WELCOME TO OUR OFFICE

PLEASE COMPLETE THE FOLLOWING:

Today's Date: _____/_____/_____

PATIENT INFORMATION			Gender:		
LAST NAME	FIRST NAME	MIDDLE			DATE OF BIRTH
HOME ADDRESS	CITY	STATE	ZIP CODE		SOCIAL SECURITY NUMBER
MOBILE PHONE	ALTERNATIVE	EMAIL ADDRESS			
EMPLOYER (OR SCHOOL)	OCCUPATION (OR GRADE)	HOBBIES/SPECIAL INTERESTS			
HOW DID YOU HEAR ABOUT OUR OFFICE?					
IF THE PATIENT IS UNDER 18 YEARS OF AGE					
NAME OF PARENT/GUARDIAN	PHONE	RELATION TO PATIENT			
EMERGENCY CONTACT					
NAME OF EMERGENCY CONTACT	PHONE	RELATION TO PATIENT			
MEDICAL INFORMATION					
PRIMARY CARE PHYSICIAN	DATE OF LAST PHYSICAL	LAST EYE DOCTOR			DATE OF LAST EYE EXAM
MEDICAL INSURANCE COVERAGE					
NAME OF MEDICAL INSURANCE	POLICY HOLDER (EMPLOYEE)	POLICY HOLDER BIRTHDATE			RELATION TO PATIENT
VISION INSURANCE COVERAGE					
NAME OF VISION INSURANCE	POLICY HOLDER (EMPLOYEE)	POLICY HOLDER BIRTHDATE			RELATION TO PATIENT

DIGITAL RETINAL IMAGING - Introducing Optos

Hazel Family Eyecare has always used advanced technology to monitor early signs of ocular disease within your eye and the layers beneath your retina. Since early diagnosis is critical, Dr. Fowler and Dr. Thomas strongly recommend our complete wellness exam every year for diagnostics and comparative documentation. These costs are typically not covered by insurance. Please select one.

☐ **$39.00 - Optos Retinal Image only**
Opto**s** is retinal image that takes place of dilation in most cases. It is a quick photo that captures a panoramic image of more than 80% of the retina, aiding in the detection of retinal tears, detachment and retinal disease pathology. It also aids in the early detection of systemic diseases such as diabetes, hypertension, cancers, autoimmune disease and stroke. It does not require drops or affect vision.

☐ **$39.00 - Retinal Scanning only with OCT**
OCT (Optical Coherence Tomography) is an imaging exam that utilizes light waves to scan the macula to detect any signs of macular degeneration, diabetic retinopathy, or any microscopic changes that are not as easily detected by the Optos.

☐ **$55.00 – As recommended, I select both services** for the most comprehensive overall eye health exam.

☐ **Dilation- Contrary to recommendation, I decline the options above and agree to dilation**. Dilation requires drops and will cause blurry vision for 3-4 hours. This service is covered by insurance.

DO YOU CURRENTLY:	ARE YOU INTERESTED TODAY IN:
☐ WEAR GLASSES? IF SO, HOW OLD ARE THEY: _____	☐ PURCHASING NEW EYEWEAR
☐WEAR POLARIZED SUNGLASSES? IF SO, HOW OLD ARE THEY: _____	☐ TRYING CONTACT LENSES
☐WEAR CONTACT LENSES? IF SO, WHAT BRAND: _____	☐ LEARNING ABOUT REFRACTIVE SURGERY

YOUR VISUAL FUNCTION: Please check all that apply to you

☐ WORK ON COMPUTERS UNDER FLOURESCENT LIGHTING	☐ CONTACT LENSES GET DRY AT LEAST ONCE A DAY
☐ SPEND TIME PLAYING OUTDOOR ACTIVITIES	☐ CONTACT LENSES ARE NOT AS CLEAR AS DESIRED
☐ ENJOY BOATING OR OTHER WATER SPORTS	☐ EXPERIENCE GLARE WHILE DRIVING AT NIGHT
☐ EYES ARE SENSITIVE TO SUNLIGHT	☐ EXPERIENCE EYE STRAIN WHILE USING THE COMPUTER
☐ DRIVE TO OR FROM WORK DIRECTLY FACING THE SUN	☐ READ BOOKS/STUDY FOR LONGER THAN 2 HOURS A DAY
☐ OCCUPATION THAT INVOLVES POSSIBILITY OF EYE INJURY	☐ WOULD LIKE INFO ON THINNER/LIGHTER LENSES

HAVE YOU EVER HAD:

☐ CATARACT SURGERY EYE MUSCLE SURGERY RETINALSURGERY LASIK SURGERY OTHER EYE SURGERY
IF SO, WHICH EYE WHEN:

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING SYMPTOMS:

☐ BLURRED VISION	☐ DRYNESS	☐ FLOATERS IN VISION	☐ SANDY FEELING
☐ BURNING	☐ EXCESSIVE TEARING	☐ GLARE SENSITIVITY	☐ SUDDEN VISION LOSS
☐ DOUBLE VISION	☐ EYE PAIN/SORENESS	☐EYE/EYELID INFECTION	☐ LOSS OF PERIPHERAL VISION
☐ DROOPING EYELID	☐ FLASHES OF LIGHT	☐ ITCHING	☐ OTHER

VISION HISTORY
Check appropriate boxes if YOU or your blood RELATIVES have:

F = Father M = Mother S = Sibling GP = Grandparent(s)

	YOU	Family Member
Amblyopia/Lazy eye	☐	F M S GP
Blindness	☐	F M S GP
Cataracts	☐	F M S GP
Color blindness	☐	F M S GP
Crossed/Turned eyes	☐	F M S GP
Diabetic retinopathy	☐	F M S GP
Glaucoma	☐	F M S GP
Herpes eye disease	☐	F M S GP
Keratoconus	☐	F M S GP
Macular degeneration	☐	F M S GP
Retinal detachment	☐	F M S GP
Traumatic eye injury	☐	F M S GP
Other eye condition	☐	F M S GP

SOCIAL HISTORY

Do you smoke? NO YES _____pack per day
Do you drink? NO YES _____drinks per wk

FEMALES, ARE YOU:

☐ Pregnant _____months/weeks ☐ Nursing

PLEASE LIST ALL ALLERGIES:

PLEASE LIST ALL CURRENT MEDICATIONS:

MEDICAL HISTORY
Check appropriate boxes if YOU or your blood RELATIVES have:

F = Father M = Mother S = Sibling GP = Grandparent(s)

	YOU	Family Member
Allergies	☐	F M S GP
Arthritis	☐	F M S GP
Blood disease (anemia)	☐	F M S GP
Breathing problems	☐	F M S GP
Cancer	☐	F M S GP
Cardio (heart, carotid)	☐	F M S GP
High Cholesterol	☐	F M S GP
Collagen (lupus)	☐	F M S GP
Diabetes	☐	F M S GP
Fatigue	☐	F M S GP
Fever blister/cold sore	☐	F M S GP
Gastro (stomach, colon)	☐	F M S GP
Genital, kidney, bladder	☐	F M S GP
Headache/Migraine	☐	F M S GP
Hearing Impairment	☐	F M S GP
Herpes	☐	F M S GP
High Blood Pressure	☐	F M S GP
HIV / Aids	☐	F M S GP
Hormonal/Thyroid	☐	F M S GP
Nose, Sinus Throat	☐	F M S GP
Psych (anxiety, depression)	☐	F M S GP
Resp.(asthma, emphysema)	☐	F M S GP
Sex. Transmitted Disease	☐	F M S GP
Skin (acne, eczema)	☐	F M S GP
Weak/numb leg/arm	☐	F M S GP
Weight changes, sudden	☐	F M S GP

Hazel FAMILY EYECARE

930 Marietta Hwy, Suite 400- Roswell, GA 30075

INSURANCE AUTHORIZATION AND FINANCIAL AGREEMENT

Providing the best possible eye care involves a mutual understanding between patient and provider. Should you have any questions regarding the following policies, please ask for clarification. Our professional services are rendered to you, not our insurance company. Ultimately, payment for our services is your responsibility.

- I authorize Hazel Family Eyecare to release any information regarding my care to expedite claims or for records transfer should such events be required.
- I hereby authorize Hazel Family Eyecare to bill my insurance company for services provided to me and with payment made directly to the providing doctor's office and that such authorization is valid until written notice is provided to cancel that authorization.
- **While Hazel Family Eyecare makes considerable effort to verify my insurance coverage, benefits, and cost shares, I understand that such information is NOT an official or legally binding estimation of my out-of-pocket expenses. Ultimately, my final cost share is dependent on the decision of my insurance carrier. I UNDERSTAND THAT ANY COPAY ESTIMATES GIVEN TO ME PRIOR TO MY EXAMINATION MAY TURN OUT TO BE DIFFERENT FROM THE FINAL DECISION OF MY INSURANCE CARRIER AND I AGREE THAT I AM DIRECTLY AND FULLY RESPONSIBLE TO HAZEL FAMILY EYECARE FOR PAYMENT OF ALL CHARGES, INCLUDING ANY AMOUNT IN EXCESS OF PREVIOUS COPAY ESTIMATES. I realize that if my insurance company fails to pay its anticipated balance in full or payment is not made within 45 days it is my responsibility to pay the doctor's bill and that I will pay associated fees for the purpose of collection on delinquent accounts.**
- In the event that I receive payment from my insurance company for services provided in this office, I agree to endorse any received payment to the doctor's office.
- **I understand there may be medical findings during the course of my exam. I understand it is a VIOLATION of Hazel Family Eyecare's provider agreement with my insurance to bill such medically related services to my vision wellness plan. In this event, my medical insurance will be billed and I understand I will be responsible for any applicable co-pays, cost-shares, and/or deductibles as per my medical findings in order to bill my vision wellness plan, as that would put Hazel Family Eyecare in direct conflict with its ethical obligations to the Georgia Board of Optometry.**
- I understand there is a $30 fee for all returned checks.
- **We strive for 100% patient satisfaction with all services and products; however we have a no return policy on all eyewear and exchanges are subject to a 20% restocking fee plus any incidental charges with remaking the prescription lenses.**

I understand and agree to all statements made herein and understand this is a legally binding agreement.

Print Name: _____ Date of Birth: _____

Signature: _____ Today's Date: _____

930 Marietta Hwy, Suite 400 Roswell, GA 30075

770-998-3937

LEGAL NOTICE OF PRIVACY POLICIES - HIPAA

This notice describes how your medical information may be used and disclosed as well as how you can gain access to this information. It is important that you review this carefully.

The Health Insurance Portability and Accountability Act (HIPAA) created national standards for the transfer of health care data between health care payers, insurance plans, and providers. Dr. Fowler and associates are required to comply with this law. Dr. Fowler and associates are also required to provide you with a privacy notice that describes their legal duty with respect to your health information, the uses and disclosures that we may make of your health information, and your rights concerning how we may handle your health information. This form will serve as your legal copy of such notice.

THE MOST COMMON WAYS YOUR HEALTH INFORMATION MAYBE BE USED AND DISCLOSED WITHOUT YOUR AUTHORIZATION:

- For treatment of eye disease, vision problems, or other medical concerns that Dr. Fowler and associates refer out for consultations to other physicians when necessary.
- For payment purposes, such as determining insurance eligibility and coverage, benefit coordination, payments of claims, billing and collections, and determining medical necessity.
- For health care operations such as professional review as well as practice management.

OTHER WAYS THE LAW MAY ALLOW OR REQUIRE US TO SHARE YOUR HEALTH INFORMATION WITHOUT YOUR CONSENT:

- When state or federal law mandates the reporting of health information for a specific purpose.
- For public health purposes such as reporting contagious disease or to report a serious public health threat.
- Disclosure to the appropriate authorities in cases of suspected abuse, neglect, or domestic violence.
- For insurance audits.

- Disclosures for law enforcement purposes and judicial or administrative proceedings.
- Disclosures regarding de-identified information.
- Disclosures to “business associates” who perform health care operations for Dr. Fowler and who commit to respect the privacy of your health information.

You may access all health information by calling Hazel Family Eyecare at 770-998-3937 or emailing us at info@hazeleyecare.com. All information requested will be sent within 1-2 business days.

Due to HIPAA laws, doctor’s offices must keep your information confidential. We have given you our policies regarding how we process your information separately. Please sign below stating you have read our statement. Your signature simply represents that we attempted to share with you our HIPAA policies.

I authorize Hazel Family Eyecare to share my related identifiable health information with the following people: _____

Patient/Guardian Name (Printed): _____

Patient/Guardian Name (Signature): _____

Patient Date of Birth: _____

Today's Date: _____

Parental Consent Statement for Vision Services

Patient Name: _____

Patient Date of Birth: _____/_____/_____

As the parent/legal guardian of the above named minor child, I hereby authorize Dr. Fowler, O.D. and Dr. Thomas, O.D., and staff to perform any and all tests to obtain an accurate assessment of visual function and eye health. I also authorize full consent for any eye/medical treatment deemed necessary by Hazel Family Eye Care.

Please choose one option below:

◯ **OPTOS:** Retinal imaging in place of dilation. A quick photo that captures a panoramic image of more than 80% of the retina, aiding in the detection of retinal tears, detachment and retinal disease pathology. Does not require drops or affect vision. **$39 charge not covered by insurance.**

OR

◯ **OPTOS and Scan**: Optos plus retinal scan that detects any signs of macular degeneration, diabetic retinopathy or any microscopic changes in the retina that are not as easily detected on the Optos. Recommended with family history of macular degeneration. **$55 charge not covered by insurance.**

OR

◯ **DILATION**: Drops used to examine the health of the eye. Dilation causes the pupil to expand to detect any retinal tears, detachment, or retinal disease pathology. The patient's vision will be blurry for 3-4 hours and they will experience sensitivity to light.

Parent/Legal Guardian:_____
Please print

Parent/Legal Guardian:_____
Signature

Date: _____