HIPAA PRIVACY
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (Print full legal name here; the Patient" or "Patient's Legal Representative") have been provided with the Notice of Privacy Policy (the "policy") of the provider and have been offered a copy of such policy to keep for my records.

_____ (Initial here) I hereby acknowledge that I have been provided with a copy of the Policy.

_____ (Initial here) I hereby refuse to acknowledge receipt of the Policy. I understand that even though I may refuse to sign this acknowledgement my provider may still provide services.

_____

Signature of Patient Date

Refused to Sign Notice of Privacy Practices

Reason: _____

_____

_____

_____

_____

_____

_____

_____

_____

Employee Signature Date

VISUAL FIELD CONSENT FORM

Attention Patients:

We have incorporated a highly sophisticated computerized visual field analyzer into our practice. This **VISUAL FIELD ANALYZER** can detect early visual field loss that is often associated with many common ocular diseases.

This field analyzer can detect diseases such as early glaucoma, retinal degeneration, tumors, and vascular problems. It gives the optometrist an important baseline diagnostic finding.

We recommend all of our patients over the age of 12 receive this test. It is important for those patients who have a history of diabetes, high blood pressure, headaches, flashes of light or floaters. It is also recommended if you have a strong eyeglass prescription, or if you have any family history of glaucoma.

This state of the art procedure requires an additional 3 minutes of your time. The fee for this test is $15. insurance or vision benefits do not generally cover this testing. However, if we pick up a field defect and recommend further testing, insurance may cover the additional fees.

Please check the appropriate space below and sign on the space provided.

☐ I would like to have the FDT visual field screening.

☐ I understand the importance of the FDT visual field screening; however, I decline the additional test at this time.

_____ _____

Patient Signature / Legal Guardian Date

DILATION CONSENT FORM

The purpose of a dilated exam is to enhance the detection of any ocular pathology, such as cataracts, glaucoma, retinal hemorrhages, retinal detachments, malignant growths, or any other ocular conditions. It is especially important for patients with a history of diabetes, high blood pressure, headaches, migraines, floaters, high spectacle prescriptions, retinal problems, glaucoma, or family history of eye disease.

This is a relatively painless procedure. There are some minor side effects associated with dilation. These include:

* **Sensitivity to light**
* **Blurred vision**
* **Mild burning on installation of the drops**
* **An inability to focus and do near work**

These side effects usually last approximately 3-5 hours. Some patients find it difficult to drive after being dilated, and thus bring a driver with them.

I understand the importance and side effects of having my eyes dilated and at this time request to:

_____ Have my eyes dilated today

_____ Not have my eyes dilated

_____ Take responsibility to reschedule my dilation

_____ _____

Patient Signature / Legal Guardian Date

OP-32 (Rev. 3-06)

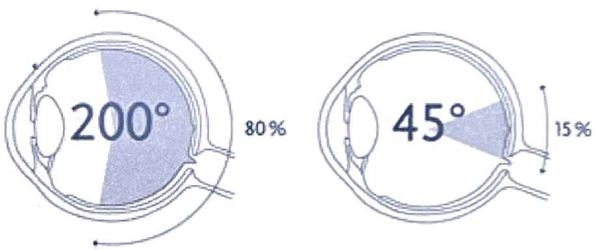
Dr. Goldman & Associates

During a comprehensive eye exam, Dr. Goldman and Dr. Collier need to evaluate the overall health of your eyes. With the **Optomap® Retinal Exam**, your doctors can monitor for retinal complications including macular degeneration, glaucoma, and retinal holes or detachments.

This screening procedure can also detect problems unrelated to the eye that may show signs in the retina such as diabetes, hypertension, cancer/tumors, auto-immune disorders, and others, earlier than possible with traditional methods.

The Optomap® Retinal Exam:

- ✓ Is as fast as taking a picture.
- ✓ **DOES NOT REQUIRE DILATING DROPS. Your doctor recommends getting both imaging and dilation at least once per year. If you don't dilate today, retinal imaging is needed.**
- ✓ Provides a permanent record for annual review.



with optomap ultra-widefield retinal imaging

without optomap

The Optomap Retinal Exam is $39. It is not covered by vision plans.

_____ I understand that the **Optomap** Retinal Exam will be performed today and do not have any questions.

Signature: _____ Date: _____

Membership # _____

HEALTH & VISION HISTORY *(Confidential)*

(Please print) Today's date: _____/_____/_____

LAST NAME _____ FIRST NAME _____ MI _____ SEX: M / F

ADDRESS _____ CITY _____ ZIP _____

HOME PHONE: ( ) _____ WORK PHONE: ( ) _____

E-MAIL ADDRESS _____ BIRTHDATE _____/_____/_____ AGE _____

OCCUPATION or FIELD OF STUDY & SCHOOL? _____ EMPLOYER _____

HOBBIES, ARTISTIC INTERESTS, SPORTS _____

_____

_____

What is your reason for coming in today? _____

Age of present glasses _____ yrs. Age of present contact lenses _____ yrs.

Date of Last Eye Exam _____ Doctor's Name & City _____

Have you had your eyes dilated before? ☐ No ☐ Yes When? _____

WHAT ARE THE REASONS FOR TODAY'S VISIT? (Check all that apply)

☐ Need Updated Exam
☐ Distance blur
☐ Near/Reading blur
☐ Double vision ☐ Headaches
☐ Problems with Computer use

Glasses are:
☐ Lost
☐ Broken
☐ Scratched
☐ Not effective
☐ Never worn glasses

Contact Lenses:
☐ Never worn contacts
☐ I am interested in contacts
☐ Irritating
☐ Not effective
☐ Torn/ Damaged/ Lost ☐ Other:

_____

DO YOU OR ANY FAMILY MEMBER HAVE ANY OF THE FOLLOWING? (Check and indicate who has the condition):

☐ Diabetes _____
☐ High Blood Pressure _____
☐ Arthritis _____
☐ Thyroid problems _____
☐ Lung Disease _____
☐ Heart Disease _____
☐ Head Injury _____

☐ Eye Disease or Injury _____
☐ Eye Surgery _____
☐ Glaucoma _____
☐ Cataract _____
☐ Macular Degeneration _____
☐ Crossed/ Turned/ Lazy eye _____
☐ Retinal Detachment _____

Are you being treated for any medical conditions? (List) _____

List any DRUGS or MEDICATIONS you are now taking _____

List any ALLERGIES you have including allergies to medications _____

Who is your Primary Care Physician? _____

WOMEN: Are you pregnant or nursing? ☐ yes ☐ no

IF YOU WEAR CONTACT LENSES, PLEASE ANSWER THE FOLLOWING:

TYPE: ☐ Soft ☐ Disposable ☐ Astigmatism ☐ Gas Permeable/Hard ☐ Monovision ☐ Tinted ☐ Bifocal

METHOD OF WEAR: ☐ Daily Wear ☐ Overnight What Contact Lens Solutions do you use? _____

Who reffered you to our office: ☐ Optical Company _____ ☐ Friend _____

☐ Family Member _____ ☐ Other _____

Names of FAMILY MEMBERS who are patients of this office: _____

Please indicate method of Payment: Type: ☐ Cash ☐ Check ☐ Charge ☐ Insurance _____