses place when reading
- Uses finger or marker to keep place
- Deficient ball-playing sports
- Poor coordination/balance
- Writing delay, mistakes, confusion
- Written spelling is worse than oral spelling
- Awkward pencil grip

Visual Perception/Visual Development

- Confuses letters, numbers and/or words
- Letter or word reversals when reading/writing
- Poor spacing/organizing while writing
- Difficulty following a sequence of directions
- Poor reading comprehension
- Difficulty classifying shapes/sizes
- Delayed development of motor skills
- Confusion of right and left
- Occasionally reads from right to left
- Inconsistent dominant handedness
- Difficulty crossing midline of the body
- Delayed learning of the alphabet
- Difficulty performing basic math
- Difficulty spelling non-regular words
- Poor recognition of likenesses and differences
- Difficulty completing reading/writing on time

Is your child achieving at his/her potential in school? Yes No

If no, please explain: _____

Is your child receiving special services at school, or working with other professionals? Yes No

If yes, please list: _____

Does your child enjoy school? Yes No

If no, explain why: _____

Has the teacher reported any difficulty your child has with school work? Yes No

If yes, please explain: _____