VISTA EYE SPECIALISTS ~ PATIENT MEDICAL HISTORY

Patient Name: _____ Birthdate: _____ Primary Care Doctor: _____

Please answer the following questions about your medical status and history. Check any conditions / symptoms you have had in the past or currently have.

MEDICAL HISTORY

- ☐ Diabetes Type _____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Other _____
- ☐ Heart Disease
- ☐ Cancer _____
- ☐ Auto-Immune Diseases
- ☐ Arthritis
- ☐ Thyroid
- ☐ Organ Transplant _____

OCULAR HISTORY

- ☐ Cataract
- ☐ Glaucoma
- ☐ Corneal Disease _____
- ☐ Previous LASIK or PRK
- ☐ Other _____
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Strabismus / Eye Muscle Problems
- ☐ Do you have prism in your glasses? Y / N
- ☐ Trauma/Injury to Eye
- ☐ Contact Lens

Type: _____

Hours worn daily: _____

Are you interested in LASIK or PRK? ☐ Yes ☐ No

LIST ANY SURGERIES / OCULAR SURGERIES DONE IN THE PAST: _____

_____

LIST ANY MEDICATIONS AND DOSAGES YOU ARE CURRENTLY TAKING: _____

_____

_____

LIST ANY DRUG OR FOOD ALLERGIES, INCLUDING REACTIONS: _____

_____

Do you take BLOOD THINNERS (i.e. Aspirin, coumadin)? ☐ Yes ☐ No

ARE YOU CURRENTLY TAKING OR HAVE YOU TAKEN ANY PROSTATE MEDS? ☐ Yes ☐ No

ARE YOU ALLERGIC TO LATEX? ☐ Yes ☐ No **HEIGHT:** FT. IN. **WEIGHT:** LBS.

PLEASE REVIEW AND MARK ANY PROBLEMS YOU MAY HAVE NOW, OR HAVE HAD IN THE PAST:

- ☐ Chronic Fever
- ☐ Anxiety
- ☐ Fatigue
- ☐ Weakness
- ☐ Sore Throat
- ☐ Sinus Problems
- ☐ Hearing Loss
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Coughing
- ☐ Abdominal Pain
- ☐ Heartburn
- ☐ Vomiting
- ☐ Urinary pain / discomfort
- ☐ Blood in urine
- ☐ Joint Pain
- ☐ Swollen Joints
- ☐ Muscle Aches
- ☐ Excessive Skin Dryness
- ☐ Skin Rashes
- ☐ Headaches
- ☐ Numbness
- ☐ Paralysis
- ☐ Abnormal Bleed / Bruise
- ☐ Unexpected weight gain / loss (circle one)
- ☐ Other: _____

FAMILY HISTORY

Medical / Eye Diseases in Family (check all that apply):

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Other _____

SOCIAL HISTORY

- ☐ Yes ☐ No Do you drive?
- ☐ Yes ☐ No Do you have trouble with night vision?
- ☐ Yes ☐ No Do you smoke or vape? How much? _____ Former Smoker / Never Smoked
- ☐ Yes ☐ No Do you drink? How much? _____
- ☐ Yes ☐ No Women: Could you be pregnant?
- ☐ Yes ☐ No Have you had any falls or injuries since your last visit?

I have fully reviewed this questionnaire and answered all questions to the best of my knowledge. I am aware that my answers could affect my health care, or that patient for whom I am responsible.

Patient/Responsible Party Signature: _____ Date: _____

VISTA EYE SPECIALISTS- PATIENT INFORMATION

PATIENT INFORMATION:

FULL NAME: _____ DATE OF BIRTH: _____

HOME ADDRESS, CITY, STATE & ZIP: _____

GENDER: _____ AGE: _____ SOCIAL SECURITY NUMBER (REQUIRED): _____

PHONE: HOME _____ CELL _____ WORK _____

OCCUPATION: _____ EMPLOYER: _____

MARITAL STATUS: S / M / W / D EMAIL(REQUIRED): _____

Referred by? (Doctor/Friend/Patient/Website/Ad): _____

PREFERRED PHARMACY: _____

SPOUSE/DEPENDENT INFORMATION: (Parent/Guardian if patient is under 18 years old)

FULL NAME: _____ DATE OF BIRTH: _____

ADDRESS, CITY, STATE & ZIP: _____

GENDER: _____ AGE: _____ SOCIAL SECURITY NUMBER: _____

PHONE: HOME _____ CELL _____ WORK _____

OCCUPATION: _____ EMPLOYER: _____

EMERGENCY CONTACT:

FULL NAME: _____ RELATIONSHIP: _____

ADDRESS, CITY, STATE & ZIP: _____

PHONE: HOME _____ CELL _____ WORK _____

MEDICAL AUTHORIZATION: Name of Family Member to Release Health Information _____

PREFERRED CONTACT METHODS:

May we send mail to your home address? YES / NO (**If not** please provide an alternate address): _____

_____

With the phone numbers you provided in the patient information section listed above which is the preferred contact method we will be able to reach you at regarding your care and leave voicemails? (Please Circle One)

HOME Number CELL Number WORK Number May we send you text messages (circle one) : Yes / No

Other than you, your insurance company, and all health care providers involved in your care, whom may we speak with about your health care information? (Child/Spouse/Caretaker/Parent/Etc.)

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Do you have any health information that you would like to be kept confidental from any person or persons? If so, please specifically describe the information and the person or persons below : _____

_____

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information. I acknowledge that I have been given the opportunity to request means of communication of my protected health information.

HIPAA DISCLOSURE & INSURANCE AUTHORIZATION / ASSIGNMENT AGREEMENT: I hereby authorize this office disclosure of my health information and/or apply to apply for benefit for covered services rendered. I request payment from my insurance company to be made in the above named provider. I certify that the information I have with regard to my insurance coverage is correct and further authorize the release of any necessary information medical information, to other treating physicians and to my insurance company in order to determine insurance benefits to which I may be entitled. Either myself or my insurance company at any time may revoke this authorization in writing. By signing below, I acknowledge that I have read or understand this authorization.

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____ **DATE:** _____

VISTA EYE SPECIALISTS

POLICIES & AUTHORIZATIONS

REFRACTION POLICY

A refraction is the test that is performed to determine your eyeglass prescription. It is performed by either a doctor or ophthalmic technician and typically includes "which is better 1 or 2". Medicare and most other insurance plans ***DO NOT COVER*** refractions because they are considered routine care. Medicare allows eye doctors to charge separately for this service. If you wish to have a refraction as part of your eye exam the charge for this service will be **$65**.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that Vista Eye Specialists may use and disclose my protected health information for purposes of treatment, payment, and health care operations. I also acknowledge that I have received, have been offered, or have received in the past a copy of the Practice's Notice of Privacy Practices, which provides information about how the Practice, and individuals involved in my care in the Practice, may use and disclose my protected health information. As provided in the Notice, the terms of the Notice may change. To obtain a current copy of any current Notice, I understand that I can contact the Privacy Officer at (888) 393-5264.

I understand that I have the right to request that the Practice restrict how my protected health information is used or disclosed for treatment, payment or health care operations, but I also understand that the Practice is not required to agree to a requested restriction. However, if the Practice does agree, it is bound by the agreement. I understand that I have the right to revoke this consent in writing at any time, except to the extent that the Practice, or individuals involved in my care in the Practice, have already used or disclosed protected health information in reliance on my prior consent.

Some insurance companies and labs require a social security number to verify coverage and obtain test results. As with your other medical information we handle this sensitive information with the utmost care to protect your privacy in compliance with Health Insurance Portability and Accountability Act (HIPAA). Without a social security number we must require payment in full at time of service and we will furnish documentation for you to file for insurance reimbursement.

PAYMENT INFORMATION

All payments including ***Co-pays and Deductibles are due at the time of service***. Co-pays that are not paid at the time of service will be billed with an additional **$10** fee. If the account has to be turned over to an attorney/collection agency, the undersigned agrees to pay all cost of collections, including attorney fees (33 1/3%), interest, commission, and court costs, whether suit is filed or not. This form will be placed in your chart and be applicable until such information is changed. There is a **$50** fee for any check returned by your bank. A $**10** surcharge on top of any balance that is due to Vista Eye Specialist will be assessed each and every month after the first bill is received by the patient *if not paid within 30 days* of receipt of said bill. Each and every month that the original balance is still outstanding an additional $10 per month will continue to accumulate until all balances are paid.

MEDICARE LIFETIME SIGNATURE ON FILE:

I request that payment of authorized Medicare benefits be made on my behalf to Vista Eye Specialists for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS/INFORMATION RELEASE:

I, the undersigned, authorize payment of medical benefits to Vista Eye Specialists for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administrating claims of benefits.

NO SHOW / MISSED APPOINTMENTS / CANCELED SURGERY

I understand that I will be charged **$50** for a no show or missed appointment where a 48 hour notice is not provided to Vista Eye Specialists. I understand that I will be charged **$250** for missed or canceled surgery if a two week notice is not provided other than for a medical reason.

REFERRALS

I understand that it is my responsibility to obtain a referral if it is required by my insurance company. ***I will be responsible for all charges if I am seen without a referral.***

By signing below, I acknowledge that I have read and understand these policies and authorizations.

Patient/Responsible Party Signature: _____ **Date:** _____

Name_____ Date_____

Quality of Vision Assessment

At Vista Eye Specialists, we strive to provide the best quality of care and customized vision solutions for our patients. This form will assist us in helping you to choose the treatment best suited for your visual needs and lifestyle. Please fill this form out completely and return it to the receptionist. If you have any questions please let us know, and we will be happy to assist you.

What are your favorite hobbies?

_____

_____

If you work, what are some of your daily work-related tasks?

_____

_____

Do you currently wear glasses? ____Yes ____No
If you currently wear glasses, for which activities do need them?
_____Near _____ Distance _____ Both

How interested are you in seeing distance without glasses?
_____ I prefer no glasses
_____It is not important. I will wear glasses for distance.

How important is it for you to see up close (Reading, computer, etc..) without glasses?
_____I prefer no glasses
_____It is not important. I will wear glasses for reading and intermediate vision.

What if you could have glasses-free vision for distance (i.e. driving) during the day and glasses-free near vision in most situations? Would you tolerate some halos and glare around lights at night, and be willing to use glasses in some situations?
____Yes ____ No

I drive a fair amount at night ? _____ Yes _____ No

Are you willing to pay an out-of-pocket charge (not covered by your insurance) if it means less dependence on glasses? (approximate price range $600 to $3900 per eye depending on what you chose; *Interest free financing* available) ____Yes _____No

How would you describe your personality?
_____ Easy going _____ Perfectionist _____ In between

It is important that you understand and remember that many people still need to wear glasses for some activities after surgery.

Patient Signature _____

MEDICAL NECESSITY FOR CATARACT SURGERY

Date	Date of Birth
Patient Name	
Reason for exam today (patient words)	
What specific improvements in your daily life do you hope to gain with surgery?	
With Advanced Technology Implants, Vista Eye Specialists is able to offer you more visual freedom from your distance and reading glasses after cataract surgery. Please print and fill out the additional forms in the Pre Cataract Questionnaire section on our website to determine if you are a candidate for this amazing technology.	

Visual Functional Status *(circle responses)*		
1) Do you have difficulty seeing street signs or to drive? (curbs, freeway exits, traffic lights, halos/glare around lights).	YES	NO
2) Do you have difficulty seeing TV or movies? (faces, numbers, or printing).	YES	NO
3) Do you have difficulty reading small print with good light, blinking and proper glasses? (books, newspaper, telephone book, medicine labels, instructions).	YES	NO
4) Do you have difficulty performing handiwork? (sewing, knitting, crocheting, embroidery or other fine task)	YES	NO
5) Do you have difficulty with personal correspondences? (writing checks, reading bills, filling out forms)	YES	NO
6) Do you have difficulty with leisure activities? (playing card games, bingo, dominoes, or sport activities such as bowling, hunting, golf, tennis, other _____)	YES	NO
7) Do you have visual difficulty with navigation around the house? (cooking, ironing, general household upkeep, climbing steps or curbs, dialing the telephone, telling time on watch, using public transportation)	YES	NO
8) Are you able to see and recognize faces of people? (in church, grocery store, clubs, and other daily activities?)	YES	NO
9) Are you able to care for yourself with your present vision? Do you live alone and wish to remain independent?	YES	NO

Do you have any of the following **VISUAL SYMPTOMS?**		
1) Double or distorted vision?	YES	NO
2) Glare, halos, rings around lights?	YES	NO
3) Difficulty with color perception?	YES	NO
4) Difficulty with depth perception?	YES	NO
5) Worsening of vision – blurred vision?	YES	NO

Advance Beneficiary Notice of Noncoverage (ABN) –

PENTACAM AND OPD TESTING - $85.00

The Pentacam and OPD testing is a type of testing that will give your surgeon important information about your eyes for the planning of your cataract surgery.

Medicare and commercial insurance do not pay for everything, even some types of care that you or your health care provider have good reason to think you will benefit from.

Although your insurance provider may consider this type of testing to be a non-covered service, it is strongly recommended by your doctor.

CHECK ONLY ONE BOX - *Please Do Not Leave Blank*:

☐ **OPTION 1** – YES, I want the items or services listed above, but I would still like the service to be billed to my insurance company. **Payment of $85.00 is due today.**

☐ **OPTION 2** – NO, I do not want the items or services listed above. **I understand that the information provided by this testing *will not* be available to my surgeon for the planning of my cataract surgery.**

Patient Name:	**Date of Birth:**
Signature:	**Date:**

Vista Eye Specialists