Eyecare in the time of COVID-19

Patient name: _____ Date:_____

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like the common cold or the flu, you may be exposed to COVID-19 (Coronavirus), either now or in the future. Please be assured that we have always followed Federal and DOH regulations regarding proper sanitization and protection protocols to limit transmission in our office, and we continue to do so. We have also implemented addition safety procedures, such as face mask regulations for patients and staff members, face shields, HEPA air filters on the HVAC system, hand sanitization and additional cleaning procedures.

Despite our careful attention to cleaning and personal protection, there is still the chance of exposure within our office. "Social Distancing" nationwide has reduced the transmission of COVID-19, and we have taken measures to implement social distancing within our office. However, due to the nature of the procedures and services we provide, it isn't possible to practice proper social distancing between the patient and the doctor, or the optician(s), at certain times during your visit.

Although exposure to the coronavirus in our office is unlikely, do you accept the risk and consent to treatment?

_____ Yes _____ No

1. Do you have a fever or have you felt feverish in the last 14-21 days? Y N
2. Are you having shortness of breath or other breathing difficulties? Y N
3. Do you have a cough, flu-like symptoms or loss of taste and smell? Y N
4. Have you, or has anyone in your household, been in contact with a person who was confirmed positive for COVID-19 within the last 6 weeks? Y N
5. Have you, or has someone in your household, tested positive for COVID-19 within the last 6 weeks? Y N
6. Do you have heart disease, diabetes, lung disease or any auto-immune disorders? Y N

PERSONAL/VISION HISTORY

Patient's Name_____ Today's Date____/____/____

Address_____ e-mail

City_____ State_____ Zip_____

Best Phone Number for contact_____ Patient's Date Of Birth____/____/____

Patient's Age Today_____yrs Patient's Gender □Female □Male

Medical Insurance type_____ Vision Insurance_____

Policy Holder's relation to Patient □self □spouse □parent □other_____

If other than self, Policy Holder's Name & Date Of Birth_____

Approximate time since last eye exam_____ Occupation_____

Previous Eye Doctor_____ Hobbies_____

GLASSES

Please check as many of the following to best describe your eyeglass use:

□full time □no-line bifocals □distance only □safety □computer use

□part time □lined bifocals □reading only □sunglasses □other

Please describe your eyeglass wants and needs_____

CONTACT LENSES

Please check as many of the following to best describe your contact lens use:

□full time □disposable □soft □bifocal □astigmatism/toric

□part time □non-disposable □hard □colors □overnight use

Brand contact lenses you currently use_____ Brand solutions you use_____

Please describe your contact lens wants and needs_____

PAST EYE HEALTH

Please check as many of the following to best describe <u>YOUR</u> past eye history:

□blindness □cataracts □glaucoma □crossed/lazy eye □eye injury □dry eye

□LASIK □eye surgery □infections □retinal disorders □allergy eyes □double vision

□eye pain □red eyes □discharge □flashes/floaters □burning/itchy □loss of vision

□sandy/gritty □macular degeneration □other_____

Doctor's notes:

FAMILY'S EYE HEALTH

Please check the following eye conditions your <u>BLOOD RELATIVES</u> have had:

□blindness □cataract □glaucoma □retinal disorders □macular degeneration □other

Doctor's Notes:

Doctor's Signature_____ Date_____

MEDICAL HISTORY FORM

CHIEF COMPLAINT: HOW CAN WE HELP YOU TODAY?

In this space, please briefly tell us any symptoms you are experiencing. (Please note: medical insurance will only cover visits if there is a medical reason for the exam such as loss of vision, headaches, eye pain, eye itching or burning, glaucoma cataracts, floaters, dry eyes, etc.)

HISTORY OF PRESENT ILLNESS

Which eye has the problem?	☐Right	☐Left	☐Both
Does the problem cause vision loss or blur?	☐Loss	☐Blur	
Did the problem occur suddenly or gradually?	☐Suddenly	☐Gradually	
How severe is the problem?	☐Mild	☐Moderate	☐Severe
Is it worse at any specific distance?	☐Distance	☐Near	☐Both
How long does the problem last?	☐Comes and goes		☐Constant
How long has the problem been occurring?	☐Short term		☐Long term
Does anything help the problem?	☐Yes	☐No	
Are there any associated symptoms?	☐Yes	☐No	

Doctor's Notes:

REVIEW OF SYSTEMS

Have YOU ever had difficulty in any of the following body systems?

	Yes	No		Yes	No
Cardiovascular (high blood pressure	☐	☐	Neurological (headaches,seizure)	☐	☐
Ears,nose,mouth,throat (allergy,sinus)	☐	☐	Psychiatric (depression,anxiety)	☐	☐
Infectious disease (HIV,hepatitis)	☐	☐	Endocrine (Diabetes,thyroid)	☐	☐
Respiratory (asthma,emphysema)	☐	☐	Musculoskeletal (arthritis)	☐	☐
Gastrointestinal (ulcer, colitis,Crohn's)	☐	☐	Hematologic (anemia,bleeding)	☐	☐
Genitourinary(genitals,kidneys,bladder)	☐	☐	Integumentary (eczema,rosacea)	☐	☐
Constitutional (fever, weight loss)	☐	☐	Are you currently pregnant?	☐	☐

Doctor's Notes:

MEDICATIONS/ ALLERGIES

Do you take any prescription or over the counter medications? ☐Yes ☐No If yes, please list type

Are you allergic to prescription or over the counter medications? ☐Yes ☐No If yes, please list type

PAST, FAMILY, AND SOCIAL HISTORY

Is there anything in your past, family, or social history which would help us care for you?

PAST:Injuries ☐Yes ☐No Surgery ☐Yes ☐No FAMILY: Diseases ☐Yes ☐No GENETIC FACTORS: ☐Yes ☐No
SOCIAL: Do you use? Tobacco ☐Yes ☐No Alcohol ☐Yes ☐No Recreational drugs ☐Yes ☐No

Patient Name_____Doctor's Signature_____Date_____
Indicate if history was completed by: ☐Patient ☐Spouse ☐Parent ☐Child ☐Caregiver ☐Other_____

Visual Field Screening

A highly sophisticated computerized visual field testing instrument electronically measures retinal and optic nerve function and sensitivity to light in both the central (straight-ahead) and peripheral (side view) areas. This measurement can assist us in early detection of many disorders, including brain tumors, glaucoma, diabetic retinopathy, and retinal disorders.

We strongly recommend that all our patients over 16 years of age and older receive the screening version of this exam. It is especially important for people who experience:

- Severe headaches
- Spots or flashes of light
- Have a history (personal or family) of diabetes
- Have a history (personal or family) of High Blood Pressure
- Have circulatory problems
- Have a strong eyeglass prescription

There is an additional charge of $29.00 for this screening, which is **NOT** covered by any insurance.

Please check the appropriate line below and sign the bottom. Thank You!

_____ I **DO** want a visual field screening today.

_____ I **DO NOT** want a visual field screening today.

Patient's Name (print)_____

Patient's Signature_____ date _____

Digital Retinal Photographs

Dr. Sulak recommends that everyone get a high- resolution digital photograph taken of the interior of their eye to provide a baseline for evaluating the health of the eye. Many patients choose to undergo retinal image screening because it aids the doctor in detecting abnormal variations inside of their eyes. Early detection enables the treatment of eye diseases such as glaucoma, cataracts and macular degeneration, as well as damage caused by conditions such as diabetes and high blood pressure (hypertension). If left undiagnosed and untreated, these conditions can cause severe damage to the sensitive interior of the eye and can even cause permanent blindness.

A digital retinal image screening is only $39.00, but in some circumstances may be billable to your health insurance.

_____ I **DO** want a digital retinal image screening today.

_____ I **DO NOT** want a digital retinal image screening today.

Patient's Name (printed)_____date:_____

Patient's signature_____

Crystal Clear Eyecare

Notice of Privacy Practices

Effective May 1st 2013

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions please contact our office.

Crystal Clear Eyecare is required by law to:

- Maintain the privacy of your protected health information;
- Give you this notice of our duties and privacy practices regarding health information about you;
- Follow the terms of our notice that is currently in effect.

HOW CRYSTAL CLEAR EYECARE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION:

Described as follows are the ways Crystal Clear Eyecare may use and disclose health information that identifies you (Health Information, or PHI). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to us and stating that you wish to revoke permission you previously gave us.

Treatment. Crystal Clear Eyecare may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. Crystal Clear Eyecare may use and disclose Health Information so that we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment. However, if you pay for your services yourself (e.g. out-of-pocket and without any third party contribution or billing), we will not disclose Health Information to a health plan if you instruct us to not do so.

Health Care Operations. Crystal Clear Eyecare may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the care you receive is of the highest quality. Subject to the exception above if you pay for your care yourself, we also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operations.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. Crystal Clear Eyecare may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you. We will not, however, send you communications about health-related or non health-related products or services that are subsidized by a third party without your authorization.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, Crystal Clear Eyecare may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, Crystal Clear Eyecare may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through an approval process. Even without approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising and Marketing. Health Information may be used for fundraising communications, but you have the right to opt-out of receiving such communications. Except for the exceptions detailed above, uses and disclosures of Health Information for marketing purposes, as well as disclosures that constitute a sale of Health Information, require your authorization if we receive any financial remuneration from a third party in exchange for making the communication, and we must advise you that we are receiving remuneration.

Other Uses. Other uses and disclosures of Health Information not contained in this Notice may be made only with your authorization.

SPECIAL SITUATIONS:

As Required by Law. Crystal Clear Eyecare will disclose Health Information when required to do so by federal, state or local law. To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers" compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

YOUR RIGHTS:

You have the following rights regarding Health Information Crystal Clear Eyecare have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to our office.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our office.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our office.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our office. We are not required to agree to all such requests. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing, to our office. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.crystalclareyecare.com . To obtain a paper copy of this notice please request it in writing.

Right to Electronic Records. You have the right to receive a copy of your electronic health records in electronic form.

Right to Breach Notification. You have the right to be notified if there is a Breach of privacy such that your Health Information is disclosed or used improperly or in an unsecured way.

CHANGES TO THIS NOTICE:

Crystal Clear Eyecare reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing. You will not be penalized for filing a complaint.

I acknowledge having been provided this Notice. Signed:_____

REGARDING VISIONCARE
&
MEDICAL INSURANCE

We often have patients that have both vision insurance and Medical (for example, BC/BS, Aetna, or Medicare, VSP, VBA or Eye Med Vision Ins.). They are very different in terms of the services they cover, and it's important for our patients to understand these differences.

Vision insurance is designed mainly to cover determining a prescription for glasses, to help pay for glasses or contacts lenses, and to cover a yearly routine evaluation of the health of the eyes in a healthy patient that has no particular problems or symptoms. It is not equipped to deal with and does not usually cover medical conditions, injuries, and /treatments. **Medical insurance** is designed to cover you when you have a medical problem, including one that affects your eyes. Medical insurance does not cover routine services or examinations for glasses, or routine vision problems such as nearsightedness, farsightedness, and astigmatism. Those are only covered by your vision insurances.

When a medical diagnosis or medical condition is present that affects your eyes, such as high blood pressure, high cholesterol, or diabetes, to name a few examples, or you have an eye disease or eye problem such as an infection (pink eye), dry eyes, allergy, or cataracts, again, just to name a few, we must file the claim with your **medical insurance,** and the co-cops and deductibles for that insurance will apply. Your vision plan does not cover these kinds of problems. Our office does not make these rules, they are made by the insurance companies themselves, and we must comply with them.

There is often no way to know prior to your examination which type of insurance will be the right one to file your claim with. We will make every effort to join as many insurance panels, both medical and vision, as we can for your convenience. If we are on your insurance company's panel we will file those claims for you. In the event that we do not accept your medical or vision insurance we will provide you an itemized receipt so that you may file a claim for reimbursement with your insurance company yourself. If you have any questions, please let us know.

I understand the information I've just read about the difference between vision and medical insurance.

I authorize: Dr. David Sulak, O.D. / Cystal Clear Eyecare to file my claim with the appropriate insurance based on the reason for my visit and the results of my examination.

Signed: _____ **Date:** _____

Signature on File Form

• *RESPONSIBILITY STATEMENT* •

Your insurance is a method for you to receive reimbursement for fees you have paid to the optometrist for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them not with our office. It is your responsibility to pay in advance for the deductible, coinsurance, or any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible, but you are responsible in advance for your bill.

• *FINANCIAL RESPONSIBILITY* •

By signing this statement you agree to be financially responsible for all charges.

• *AUTHORIZATION TO RELEASE MEDICAL INFORMATION* •

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be as valid as the original.

Patient Signature_____ Date_____

Witness _____ Date_____