

**Optical Reflections, LLC**

16300 Mill Creek Blvd #118 ● Mill Creek, WA 98012

**Dr. Viola Gay, OD**

**THE FOLLOWING INFORMATION WILL BE HELD STRICTLY CONFIDENTIAL**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  Male  Female Date \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City \_\_\_\_\_ Zip: \_\_\_\_\_ Social Security #: \_\_\_\_\_

E-mail: \_\_\_\_\_ Referred By: \_\_\_\_\_

Employer: \_\_\_\_\_ Cell Phone \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_

Do you have vision care insurance?  Yes  No

Primary Vision Insurance:

Insurance Company: \_\_\_\_\_

Insurance Address \_\_\_\_\_

ID # \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Group # \_\_\_\_\_

Employer \_\_\_\_\_ Patient Relationship to Subscriber:  Self  Spouse  Child  \_\_\_\_\_

Person Responsible for Payment \_\_\_\_\_

**Please Note: The Doctor's fees are billed separately from the optical fees (glasses & contacts). There are several insurance companies we can bill directly for you. If yours is not one of these, we will provide you with a receipt after payment showing appropriate codes so you may submit it to your insurance company.**

**OFFICE FINANCIAL POLICY AND AUTHORIZATION TO BILL YOUR INSURANCE**

I understand that I must pay any balances including all co-pays and estimated portions not covered by my insurance company at the conclusion of today's visit. Most insurance companies will not pay for a contact lens fit and evaluation exam. The contact lens fit and evaluation fee is your responsibility.

If you have insurance, we will submit your claim for you. Please be advised that all charges incurred at our office are ultimately **your responsibility**. If payment is not received from your insurance company, you will be required to pay the balance. A finance charge computed at a periodic rate of 1.5% per month will be added to past due accounts, plus collection cost and attorney fees incurred by Optical Reflections, LLC. **We will submit a claim to your primary insurance; any secondary insurance will be the subscriber responsibility to submit. We will supply the subscriber with any necessary forms or EOB.**

I hereby consent to and authorize the administration of all treatments as deemed necessary by the attending physician. I authorize my insurance benefits to be paid directly to the physician. I also authorize the doctor to release any information required by my insurance company. No other records shall be released without my signed consent.

Patient/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

(OVER)

List any allergies to medicines: \_\_\_\_\_

List any medications you take (including birth control pills, aspirin, over the counter medications and home remedies)

Are you pregnant or nursing?  Yes  No

Date of Last Comprehensive Eye Exam: \_\_\_\_\_

Do you wear glasses?  Yes  No If yes, how old is your prescription? \_\_\_\_\_

Do you wear contact lenses?  Yes  No If yes, how old is your current pair? \_\_\_\_\_

What type of contact lenses:  Disposable Soft Lenses  Standard Soft Lenses  Rigid Lenses

If you use disposable lenses how often do you throw them away? \_\_\_\_\_

Do you ever sleep with your lenses on?  Yes  No

Have you ever had refractive surgery?  Yes  No If yes, specify type:  RK  PRK  LASIK

Are you interested in refractive surgery?  Yes  No

### **Personal/Family History**

Please answer the questions below regarding you or your immediate family (parents, grandparents, siblings, and children)

	You		Family			How are they related to you?
	Yes	No	Yes	No	?	
Blindness/Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes/Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

### **ROUTINE PUPIL DILATION**

I authorize the attending doctor to dilate my pupils. I understand that the dilating drops may cause some blurring of my vision. **YES / NO**

### **Patient Consent for Optional Computerized Visual Field Testing**

Our office now offers a very sophisticated computerized test capable of detecting both visual and neurological problems NOT detected by normal examination methods. This test, called "automated perimetry," gives your eye doctor the ability to more accurately diagnose very serious conditions including: optic nerve tumors, brain tumors, brain aneurysms, localized retinal detachments, glaucoma and strokes.

Unfortunately, vision insurance does not pay for routine use of this technology. The cost for this test is \$20. Although our doctors strongly recommend this test for every patient every year, we respect the right of each patient to choose for himself or herself.

**I understand that my doctor has recommended automated perimetry to screen me for potentially serious eye or neurological diseases. I understand that this test is totally non-invasive and takes approximately 2 minutes per eye. I understand that the cost is \$20 for both eyes, and that vision insurance will not cover the cost of this test.**

Please check (X) one:

\_\_\_\_\_ **I agree to receive this test**  
\_\_\_\_\_ **I decline to receive this test**

\_\_\_\_\_  
**Patient/Guardian Signature**

\_\_\_\_\_  
**Date**

## NOTICE OF PRIVACY PRACTICES

### How We Use your Health Information

#### TREATMENT

Your information will only be used to provide optimal health care. This includes administration of scheduling and coordination of care between the optometrist and office staff. Health information may also be shared with referring physicians, clinical or pathology laboratories, pharmacies or other health care providers involved in your treatment.

#### BILLING

Your health information may be included when insurance forms are filed or when we bill you directly. We work with insurance companies that are committed to keeping your information secure as well.

#### QUALITY ASSURANCE

It is possible that health care information may be shared during audits by insurance companies or government agencies as part of their routine compliance reviews. This also applies to the routine processes of certification, credentialing and licensing.

#### CAREGIVERS, FAMILY, AND EMERGENCIES

With your permission, we may share health information with those whom you have named to assist you with medical treatment and prevention. If there is an emergency, and you cannot give consent, we will rely on professional judgment to inform those who will necessarily participate in your care. The law may also require us to share health information with coroners, funeral directors or medical examiners to determine cause of death.

#### ABUSE OR NEGLECT

We will inform the appropriate authorities as required by law, ethical standards, or with a patient's consent, if abuse, neglect, or domestic violence is suspected.

#### LAW ENFORCEMENT

Health information may be shared with the state or federal government according to the laws regarding criminal acts.

#### PUBLIC SAFETY

Federal or military authorities can obtain your health information for the purpose of maintaining public health or national security. Prevention of epidemics or investigating new side effects of medical treatment is examples of this.

#### AUTHORIZATION

For your protection, any circumstances requiring your personal health information other than those explained in this notice will require a written release from you.

I acknowledge that I have received a Notice of Privacy Practices regarding the use and disclosure of my health information. I understand that this may change in the future and that I may contact this office at any time to obtain a current copy of the Notice. I understand that I may request in writing reasonable restrictions of the use of my information for the purposes of treatment, payment or health care operations. We are committed to confidentiality of your health information.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_