PATIENT'S NAME: _____ Today's Date: _____

SSN: _____ ☐ Male ☐ Female D.O.B. : _____

Mailing Address: _____
(Street Address or P.O. Box) (City) (State) (Zip Code)

Email Address for Notifications: _____

Phone Number: _____ Alternate Phone Number: _____

GUARANTOR'S NAME: _____ Today's Date: _____

SSN: _____ ☐ Male ☐ Female D.O.B.: _____

Mailing Address: _____
(Street Address or P.O. Box) (City) (State) (Zip Code)

Phone Number: _____ Alternate Phone Number: _____

PRIMARY **MEDICAL INSURANCE:** _____ ID# _____

Primary Insured: _____ Relation to Patient: _____

D.O.B. of Primary : _____ SSN if required by Insurer: _____

Employer of Primary Insured : _____ GRP# _____

SECONDARY **MEDICAL INSURANCE:** _____ ID# _____

Primary Insured: _____ Relation to Patient: _____

D.O.B. of Primary : _____ SSN if required by Insurer: _____

Employer of Primary Insured: _____ GRP# _____

VISION Insurance: _____ ID# _____

Primary Insured: _____ Relation to Patient: _____

D.O.B. of Primary : _____ SSN if required by Insurer: _____

Employer of Primary Insured (Notate if Retired) : _____ GRP# _____

REFERRAL INFORMATION Name of Doctor: _____ ☐PCP ☐ PEDS ☐ SPECIALIST

Reason for Referral: _____

Referred by Friend or Family Member: _____

SPECS Eye Care Medical History

Name of Patient_____ **Today's Date**_____

Do you have any concerns with your eyes or vision? ☐ **No** ☐**Yes, please describe:**

_____

Please check any problems you have currently or have been diagnosed with in the past:

☐Age-related macular degeneration
☐Glaucoma
☐Diabetes; last A1C:_____; doctor who treats:_____
☐Diabetic Retinopathy
☐Dry Eyes
☐Eye Infection
☐Floaters/Flashes of light
☐Iritis/Uveitis
☐Retinal defects (tears, detachments)
☐Eye Surgery: Type_____
☐Amblyopia/Patching
☐Keratoconus
☐Injury to Eyes
☐Nystagmus

Do you currently wear? ☐**Glasses or** ☐**Contact Lenses: please list the brand (if known)** _____
How often do you sleep in your contact lenses?_____ **How often do you replace them?**_____

Review of Systems (Check any that apply):

Constitutional
☐developmental delays/disabilities
☐cancer
☐fever
Ears/Nose/Throat
☐Hearing loss
☐Allergies/sinusitis
Neurological
☐Multiple Sclerosis
☐Seizures
☐Cerebral Palsy
☐Tumor
☐Stroke
☐Migraines ☐Headaches
Psychiatric
☐Depression/Anxiety
☐Attention deficit disorder
Cardiovascular
☐High Blood pressure
☐Heart disease
Respiratory
☐Asthma
☐Emphysema ☐ COPD
☐Sleep Apnea
Gastrointestinal
☐Crohn's
☐Acid reflux
Genitourinary
☐Kidney disease
☐Prostate
☐STD
☐Pregnant ☐ Nursing
Musculoskeletal
☐Arthritis
☐Fibromyalgia
Integumentary
☐Rosacea
☐Psoriasis
☐Cold Sores ☐ Shingles
Endocrine
☐Type 1 ☐ Type 2 Diabetes
☐Thyroid
Hematologic/Lymphatic
☐Anemia
☐High cholesterol
Allergy/Immunology
☐Drug Allergy:_____
☐Environmental Allergy
☐Rheumatoid arthritis
☐Lupus
☐Sjogren's Syndrome

Please list any other medical conditions:_____

Please list any current medications with dosage if known:_____

_____

Social History:

Do you smoke or use tobacco? ☐ No ☐ Yes: How much/often? _____

Do you drink alcohol? ☐ No ☐ Yes: How much/often? _____

Family History:

Does anyone in your **immediate** family **(parents, grandparents, siblings, children)** have any of the following medical conditions? **If yes**, please **check** all that apply and **list who** next to the condition:

☐Cataracts:	☐Glaucoma:	☐High Blood Pressure
☐Macular Degeneration:	☐Amblyopia:	☐Cancer
☐Retinal tear/detachment:	☐Diabetes	☐Heart Disease

Specs Eye Care

Consent for Testing and Dilation

Patient's Name_____ Date_____

At Specs Eye Care, we pride ourselves on investing in new technology to provide the best possible patient care. Our doctors now recommend the Optomap® Retinal Exam on **ALL** patients and Wellness OCT on all patients over 30. These quick, non-invasive procedures enhance your eye exam and allow the doctor to see a much broader and more detailed view of the retina compared to undilated (and in some cases, dilated) examinations. The scans become a permanent part of your medical file, enabling your doctor to make important comparisons should potential vision threatening conditions present at a future examination. **Dr. Roland and Dr. Spencer strongly believe that the Wellness OCT and Optomap® are essential parts of your comprehensive eye exam and prescribes it for all patients once per year.**

The fee for these scans is $64 ($44 for Optomap and $20 for Wellness OCT) and is **not** covered by your vision care plan or health care plan unless they reveal a problem with the health of your retina. If a health problem exists, your medical insurance will be filed as a courtesy for the testing.

***Without either the Optomap or dilation of the pupils, your eye doctor may be unable to detect some health problems such as glaucoma, cataracts, retinal detachments or tears, diabetes, high blood pressure and some tumors. The only way to have a complete and thorough eye exam is to get a good look at the retinas.**

Please INITIAL:

_____ I prefer to have the Optomap® Retinal Screening Exam.* In some instances, the doctor may need to perform a dilated fundus exam in addition to the scans. I understand that there is an **additional copayment for the tests**. In some cases, we may be able to file your **vision** or **medical insurance** for your photos.

_____ I prefer to have my eyes dilated today. I understand the risks/potential **side effects** of the dilation, including **blurry vision and light sensitivity**. I have a driver with me or will arrange for one at the conclusion of the exam if I feel I am unable to drive safely. A dilated fundus exam is included with the comprehensive eye exam at no additional charge.

Patient's/Guardian's Signature: _____ Date:_____

Casey N. Roland, O.D.
Alexis Spencer, O.D.

PAYMENT & INSURANCE POLICY, CONSENT & HIPAA

Patient Name: _____ Date: _____

Current Address: _____

PAYMENT POLICY/ASSIGNMENT OF BENEFITS to FILE INSURANCE/RELEASE OF INFORMATION:

I hereby authorize payment directly to SPECS Eye Care. All Self-Pay or Insurance Co-Pay, including non-covered services, are due at the time of service. I understand that I am responsible for all charges not covered by my insurance. Self-Pay discount is not allowed for services billed to my insurance carrier. I hereby authorize release of all information necessary to pay my claim. There is a $50 insufficient funds fee for all returned checks. There will be additional fees for any past due balances that are transferred to a collection agency.

Insured/Parent/Guardian Signature: _____ Date: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION (HIPAA)

I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Insured/Parent/Guardian Signature: _____ Date: _____

Other than yourself, do you authorize our office to discuss your health information with another family member or spouse? (Circle one) YES NO Name of person: _____

ROUTINE VISION PLAN vs. MEDICAL INSURANCE

There are two types of health insurance that will help pay for your eye health services and products. You may have both types and Specs Eye Care accepts most vision care plans and insurance plans in both categories: (1) **Routine** Vision plans (such as VSP or EyeMed) and (2) **Medical** insurance (such as Blue Cross/Blue Shield, United Health Care, Medicare and others).

- Vision Plans cover **ONLY** routine vision wellness exams and may include eyeglasses, sunglasses and contact lenses. Routine Vision plans do **NOT** provide for MEDICAL EYE HEALTH CARE NEEDS (such as diabetes, dry eye disease, infections, floaters, etc)• Medical •Insurance **MUST** be submitted for any medical eye healthcare diagnoses and treatment care and follow-up per national billing guidelines.
- If you have both Routine 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 maximize your best advantage and least cost to 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 routine vision plan provider and medical insurance card(s) and identification, for your benefit, to our staff so we can make a copy. 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.

By signing below, I acknowledge that I fully understand the difference between Routine vs. Medical Insurance:

Insured/Parent/Guardian Signature: _____ Date: _____