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: _____

Please Turn To The Next Page →

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: _____

730 NORTH OPTOMETRY LIBERTYVILLE, IL 60048 (847)362-9900

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.

730 NORTH OPTOMETRY

Dry Eye Self Evaluation

Required for everyone age 13 and older

Name: _____ Date: ____/____/____ DOB: ____/____/____

Please check the box that best represents your answer. Select only one answer per question.

1. Report the type of **SYMPTOMS** you experience and when they occur:
If no response, jump to question #5.

Symptoms	At this Visit	Within past 72 Hours	Within past 3 months
Dryness, Grittiness or Scratchiness	☐	☐	☐
Soreness or Irritation	☐	☐	☐
Burning or Watering	☐	☐	☐
Eye Fatigue	☐	☐	☐

2. Report the **FREQUENCY** of these symptoms using the rating list below:

0 = Never **1** =Sometimes
2 = Often **3** = Constant

Symptoms

Dryness, Grittiness or Scratchiness	
Soreness or Irritation	
Burning or Watering	
Eye Fatigue	

3. Report the **SEVERITY** of your symptoms using the rating list below:

0 = No Problems **1** = Tolerable
2 = Uncomfortable **3** = Bothersome
4 = Intolerable

Symptoms

Dryness, Grittiness or Scratchiness	
Soreness or Irritation	
Burning or Watering	
Eye Fatigue	

4. Have the above symptoms limited you from performing any of the following during the last week?

Symptoms	All of the time	Most of the time	Some of the time	None of the Time
Reading?	☐	☐	☐	☐
Driving at night?	☐	☐	☐	☐
Working with a computer?	☐	☐	☐	☐
Watching TV?	☐	☐	☐	☐

5. Do you think you have dry eyes? ☐ YES ☐ NO

6. Do you use lubricating eye drops? ☐ YES ☐ NO If yes, how often? _____