Academy of EYE CARE

Welcome to Academy of Eyecare! We hope to make your experience as comfortable as possible and appreciate you choosing us for your eyecare needs. Our doctors and staff want you to be your best healthcare advocate and hope that you will not hesitate to ask questions or voice any concerns about your vision. In addition to medical services, we have a full optical store that offers today's best lines of prescription glasses, contacts and sunglasses. If you need special assistance while you are here, please let a member of our staff know.

Dr. Amanda Byers Dr. Julie Campbell Dr. Stephanie Quesada

Patient Information

Name: _____ Date: _____

Address: _____ SSN: _____ Sex: M F

City: _____ State: _____ Zip: _____ DOB: _____ Age: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Occupation: _____ Employer: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

If patient is a minor, please fill out the following:

Parent/Guardian: _____ Phone: _____

How did you hear about us: Advertisement Insurance Website Search Engine Physician Family/Friend

If you were referred by a family member of friend, please let us know who: _____

Insurance

Vision Plan: _____ Member #: _____

Relationship to Member: Self Spouse Dependent

Medical Insurance (Primary): _____ Member #: _____

Group #: _____ Relationship to Member: Self Spouse Dependent

Secondary Insurance: _____ Subscriber's Name: _____

Member #: _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the company listed above on the date of service, and assign directly to Academy of Eyecare and its doctors, all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. Academy of Eyecare may disclose health care information to my insurance company and their agents for the purpose of obtaining payment for services. I authorize the use of my signature for all insurance submissions on my behalf and this consent will end when requested in writing.

Signature: _____ Date: _____

For Office Use Only:

Information Verified By: _____

(Please complete back page)

Dilation Consent

Our doctors use eye drops to dilate your pupils as part of a comprehensive eye evaluation. There is no additional fee for this service. Pupil dilation allows the doctor to view key structures of the eye and to determine is you have any disease that my affect your vision. These drops typically cause decreased reading vision and light sensitivity for approximately three (3) hours. Usually distance vision is minimally affected.

_____ Yes, I consent to having my eyes dilated to allow a comprehensive evaluation of my eyes.

_____ No, I decline to be dilated. I understand that certain medical conditions that may affect my vision may not be detected in a timely manner by my refusal. I accept and all risks and responsibility for any untimely diagnosis as a result. Though digital retinal imaging provides a wide-angle view of my eye, the doctor has made no representation that it replaces the benefits of pupil dilation and cannot be performed on some undiluted pupils.

Digital Retinal Imaging

Our office has the latest in ocular diagnostic technology, Topcon 3D OCT Imaging. This allows instant viewing of the retina, the optic nerve and other structures of your eye in great detail. The magnification of this image obtained often provides for more timely diagnosis of conditions of the eye, likely decreasing effects on your vision.

The doctors at Academy of Eyecare will review the images with you on a computer monitor and we digitally store these images for future comparison. You may request a copy to be emailed to you for your medical records. We are excited with the results obtained through this new technology and we highly recommend retinal imaging as an additional option during your eye examination.

_____ Yes, please perform the Digital Retinal Imaging as recommended. **I understand that there is a $30.00 fee for this service and that it is NOT covered by insurance as a part of a routine exam.**

_____ No, I do not wish to have the optional imaging performed.

In the event a medical condition of the eye is found during your dilated exam, additional scans will be taken and your medical insurance may cover the fees for retinal imaging. If imaging is required for continued care of a medical condition, by checking the box below, you acknowledge this is something that is not covered by your vision plan and will be filed medically. If no medical insurance is on file, I understand the fee is $80.00.

_____ Yes, I acknowledge the retinal imaging pictures/scans being done are filed with my medical insurance or that I am responsible for the fee.

Notice of Privacy Practices

This notice describes how medical/protected health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice was last updated as of March 2013 per the U.S. Department of Health and Human Services.

By law, we are required to provide you with our NOTICE OF PRIVACY PRACTICES (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information. As a patient, you have the following rights:

> The right to inspect and copy your information; to request corrections to your information; to request that your information be restricted; to request confidential communications; to a report of disclosures of your information; and to a paper copy of this notice.

We want to assure you that all of your medical/protected health information is secure with us. We will NOT sell ANY information to ANY companies for ANY purpose. Our staff will contact you SOLELY for the purpose of your patient care.

Please address concerns and questions to:

Amanda Byers, OD
Academy of Eyecare
826 Harrison Avenue
Panama City, Florida 32401

Acknowledgement of Notice of Privacy Practices:

I hereby acknowledge that I have access to a copy of this practice's NPP. In addition, it is clearly posted in the office for easy viewing. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me updates to this NPP should it be amended, modified or changed in any way.

Signature/Guardian's Signature (if patient is a minor): _____ Date: _____

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MEDICAL HISTORY

Patient Name: _____ DOB: _____ Date: _____

Date of last eye examination: _____ Previous Eye Doctor: _____

Do you wear glasses? YES NO Age of current pair: _____ 2nd pair: _____

Do you wear contacts? YES NO Type: Daily Bi-Weekly Monthly

Brand: _____ RX: _____ Are you interested in contacts? YES NO

Have you had any eye surgeries? YES NO Date of surgery: _____

If yes, please describe: _____

Have you had an eye injury? YES NO Date of injury: _____

If yes, please describe: _____

Primary Care Doctor: _____ Address: _____

List and Dosages of Medications:

_____
_____
_____
_____
_____

List of Allergies:

_____
_____
_____
_____
_____

Please list below any additional information that may be pertinent to your care:

_____
_____
_____

Do you or your family have any of the following?

	Yourself		Family		Mother/Father/Sibling
Cataracts	Y	N	Y	N	
Glaucoma	Y	N	Y	N	
Macular Degeneration	Y	N	Y	N	
Lazy Eye (Ambiyopia)	Y	N	Y	N	
Diabetes	Y	N	Y	N	
High Blood Pressure	Y	N	Y	N	
High Cholesterol	Y	N	Y	N	
Heart Disease/Attack	Y	N	Y	N	
Stroke	Y	N	Y	N	
Headaches/Migranes	Y	N	Y	N	
Autoimmune Disease	Y	N	Y	N	
Arthritis	Y	N	Y	N	
Thyroid Disease	Y	N	Y	N	
Sickle Cell Disease	Y	N	Y	N	
Sinusitis	Y	N	Y	N	
Asthma/Emphysema	Y	N	Y	N	
Hepatitis	Y	N	Y	N	
Kidney Disease	Y	N	Y	N	
HIV/AIDS	Y	N	Y	N	
Shingles	Y	N	Y	N	
Cancer	Y	N	Y	N	
Other	Y	N	Y	N	

Do you have any of the following?

Blurred Vision	Y	N
Tearing	Y	N
Burning	Y	N
Itching	Y	N
Redness	Y	N
Sandy/Gritty Feeling	Y	N
Light Sensitivity	Y	N
Eye Pain	Y	N
Flashes of Light	Y	N
Floating Spots	Y	N