PATIENT REGISTRATION CONFIDENTIAL

PATIENT INFORMATION

Date_____

SS #_____

Patient name_____

Home Phone # (____)_____

Work/Cell Phone # (____)_____

Address_____

City_____

State_____ Zip_____

E-Mail_____

Sex ☐ M ☐ F Age_____ Birthdate_____

☐ Married ☐ Widowed ☐ Single ☐ Minor

Occupation_____

Hobbies_____

Do you use a computer? ☐ Yes ☐ No Hrs/day_____

Patient Employer/School_____

Date of last eye exam _____

Name of eye health provider _____

INSURANCE

Responsible Party?_____

METHOD OF PAYMENT ☐ Cash ☐ Check ☐ Visa/MC

Relationship to Patient_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Primary Subscriber's Name_____

Subscriber's ID #_____

Birthdate _____ SS#_____

Insurance Co_____

Group #_____

ASSIGNMENT AND RELEASE

I certify that I, and/or dependent(s) have insurance coverage with

_____ and assign directly to

Dr. Gary A. Bodofsky all insurance benefits, if any, 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 on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my treatment plan is completed with the above-named doctor.

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____

Signature of Patient, Parent, Guardian or Personal Representative

FAMILY HEALTH HISTORY

Do you wear glasses? ☐ Yes ☐ No

☐ All the time ☐ Occasionally

☐ Reading Only ☐ Distance Only

Are you interested in contact lenses?

☐ Yes ☐ No

Do you wear contacts? ☐ Yes ☐ No

Type_____Hours/Day_____

Describe any problems you have with your contacts_____

_____

Mark all conditions that apply to your family's health history:

☐ Cancer

☐ Diabetes

☐ Heart Condition

☐ High Blood Pressure

☐ Thyroid Condition

☐ Glaucoma

Relationship to patient

_____

☐ Asthma

☐ Allergies

☐ Cataracts

☐ Blindness

☐ Migraines

☐ Macular Degeneration

Relationship to patient

_____

OUR FINANCIAL POLICY

Revised 12/28/2011

The Vision Centers are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees or your financial responsibility.

Patients must complete all information forms prior to seeing the doctor. A copy of your insurance card(s) may be required for your file. Missed or broken appointments will be subject to a $45 charge without at least a 24-hours notice.

CO-PAY PLANS: If your plan requires a co-payment and we participate, we will accept the designated fees. You are responsible for any deductible and balance your plan indicates in the explanation of benefits. State law and insurance carriers require all deductibles and co-pays to be paid at the time of your visit.

SELF-PAY: Payment is expected when services are rendered unless other financial arrangements have been made prior to your visit.

USUAL AND CUSTOMARY: This is a term developed by the insurance industry to reflect "average charges" from specific geographic localities. The usual and customary amount noted in the explanation of benefits does not accurately reflect individual charges. Therefore, the usual and customary charges do NOT supercede our fees.

PRESCRIPTION GLASSES AND CONTACT LENSES: We are dedicated to providing you with the best possible prescription. If, however, you are not satisfied with your vision, we will make every effort to verify your prescription and make any necessary changes within the first sixty (60) days subsequent to your initial exam. As prescription eyewear is custom made specifically for you, **NO CASH REFUNDS** will be given; store credit may be given at the discretion of management. Prescriptions not filled in our dispensary are subject to a re-evaluation fee, if necessary.

"I acknowledge my responsibility for payment of all fees regardless of the insurance I may have to assist me. The only exception will be charges for services covered under a contractual agreement that has been entered into between the Vision Centers and an insurance company, HMO, or other managed care entity. **If for any reason the account should become delinquent, I am liable to pay for all collection and legal fees.**"

X _____ **Date:** _____

PRIVACY PRACTICE ACKNOWLEDGEMENT

Please Check All That Apply

____ We may discuss your protected medical information with _____.

____ We may leave messages concerning your protected medical information on an answering machine and/or voice mail

____ We may **not** leave any messages on an answering machine and/or voice mail

I am aware of the Notice of Privacy Practices and had the opportunity to review it, upon my request.

Signature: _____ **Date:** _____

Print Name: _____ **Birth date:** _____

PATIENT HEALTH HISTORY UPDATE FORM

Case: General Exam ☐ Contact Lens Exam ☐ Date: _____

Patient's Name: _____ Parent (if minor): _____

Change of Address: _____ Home Phone: _____

_____ Work/Cell Phone: _____

METHOD OF PAYMENT: Cash ☐ Check ☐ Credit Card ☐

Changes in Patient's or Family's Health History (Please be specific):

_____

_____

_____

Ocular/Visual Symptoms: _____

Amount of computer work per day: _____

Medications: _____

_____

Drug Allergies: _____

DILATION INFORMED CONSENT

Dilation is the procedure in which the doctor puts drops into the eyes in order to enlarge the pupil.

Dilation of the pupils is necessary in order for the doctor to view virtually the entire retina. It also aids the doctor in the diagnosis of glaucoma, diabetes, hypertension and retinal detachments, as well as other diseases.

Without dilation, the doctor can only view the back portion of the eye. This has been described as "looking into a closet through a keyhole".

Dilation is necessary if any of the following applies to you: 1) have not had a comprehensive eye exam in more than two years; 2) have diabetes or hypertension; 3) have glaucoma or cataracts; 4) are highly myopic (near-sighted); 5) have frequent and/or unexplained headaches; 6) see spots, floaters, or flashes of light in your vision; 7) have unexplained loss of vision; 8) if this is your first comprehensive eye exam.

Dilation is **NOT** necessary to determine your prescription. It only aids the doctor in evaluating your ocular health. Once dilated, driving may be difficult as it can take up to 4-5 hours to fully recover from the dilating drops. The doctor does not dilate on every patient at every exam; only when he feels it necessary and when given your permission.

I fully understand the need for dilation and: **(CHECK ONLY ONE)**

☐ I do give the doctor permission to dilate my eyes today.

☐ 1 do not give the doctor permission to dilate my eyes today.

_____

Patient signature (or guardian, if patient is a minor)

Dr. Gary A. Bodofsky The Vision Centers

EyeScreen Photographic Examination

We at The Vision Centers are pleased to provide our patients with an advanced digital retinal exam called EyeScreen. EyeScreen is a high resolution screening photograph of your retina which will help us document, review, and compare your retina over time. We will use the EyeScreen exam to document your retinal image for our records, screen for eye diseases and improve our ability to view your internal retinal health at a much higher resolution than a conventional biomicroscope (slit lamp) or ophthalmoscope.

Dr. Bodofsky is concerned with retinal problems such as macular degeneration, glaucoma, retinal holes, detachments, and diabetic retinopathy. All of these conditions can lead to loss of vision or blindness. Additionally many symptoms of systemic diseases such as diabetes, the effects of high blood pressure and other diseases can be detected with the EyeScreen Examination.

You can expect from this exam:

- An annual eye wellness EyeScreen photograph
- An in depth view of the retinal surface (where eye diseases first manifest)
- The ability to review the images with you (we will show you your retina)
- A permanent record for your medical file, for serial analysis, comparison and diagnosis
- To be fast, easy and comfortable
- Usually no dilation drops for the test (we will inform you if they are required)

Since insurance will not pay for the EyeScreen Exam or any retinal image unless eye disease is present, the EyeScreen Examination is an out-of-pocket expense.

Dr. Bodofsky recommends this procedure for all of his patients and we will perform the EyeScreen Exam at an additional fee of $32.00 to the comprehensive eye exam you are receiving today. Please check only ONE of the following:

___ I AGREE TO have my retinal health evaluated with the EyeScreen Exam.

___ I DO NOT wish to have the Retinal Photographic Exam. I understand that I will still have a thorough eye examination.

_____ _____

Patient's (or guardian's) signature Date

THE VISION CENTERS

There are two types of health insurance that will help pay for your eye health services and products. You may have both types and The Vision Centers accepts most vision care plans and insurance plans in both categories: (1) vision plans and (2) medical insurance (such as Blue Cross/Blue Shield, Medicare, and others).

- Vision Plans cover ONLY routine vision wellness exams and may include eyeglasses, sunglasses and contact lenses. Vision plans do NOT provide for MEDICAL EYE HEALTH CARE NEEDS.

- Medical Insurance MUST be submitted for any medical eye healthcare diagnoses and treatment care and follow-up.

- If you have both vision care benefits and medical insurance plans, it may be necessary for us to submit and bill some services to one plan provider and some services to the other plan provider. We will follow a procedure called "Coordination of Benefits" to do this properly and to your best advantage and least cost for you.

- Where some fees for services and products are not paid by your vision plan or medical insurance providers, you will be responsible for them, including deductibles, co-payments and non-provider services as specified by the insurance contract.

Please provide both your vision plan and medical insurance card(s) and picture identification to our team member. We will need your medical insurance or Medicare card on file in case we should need it in the future for submitting a claim on your behalf with your insurance.

I have read and accept this office procedure.

Signature: _____ **Date:** _____

CONTACT LENS AGREEMENT

Contact lenses are medical devices that can cause serious consequences, such as infection, inflammation, permanent damage and loss of vision if not fit and taken care of properly. Examining a contact lens patient takes additional time and expertise. For that reason, there are additional fees associated with the examination and fitting of contact lenses. If, while wearing contact lenses, you experience any pain, unusual redness, discharge, or any sudden change in vision, remove them and call our office. We will attempt to solve your problem, or, when necessary, refer you to the appropriate professional who can. Any medical expenses incurred from these problems are the responsibility of the patient and *not part of your routine follow-up care.*

In addition to your regular eye examination, there is a fitting fee associated with trying new contact lenses. There are hundreds of types of lenses, and the doctor will need to take special measurements and determine which lens type will work best for you. Your initial design fee will cover ocular surface evaluation, diagnostic lenses, lab or shipping fees, fitting analysis and any follow-up visits necessary to obtain a satisfactory fit. If you have never worn lenses before, your fitting will include a class in which new wearers receive instruction on insertion and removal of the lenses and proper care and cleaning of the lenses. Proper care is always necessary. You must care for your lenses as directed and *dispose of them as prescribed.* Over wear of the lenses can lead to the complications described earlier in this agreement. Use only recommended solutions as substitutions may not be compatible with your eyes and must be approved through our office. The fee may also depend on what type of lenses you wear: for example, bifocal contact lenses are more difficult to fit and take longer to adjust and fine-tune than standard lenses. The fit is finalized after the doctor agrees the fit is successful, or if he determines that contact lenses are not an acceptable option for your eyes. Your initial fitting includes up to 30 days of follow-up; any additional visits required to finalize your fit are subject to a per-visit fee. Once finalized, any future lens changes in brand or type will be considered a refit and may be subject to new fees.

After you have been fit with an appropriate lens, you will have the option of buying a supply of lenses that will last up to one full year. You will have to replace lenses as directed, which can range anywhere from daily, to every 2 weeks, monthly, or quarterly depending on the kind of lens worn. Buying a year's supply of contact lenses at one time is beneficial because discounts or rebates may be available, and because you will have the convenience of having new lenses on hand when you need to replace them, so that you are not tempted to wear old, dirty or damaged lenses that can cause harm to your eyes. Also, you will need to keep your glasses current in order to give your eyes periodic breaks as prescribed by the doctor.

Once finalized, per South Carolina state regulations, your contact lens prescription will be valid for up to 1 year. This means you can purchase enough lenses to last for 12 months and no more. After 12 months, the prescription expires. If you want to continue to wear contact lenses, you must return for a comprehensive eye examination and contact lens evaluation. The doctor will verify that your eyes are responding well to contact lens wear, check the ocular surface for any damage and make sure the lenses are still fitting properly and are the correct prescription for your eyes. The doctor will not renew expired prescriptions without first making sure that your eyes are healthy enough to wear lenses. To avoid any inconvenience, make sure your annual examination is scheduled on time so that you do not run out of lenses before you are seen. If you wear contact lenses, this examination must be done annually, *even if your insurance only allows for a 2-year examination interval.*

I completely understand the above agreement and realize my responsibilities concerning my contact lenses.

Signature of Patient (Parent or Guardian, if Minor) Date

PATIENT HEALTH HISTORY CONFIDENTIAL

Reason for visit today? _____

SYMPTOMS — Check symptoms you have or have had in the past year

EYE HEALTH HISTORY
___Blurred Vision Distance
___Blurred Vision Near
___Burning Eyes
___Cataracts
___Poor Color Vision
___Crossed Eyes/Lazy Eyes
___Discharge from Eyes
___Double Vision
___Dry Eyes
___Eye Infection
___Eye Injury
___Eye Strain
___Floaters/Spots in Vision
___Glaucoma
___Itching Eyes
___Light Sensitivity
___Loss of Vision
___Migraine Headaches
___Poor Night Vision
___Red Eyes
___ Seeing Flashes of Light
___ Halos Around Lights
___Watering Eyes
___Twitching Eyelid

GASTROINTESTINAL
___ Loss Of Appetite
___Bloating
___Bowel Changes
___Constipation
___Diarrhea
___Excessive Hunger
___Excessive Thirst
___Gas
___Hemorrhoids
___Indigestion
___Nausea
___Rectal Bleeding
___Stomach Pain
___Vomiting
___Vomiting Blood

SKIN
___Bruise Easily
___Hives
___Itching
___Change in Moles
___Rash
___Sore that won't heal

EAR, NOSE, THROAT
___Bleeding Gums
___Difficulty Swallowing
___Earache
___Ear Discharge
___Hay Fever
___Hoarseness
___Loss of Hearing
___Nosebleeds
___Persistent Cough
___Ringing in Ears
___Sinus Problems

CARDIOVASCULAR
___Chest Pain
___High Blood Pressure
___Irregular Heartbeat
___Low Blood Pressure
___Poor Circulation
___Rapid Heartbeat
___Swelling of ankles
___Varicose Veins

GENERAL
___Chills
___Depression
___Dizziness
___Fainting
___Fever
___Forgetfulness
___Headaches
___Loss of Sleep
___Loss of Weight
___Nervousness
___Numbness
___Sweats

MUSCLE/JOINT/BONE
Pain, numbness, weakness :
___Arms ___Hips
___Back ___Legs
___Feet ___Neck
___Hands ___Shoulders

GENITO-URINARY
___Blood in Urine
___Frequent Urination
___Lack of Bladder Control
___Painful Urination

CONDITIONS — Check conditions you have or have had in the past

___AIDS/HIV Positive
___Alcoholism
___Anemia
___Anorexia
___Appendicitis
___Arthritis
___Asthma
___Bleeding Disorders
___Breast Lump
___Bronchitis
___Bulimia
___Cancer
___Chemical Dependency
___Chicken Pox
___Diabetes
___Emphysema
___Epilepsy
___Goiter
___Gout
___Heart Disease
___Hepatitis
___Hernia
___Herpes
___High Cholesterol
___Kidney Disease
___Liver Disease
___Measles
___Mononucleosis
___Multiple Sclerosis
___Mumps
___Pacemaker
___Polio
___Prostate Problems
___Psychiatric Care
___Rheumatic Fever
___Scarlet Fever
___Stroke
___Thyroid Problems
___Tonsillitis
___Tuberculosis
___Typhoid Fever
___Ulcers
___Venereal Disease
___Pregnant
How many weeks?
_____

Primary Physician's Name_____ Last physical exam___/___/____

List MEDICATIONS you are currently taking.		ALLERGIES to Medications
_____	_____	_____
_____	_____	_____
_____	_____	_____