Gardendale Eye Care

655 Fieldstown Road St 114, Gardendale, AL 35071

Patient Information:

Name_____ / _____ Date _____
First MI Last Preferred Name

Address _____City _____ State _____Zip _____

Date of Birth _____ **Social Security#**: _____Home/cell Phone _____

Employer /School _____ Occupation/Grade _____

Spouse/Parent's Name _____ Email _____

Insurance Information:

Do you have insurance for ____Medical ____Vision ____Both? Patient's relationship to insured: _____

Vision insurance company _____ Contract & group #: _____

Medical insurance company _____ Contract & group #: _____

Name on insurance card: _____ Insured date of birth: _____

Insured **social security number** (SSN): _____

Responsible Party Information (if different than patient information):

Name _____ DOB _____SSN: _____

Address _____ City _____ State _____Zip _____

Home Phone _____Work Phone _____ Cell Phone _____

Reason for today's visit/Chief Complaint: _____

Personal/Family/Social Health History:

Date of last eye exam _____ Name of Eye Doctor _____

Date of last physical exam _____ Name of Primary Care Physician _____

Do **YOU** or anyone of your blood relatives (mother, father, brother, siblings, etc.) have a history of the following, **PLEASE SPECIFY:**

	SELF	FAMILY	SELF ONLY:	YES	NO	SELF ONLY:	YES	NO
Diabetes	_____	_____	Respiratory condition	____	____	Blurred vision	____	____
Thyroid disease	_____	_____	Cardiovascular condition	____	____	History of Eye injury	____	____
High blood pressure	_____	_____	Musculoskeletal condition	____	____	History of Eye surgery	____	____
Heart Disease	_____	_____	Neurological condition	____	____	Sensitivity to light	____	____
Cancer	_____	_____	Gastrointestinal condition	____	____	History of Dry Eyes	____	____
Stroke	_____	_____	Ear/Nose/throat condition	____	____	Floaters /spots in vision	____	____
Macular Degeneration	_____	_____	Blood disorder	____	____	Severe eye pain	____	____
Cataracts	_____	_____	Autoimmune condition	____	____	Do you drive	____	____
Glaucoma	_____	_____	Endocrine condition	____	____	Do you use tobacco	____	____
Blindness	_____	_____	Genitourinary condition	____	____	Do you drink alcohol	____	____
Crossed eye	_____	_____	Skin condition	____	____	Pregnant or Nursing	____	____
Lazy eye	_____	_____	Drug Allergies	____	____	_____		

List ALL current Medications: _____

Do you wear glasses? _____ or Contacts? _____ Brand _____ Are you interested in contact lenses? _____

Authorization. Please READ and SIGN below:

If you plan to pay with insurance, please read: It is your responsibility to know of and pay any co-payments, non-covered portion of the visit, or payments toward your deductible at the time of service is rendered. It is also your responsibility to know what services are covered under your insurance plan. I authorize and request my insurance company to pay directly to the eye doctor insurance benefits otherwise payable to me. I understand that my vision/medical care insurance carrier may pay less than the actual bill for services. We are not responsible for misunderstandings between you and your insurance company.

ALL patients/guardians, please read:

I certify that I have completed the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release information (including diagnosis and treatment) rendered to me or my child to third party payers and/or other health practitioners. I agree to be responsible for payment of all services rendered on my behalf or my dependents. If I am ever in need of after-hours emergency optometric care, I understand that I will need to contact Callahan Eye Foundation Hospital at 205-325-8254 or a local hospital emergency department.

_____ _____

SIGNATURE OF PATIENT (or parent/guardian if a minor) Date

Marvelous Eyes, LLC dba Gardendale Eye Care

Receipt of Notice of Privacy Policies and Consent Form

You may view the full document by request by going to our website or asking an employee for a full copy.

Patient Name: _____

Patient Phone: _____ cell number _____

Patient email address _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy here at the office or by e-mail marvelouseyes17@gmail.com.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices***.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment and healthcare operations. I acknowledge that I have received the ***Notice of Privacy Practices*** from Marvelous Eyes, LLC dba Gardendale Eye Care.

→_____ _____

Signature Date

Persons authorized to receive personal information:

*Name:*_____ *Relationship:*_____

*Name:*_____ *Relationship:*_____

If signing as a personal representative of the patient, describe the relationship to the patiet and the source of authority to sign this form:

_____ _____

Relationship to Patient *Print Name*

*Source of Authority:*_____

GARDENDALE EYE CARE
CONTACT LENS POLICY AND CONSENT FORM

Patient Name:_____ Date:_____

Contact lenses are considered medical devices, which need to be monitored on a regular basis. By federal and state law, contact lens prescriptions must be renewed EVERY 12 MONTHS.

The process of acquiring and obtaining a contact lens prescription involves the evaluation and management of a properly fitted contact lens. In addition to a comprehensive exam, a successful fitting process includes the following professional services:

1.) Measurement of the curvature and size of the cornea to help determine appropriate lens type and parameters
2.) Evaluation of the contact lenses on your eyes
3.) Follow-up care and any necessary lens changes **for up to 45 days**

The following fitting fees will be applied **in addition** to your comprehensive eye exam. Some vision insurances DO NOT cover the additional fitting fee. Please ask in advance if you have any questions. These fitting fees are for the above mentioned professional services:

- Spherical (no astigmatism): $45
- Toric (astigmatism) and monovision: $55
- Multifocal (bifocal): $75
- RGP (hard contacts): $150 (new wearer $175)
- No change to your prescription: $30 re-evaluation fee

There is an additional $15 fee to teach insertion and removal to new soft contact lens wearers. We cannot guarantee in advance if a patient will be a successful contact lens wearer, therefore **all professional fees are non-refundable.** If a patient does not adhere to the recommended follow-up appointments than an additional $30 fee will be charged for a CL re-fit.

As with any medical device, there are some potential risks involved, especially when patients elect not to follow recommended wear schedules and disinfecting procedures.

DO…..	**DO NOT…..**
Wash your hands before inserting and removing your contact lenses	Wear your lenses longer than prescribed
Clean and disinfect your lenses as directed	Wear your lenses if you have a red eye or loss of vision
Replace your contact lenses as prescribed	Reuse your disinfecting solution
Replace your contact lens case every 3 months	Use saline solution in place of disinfecting solution
Call our office if you experience any unusual symptoms	Ignore any unusual symptoms

Always remove your contact lenses immediately if you experience any of the following, unexplained symptoms:

- Eye pain or redness
- Watering or discharge of the eye
- Decrease or loss of vision
- Increased sensitivity to light

If removal of contact lenses does not resolve the issue, please make arrangements as soon as possible to be seen by our office, especially if symptoms are associated with extended or overnight wear.

The undersigned hereby acknowledges understanding the risks, benefits, and stated polices.

Patient or Legal Guardian Signature_____ Date:_____

WE PREFER TO DILATE

When indicated, pupillary dilation improves our doctor's ability to examine the internal structures of the eye for signs of disease, which is important for your health and well-being. Normal side-effects usually last 3 to 5 hours, and they include sensitivity to bright light (for which disposable eye shades are provided upon request) and difficulty focusing on near objects. Normally, your distance vision is not affected very much, and it is possible to drive safely after dilation if you currently have fairly up-to-date prescription eyeglasses.

PATIENTS MAY REFUSE

Patients reserve the right to refuse any test or diagnostic procedure recommended. If a patient refuses, however, he or she assumes all of the risk for potentially not detecting, and thereby treating in a timely manner, any serious eye conditions.

PATIENTS MAY RESCHEDULE

Some patients prefer to reschedule their dilated retinal exam for a different day and time to minimize visual side-effects upon their return to work or school. We will be happy to schedule a second appointment at a later time for this purpose, **privately charging an additional fee of $40.00.** There is absolutely **NO ADDITIONAL CHARGE** if we complete the dilated retinal exam during your initially scheduled comprehensive eye examination.

DILATION REFUSAL/WAIVER
(To Be Signed ONLY If You Are Refusing Dilation)

I, under my own will and judgment, refuse to have my eyes dilated. As a consequence, I understand that the doctor may not be able to detect cases in which the retina is diseased, physically compromised, or harboring cancerous growths. As such, early detection and diagnosis of certain eye conditions, along with timely and effective treatment, may not be possible. I accept all risk for the possibility of not detecting these eye conditions without pupillary dilation, and I understand that these conditions may result in permanent blindness, or even death.

Name: _____

Signature: _____ **Date:** _____

Fundus Photography and Optical Coherence Tomography

Funds Photography and Optical Coherence Tomography Screening devices take high resolution images and scans of the retina (nerve layer inside the back of your eye). These procedures assist the doctor in the early detection of many disorders, including glaucoma, diabetic retinopathy, macular degeneration, hypertensive retinopathy, and other sight threatening conditions. The scans will be used to compare with future images to observe changes in the health of the inside of your eyes. The doctor recommends all patients have this procedure performed routinely, every year. **Medical and Vision insurances do not pay for routine photos.** The charge for Fundus Photography and Optical Coherence Tomography screening is only **$39.**

If there is a medical diagnosis, your medical insurance may pay for this procedure. This requires a written interpretation and report by the doctor and additional fees will be submitted to your insurance company. The doctor will not know prior to your exam if there is a medical diagnosis that would allow for insurance submission.

If you have Medical Insurance, we can provide claim submission for you. However, please realize some insurance companies will deny payment as “not medically necessary” or “not a covered service.”

Informed Consent for
Fundus Photography and Optical Coherence Tomography Screening
Your medical insurance is a contract between you (the patient), your employer, and the insurance company. The responsible party for payment is the patient.
Payment is due when services are rendered.

By signing this informed consent, you acknowledge reviewing the Fundus Photography and Optical Coherence Tomography descriptions above and agree to the associated fees, if applicable.

Please place a check mark in the appropriate boxes, sign and date.

Fundus Photography(FP) and Optical Coherence Tomography (OCT)
____Yes, I want to receive the FP and OCT tests I understand and agree to the above terms.
____No, I Decline the FP and OCT tests. I understand the benefit of these procedures and the risks involved in refusing the tests. I therefore release Dr. Frank Francisco and associates from any liability resulting from failure to diagnose or treat any eye condition due to the lack of diagnostic information, which could have been obtained by performing these tests.

Patient’s signature: _____ Date:_____

Print Name: _____