Welcome

Please fill this form out as completely as you can

Patient Information

Date _____

SSN/ID:_____
Name(Last)_____
(First)_____ (MI) _____
Address _____
City _____
State _____ Zip_____

(circle) Sex: M F Married Single
Age _____ Birthdate _____

Occupation _____
Employer_____

Phone:(home) ( ) _____
(cell) ( ) _____
Best time to call: _____
IN CASE OF EMERGENCY, Contact:
_____

Whom may we thank for referring you to our office? _____

Please notify a member of our staff if you need any unique assistance while in our office today. A handicap accessible restroom is available in the rear of the building.

Insurance

Who is responsible for this Account/sponsor?
_____
Relationship to patient_____
Primary Ins_____
Group#/SSN#_____

Please list any secondary insurance plans:
_____
Subscriber's name_____
Plan#_____

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 Eye Care** or its team of doctors, all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges ***whether or not paid*** by insurance. I authorize the use of my signature for all insurance submissions on my behalf. Palm Eye Care may use my health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Patient sign/guardian_____
Date _____ relation to patient _____

Dilation Consent Form

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, to determine if you have any disease that may affect your vision. These drops typically cause decreased reading vision and light sensitivity for 3 hours. Usually, distance vision is minimally affected. We will discuss with you whether your legal driving vision may be affected; however, it is your responsibility to ensure that you are safe to operate a vehicle before you leave the office.

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

_____ No, I decline the dilation test. I understand that I have a choice as to whether I will receive the test. I understand that certain medical conditions that may affect my vision may not be detected in a timely manner by my refusal. I accept any and all risks and responsibility for any untimely diagnosis as a result of my refusal. I have also been informed that even though Digital Retinal Imaging provides a wide angle view of my eye, the doctor has made no representation that it replaces all of the benefits of a pupil dilation.

Digital Retinal Imaging

Our office has the latest in ocular diagnostic technology, Topcon 3D OCT Imaging. We highly recommend retinal imaging as part of your comprehensive eye examination. This new technology provides a magnified picture of the back of your eye. The image allows instant viewing of the retina, the optic nerve, and other structures of your eye in great detail. Your doctor will review the images with you on a computer monitor.

This method of examining and documenting the retina provides for more timely diagnosis of abnormal conditions, which may allow us to prevent permanent vision loss in the event a disease is detected. Further, we can store the images and compare them for changes that may occur in the future. You can receive a digital copy of your photo via email if you request.

We are very excited with the results obtained with this new technology, and we highly recommend retinal imaging as an additional option during your eye examination.

The fee for this service is $25, and it is not covered by your insurance company during a routine office visit.

_____ Yes, please perform the Digital Retinal Imaging as recommended.

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

In the event certain medical conditions of the eye are found, your medical insurance (and not VSP, VCP, or vision plans) may cover the fees for retinal imaging. Your doctor will discuss this with you before images are taken.

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.

Summary: 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:

1. 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 other companies for ANY purpose. Our staff will contact you SOLELY for the purpose of your patient care.

Effective Date of this notice: June 10, 2011 Contact Person: Amanda Byers, O.D. Phone: 850-769-1404

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_____Date_____