Hillsborough Eye Care

Dr. Sam Lee & Associates

601 Rt. 206, Unit 36 - Hillsborough, NJ 08844

We are pleased to welcome you to Hillsborough Eye Care, please take a moment to fill out the questionnaire given below as accurately as possible. These questions will help us have a preliminary insight into attending to your eye care needs with efficiency and professional care.

Patient Information

Last Name _____ First Name _____ DOB ___/___/___

Address _____ Birth Sex Male [ ] Female [ ]

City _____ State _____ Zip _____ Married Yes [ ] No [ ]

Best Phone _____ Email _____ Occupation _____

How did you hear about our office? _____

Medical and Ocular History

Reason for Exam _____

Last eye Exam _____ Doctor of Last Exam _____

Do you currently wear or have worn contacts? Yes [ ] No [ ] What type? _____

Do you have problems with any of the following?

	Yes/No		Yes/No		Yes/No
Eyes	[ ] [ ]	Integumentary (skin)	[ ] [ ]	Cancer	[ ] [ ]
Ear/Nose/Mouth/Throat	[ ] [ ]	Neurologic (seizure/stoke)	[ ] [ ]	Infectious Disease	[ ] [ ]
Cardiovascular	[ ] [ ]	Psychiatric/Mental	[ ] [ ]	Glaucoma/ARMD	[ ] [ ]
Respiratory	[ ] [ ]	Hematologic/Lymph	[ ] [ ]	Surgery	[ ] [ ]
Gastrointestinal	[ ] [ ]	Endocrine	[ ] [ ]	Allergies	[ ] [ ]
Musculoskeletal	[ ] [ ]	Diabetes/Thyroid/Etc.	[ ] [ ]		

Please explain "yes" conditions from above, or list any other problem:

_____

_____

Medications:

_____

_____

Physician caring for medical condition(s):

_____

	Yes/No		Yes/No	
Difficult driving at night	[ ] [ ]	Computer Use	[ ] [ ]	How many hours? _____

Special visual demands (For work, sports, and hobbies):_____

Notice of Privacy

I acknowledge that I have read and reviewed a copy of Hillsborough Eye Care HIPAA Notice of Privacy.

× _____ **Date**_____

Signature of Patient, Parent, Legal Guardian or Personal Representative

Contact Lens Evaluation and Fitting Policy

A contact lens evaluation determines if your eyes are healthy and suitable for contact lenses, and includes measurements for a proper fit. The contact lens prescription may differ from your eyeglass prescription and the fitting and management is a separate procedure, above and beyond that of a comprehensive routine exam. Therefore, contact lens evaluation and fitting requires a non-refundable fee depending on fit and insurance coverage.

Vision Discount Plans (i.e. VSP, Eyemed) often have allowances or co-pays that cover the evaluation, often at a discounted rate. Most medical insurances (i.e. Aetna and Horizon BCBS) do not cover the contact lens evaluation and fitting in the vast majority of the cases, even if routine eye care is covered. In this case, the contact lens evaluation is collected in addition to any applicable co-pay. These fees cover follow-up visits within 90 days, but if you need to be seen after 90 days, you will be responsible for a new refraction and fitting charge.

New wearers will receive instructions on insertion, removal, and lens care. Trial lenses will be provided, and a follow-up may be necessary to finalize your prescription. For existing wearers, the contact lens evaluation ensures that lenses are used properly and that no detrimental side effects are occurring. Any necessary changes or improvements in contact lenses will be discussed and trialed, based on a mutual decision between the patient and the doctor.

All patients must finalize their contact lens prescription within 90 days from the dispense date of the first trial lenses. If this period expires, a new contact lens evaluation will be necessary and charged. Please remember to finalize your contact lens prescription within the 90 day period.

All contact lens evaluation and fitting service fees are due paid in full prior to receiving any supply of contacts or release of the contact lens prescription. Contact lens prescriptions are valid for one year and, in order to ensure continued ocular health and patient satisfaction and safety, require a yearly evaluation to renew the prescription, even if no changes are made. This is also required by law in New Jersey. For more details, visit NJ Consumer Affairs FAQ.

The fees do not include the cost of the contact lenses themselves. We will assist in providing your prescription and ordering lenses. If ordered from our office, unopened, unused, and non-expired soft contact lens boxes may be exchanged or credited, if not expired and if changes are made to the prescription. Rigid contact lenses may be returned within 30 days for credit.

By proceeding, you acknowledge that you have read and understood the policy outlined above, and agree to the non-refundable nature of the contact lens fitting fees.

× _____ **Date**_____

Signature of Patient, Parent, Legal Guardian or Personal Representative

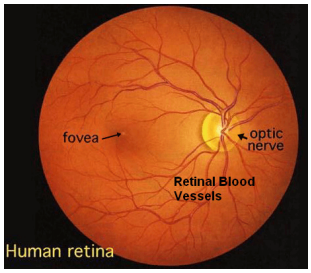
Wellness Screening with Digital Retinal Imaging

As part of your comprehensive eye exam, Hillsborough Eye Care is pleased to offer digital retinal imaging as a wellness screening. This advanced technology produces a detailed digital image of the retina (back of the eye) as well as the blood supply and the optic nerve. These images become a permanent record of your eye health which enables the Doctor to detect and monitor subtle changes. We can identify the following eye pathologies:

- Glaucoma
- Macular Degeneration
- Signs of cataracts
- Hypertension and Diabetes
- Evidence Of stroke
- Retinal abnormalities (i.e., bleeding, edema (swelling) and ischemia (lack of oxygen to tissue)

In most cases, dilation is not needed for retinal photos. However, patients may still require dilation, including those with diabetes, cataracts, macular degeneration, or glaucoma, but can still benefit from advanced imaging. It is faster than a dilated exam without blurred or light-sensitive vision afterward. Our staff and doctors can address any questions or concerns you have.

Our office will apply an applicable co-pay for this procedure based on the patient's vision care benefits. For those without such coverage, we can keep the fee affordable at a discounted rate of $39. Please indicate below whether you elect or decline to have retinal imaging performed today and annually to ensure the continuity of your eye health.



___ **Yes**, I elect to have retinal imaging performed. I understand there is an **additional fee of $39 unless stated otherwise,** and that my eyes may still have to be dilated depending on the results and my medical history.

___ **No**, I decline to have retinal imaging performed. I understand that I may be dilated today to assess my retinal health.

× _____ **Date**_____
Signature of Patient, Parent, Legal Guardian or Personal Representative