EAST CAROLINA OPTOMETRIC CARE

Patient Name: _____ **Male / Female** **Birthday:** _____

Reason for Visit:_____ **SSN#** _____

Address: _____ **Phone Number:** _____

Email: _____

Race: _____ **Ethnicity:** _____

Primary Care Physician:_____ **Pharmacy:**_____

_____ _____

Today's Date **Signature**

OFFICE USE ONLY BELOW THIS LINE

Vision Insurance	Self-Pay	Medical Insurance

☐ Dilation ☐ Tetracaine Time: _____

Records From: _____

Letter To: _____

Med Rx: _____

Next Appointment: ____Y ____M ____W ____D

Scanned _____ Coded _____ **PAID:** _____

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please read it carefully. The privacy of your health information is important to us.
Our Legal Duty: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We reserve the right to change our privacy practices and terms of this Notice at any time, provided such changes are permitted by applicable law. We will use and communicate your health information only for the purpose of providing your treatment, obtaining payments and conducting health care operations.

USE AND DISCLOSURES OF HEALTHCARE INFORMATION:

To Provide Treatment: We will use and disclose your health information within our office to provide you with the best health care possible. This may include business office staff, assistants, opticians, physician assistants, nurses, and physicians. In addition, we may share our health information with referring physicians, laboratories, pharmacies, and other health care personnel providing you treatment, including contact lens and frame companies.
To Obtain Payment: We may use and disclose your health information to obtain payment for services, materials, and treatment you received in our office. We may do this with insurance forms filed for you by mail or send electronically.
Appointment Reminders: Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time to contact us for an appointment. Additionally, we may contact you for a follow upon your care and inform you of treatment options or services that may interest you or a family member. These may include postcards, folding cards, letters, telephone, voice mail, or email.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we believe a patient is a victim of abuse, neglect or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or health or safety of others.
Law Enforcement: As permitted or required by State or Federal Law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including under certain limited circumstances if you are a victim of a crime or in order to report a crime.
Family, Friends, and Caregivers: We may disclose your health information to a family member, friends, care giver, or other person who you tell us will be helping you with your home hygiene, treatment, medications, or payment. IN case of an emergency, where you are unable to tell us what you want, we will use our very professional judgment when sharing your health information. We will also use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, materials, or other similar forms of health information.

PATIENT RIGHTS:

Access: You have the right to look for or get copies of your health information, with limited exceptions (you must make a request in writing to obtain access to your health information). If you request copies, we will charge you a fee for each page, and per hour for staff time to locate, duplicate and assemble your copy, and postage if you request the copies to be mailed to you.
Documentation of Health Information: You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment of health care operations and certain other activities. Our documentation procedures will enable us to provide information from April 14, 2002, and forward. Please let us know in writing the time period for which you are interested. Your request must be limited to no more than six years at a time. We may charge you a reasonable fee for your request
Amendments: You have the right to ask us to amend your health information. IN order to standardize our process, please submit your request in writing and describe the reason for the change. Your request may be denied under certain circumstances.
Request a Paper Copy of this Notice: You have the right to obtain a copy of this Notice of Privacy Practices from our office at any time.
Complaints: If you think that we have not properly respected the Privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office of Civil Rights. We support your right to the privacy of your health information. If you want more information, please contact our office.

COPY AVAILABLE UPON REQUEST

Do you want a glasses prescription today? ☐ Yes ☐ No

Glasses prescription if billed under medical insurance will be $55.00

Do you want a contact lens prescription today? ☐ Yes ☐ No

Contact lens prescription is not covered by Medicaid or medical insurance. Fitting fees vary depending on fit.

Eye Surgeries (Check all that apply):

☐ LASIK Surgery ☐ Cataract Surgery ☐ Glaucoma Surgery ☐ Other: _____

Eye Conditions (check all that apply):

☐ Redness ☐ Burning ☐ Itching ☐ Tearing ☐ Discharge

Please list any additional eye concerns:_____

_____

Vision Concerns (Check all that apply):

☐ Blurred Vision ☐ Eye Strain ☐ Eye Pain ☐ Severe Light Sensitivity ☐ Headaches
☐ Poor Night Vision ☐ Bothersome Night Glare ☐ Double Vision ☐ Total Loss of Vision

Average Hours of Computer Use: _____

Review of Symptoms (Check ALL that apply):

Constitutional

☐ Developmental Disabilities ☐ Cancer _____ ☐ Fatigue Syndrome ☐ Cognitive Delays

ENT

☐ Hearing Loss ☐ Sinusitis ☐ Dry Mouth ☐ Laryngitis

Neurological

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

Psychiatric

☐ Depression ☐ Attention Deficit ☐ Anxiety Disorder ☐ Bipolar Disorder

Cardiovascular

☐ Hypertension ☐ Heart Disease ☐ Vascular Disease ☐ Congestive Heart Failure ☐ Oxygen Therapy

Respiratory

☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Sleep Apnea

Gastrointestinal

☐ Chron's ☐ Colitis ☐ Ulcer ☐ Acid Reflux ☐ Celiac Disease

Genitourinary

☐ Kidney Disease ☐ Prostate Disease/Cancer ☐ STD _____ ☐ Pregnant/Nursing

Endocrine

☐ Diabetes Type 1 / 2 ☐ Thyroid Dysfunction ☐ Hormonal Dysfunction

Musculoskeletal

☐ Arthritis ☐ Fibromyalgia ☐ Muscular Dystrophy ☐ Osteoporosis ☐ Gout

Hematologic

☐ Anemia ☐ Large Volume Blood Loss ☐ Ulcer ☐ Hypercholesteremic

Integumentary

☐ Eczema ☐ Rosacea ☐ Psoriasis ☐ Cold Sores / Shingles

Allergy/Immune

☐ Drug Allergies ☐ Environmental Allergies ☐ Rheumatoid Arthritis ☐ Lupus ☐ Sjogren's Syndrome

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

_____

_____

_____

_____

_____

LIST ALL ALLERGIES:

_____

_____

_____

Family Ocular History (*M=Mother, F=Father, B=Brother, S=Sister* ***or* *Other Family Member*):**

Blindness: M F B S Other **Cataracts:** M F B S Other **Macular Degeneration:** M F B S Other
Glaucoma: M F B S Other **Retinal Detachment:** M F B S Other **Crossed Eyes:** M F B S Other

Are you a smoker? ☐ YES ☐ No Do you drink alcohol? ☐ YES ☐ NO ☐ Socially Only

Consent for Dilation

We recommend that you have your eyes dilated yearly. Dilation allows for a more thorough evaluation to assess the risk for eye conditions such as glaucoma, macular degeneration, cataracts, diabetes, and other disorders. If you refuse dilation, there is a much greater chance that an eye disease could remain undetected.
Dilating drops have side effects, all of which last approximately **four hours.** These include blurred near vision and increased sensitivity to sunlight. Blurry distance vision may occur, but patients usually feel comfortable driving with their glasses or contact lenses.

There is no additional cost for dilation.

☐ **Yes, I agree to have my eyes dilated**

☐ **No, I do NOT want my eyes dilated**

If no, would you like to have an Optos scan today? ☐ **Yes** ☐ **No**

The Optos scan can give the doctor a wider than normal view of the retina when not dilated. It cannot replace dilation but is a good option if unable to dilate today. If you have further questions, please ask our staff.
The cost is $39.00 if using vision insurance for the visit, fully covered under most medical insurances.

Payment is expected at the time of service.

MEDICAL INSURANCE VERSUS VISION PLAN

Routine vision plans, or vision benefits plans, only cover wellness eye exams in which there are absolutely no problems noted other than the need for glasses or contact lenses. Examples include VSP, Community Eye Care, Superior Vision, and Eyemed Plans.

Major medical insurance covers your visits to our office when problems are diagnosed or found. The findings that trigger major medical processing are many and varied. Relatively minor problems such as dryness, fluctuating vision, floaters, headaches, excessive tearing, and itchy eyes all constitute routine vision care. More significant findings such as red eyes, eye pain, injuries, infections, cataracts, glaucoma, diabetes, high blood pressure, and retinal problems do not constitute routine vision care. Accordingly, such visits are processed through your major medical insurance and are subject to those co-pays and deductibles.

Co-pays and deductibles vary widely from one company to another. We do not set the co-pay amounts or the deductible amounts. Please remember that we are your advocates in this process and want to make the insurance paperwork process as simple as possible. If you have any questions, please do not hesitate to ask.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

Signature: _____ Print Name: _____ Date: _____