ADVANCED LASER & CATARACT CENTER

Patient Name:		**Date of Birth:**	
Address:			**Apt#:**
City:	**State:**	**Zip:**	
Home Phone:	**Work Phone:**	**Cell phone:**	
Gender: Male Female	**Race:**	**Social Security #:**	
Email Address:	**Occupation:**	**Employer:**	
How did you hear about us?			
Emergency Contact:	**Phone:**		
Relationship to Emergency Contact:			
Are you Pregnant or Nursing? YES NO			
Languages Spoken:			
Current Optometrist:	**Primary Care Doctor:**		
Pharmacy:		**Phone:**	
Pharmacy Address(or cross streets):			

Medications (Including Over-the-Counter)	**Dosage**	**Frequency**

Allergies:	**Reaction:**

History of Latex Allergy: ☐ **Yes** ☐ **No**

Have you ever taken or are you currently taking any of the following:

☐ Uroxatral	☐ Amiodarone	☐ Cardura	☐ Risperdal	☐ Tamoxifen
☐ Amitriptyline	☐ Flomax	☐ Hytrin	☐ Niacin	☐ Plaquenil
☐ Finasteride	☐ Enbrel	☐ Jalyn	☐ Chlorpropamide	

PATIENT HISTORY

Please check all that apply:

☐ Glaucoma	SELF	N/A	**Family Members**	_____
☐ Cataracts	SELF	N/A	**Family Members**	_____
☐ Corneal Transplant	SELF	N/A	**Family Members**	_____
☐ Keratoconus	SELF	N/A	**Family Members**	_____
☐ Eye Injury			**Family Members**	_____
☐ Eye Surgery (please list):	_____	SELF N/A	**Family Members**	_____
☐ Vision Correction Surgery:	RK/ALK/PRK/LASIK	SELF N/A	**Family Members**	_____
☐ Rheumatoid Arthritis	SELF	N/A	**Family Members**	_____
☐ Lupus/Auto Immune Disease	SELF	N/A	**Family Members**	_____
☐ HIV/AIDS	SELF	N/A	**Family Members**	_____
☐ Diabetes	SELF	N/A	**Family Members** _____	Avg. Blood Sugar _____
☐ Lazy Eye/Amblyopia	SELF	N/A	**Family Members**	_____
☐ Ocular Herpes Simplex	SELF	N/A	**Family Members**	_____
☐ Heart Disease	SELF	N/A	**Family Members**	_____
☐ Pacemaker/Defibrillator	SELF	N/A	**Family Members**	_____
☐ High Blood Pressure	SELF	N/A	**Family Members**	_____
☐ High Cholesterol	SELF	N/A	**Family Members**	_____
☐ Kidney Disease/Failure	SELF	N/A	**Family Members**	_____
☐ Liver Disease	SELF	N/A	**Family Members**	_____
☐ Stroke	SELF	N/A	**Family Members**	_____
☐ Anemia	SELF	N/A	**Family Members**	_____
☐ Thyroid Disease	SELF	N/A	**Family Members**	_____
☐ Cancer/Tumors _____	SELF	N/A	Family Members	_____

Other Medical Issues -

SOCIAL HABITS AND HISTORY

Tobacco Use Cigars Cigarettes Marijuana Dipping Chewing Other _____

How Often? Currenty Formerly Never Quit how long ago? _____

Alcohol Consumption Daily Weekly Occasionally Never

Height _____ **Weight** _____

Do you primarily wear:	**☐ Glasses**	**☐ Contacts**	**☐ Hard/Rigid Gas Permeable Lenses**		
Do you wear reading glasses over your contact lenses, or take your glasses off to read?				**☐ Yes**	**☐ No**
Has your prescription changed significantly every year?		**☐ Yes**	**☐ No**		
Do you have prism in your glasses?		**☐ Yes**	**☐ No**		
Have you ever been diagnosed with dry eye disease?		**☐ Yes**	**☐ No**		
Have you had significant fluctuation in your vision?		**☐ Yes**	**☐ No**		
Have you had lens discomfort? (If you wear contacts)		**☐ Yes**	**☐ No**		
Do you have light sensitvity?		**☐ Yes**	**☐ No**		
Do you have the feeling of sand or grit in your eyes?		**☐ Yes**	**☐ No**		
Do you notice the following symptoms?	☐ Watery Eyes	☐ Burning	☐ Redness		
	☐ Itching	☐ Tired eyes			
Do you use moisturizing/lubricating eye drops?	**☐ Yes**	**☐ No**	**If yes, which brand?**		
While wearing contacts or glasses (circle yes to all that apply):					
☐ Difficulty reading small print	☐ Difficulty driving at night				
☐ The need to use reading glasses while reading	☐ You don't see well enough to read road signs				
☐ Difficulty seeing the television clearly	☐ Not able to see street signs				
☐ Difficulty seeing due to bright sunlight	☐ Difficulty seeing due to glare of oncoming headlights				
Do you dislike being dependent on glasses for clear vision?				**☐ Yes**	**☐ No**
Have you ever been told you are not a good contact lens wearer candidate?				**☐ Yes**	**☐ No**
Activities (check all that apply):	☐ Jogging	☐ Tennis	☐ Traveling		
☐ Sports _____	☐ Hiking	☐ Biking	☐ Weight Training		
☐ Other _____	☐ Golfing	☐ Skiing	☐ Swimming		
Why would you like to have laser correction? _____					
_____					
If alternatives to LASIK would be better for you, would you like information about them?				**Yes**	**No**

If you would like your prescription released for glasses or contacts, there will be a fee of $100 _____(initial)
Pre-Op only

INFORMATION REGARDING DILATING DROPS

- Dilating drops frequently blur vision for a length of time and varies from person to person and may make bright lights bothersome.
- It is not possible for your eye doctor to predict how much your vision will be affected.
- Because driving may be difficult immediately after examination, it is best if you make arrangements not to drive yourself.

I hereby authorize the doctors and/or medical staff of Advanced Laser & Cataract Center to administer dilating eye drops, as they are necessary for diagnosing my condition.

Patient Signature: _____ **Date: _____**

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change. If so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of information but the practice doesn't have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent is signed by: _____

(PLEASE PRINT NAME)

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Office Policy and Financial Responsibility Agreement

Please review carefully

- Advanced laser Center verifies and files insurance as a courtesy to our patients. However, **it is ultimately the patient's responsibility** to understand what their medical and/or vision insurance is and what it covers prior to an appointment. Please contact your insurance company for complete plan information prior to your visit.

- With the number of insurance companies and complexity of plans, it is impossible for Advanced Laser center to guarantee coverage under each plan with every provider. **It is the patient's responsibility to make sure the doctor you are seeing is in-network with the insurance plan you intend for us to file at your visit.** Please contact your insurance provider for a complete provider list.

- Medical insurance and vision insurance are not the same. It is the patient's responsibility to understand if they have both types and to present them to reception upon time of check-in. **Only medical OR vision insurance can be filed for a visit--not both.** This is a standard policy determined by your insurance provider.

- **Medical diagnoses (ex: cataracts, diabetes, glaucoma, dry eyes, etc.) are not covered under vision insurance and will not be filed under vision.** Please be aware that although a patient may be scheduled for a routine vision exam, the type of exam you receive is determined upon examination *by you* when discussing the eye issues *you present to us* . **Medical insurance may need to be filed in lieu of vision insurance.** This may change the amount due for your visit at checkout. **It is the responsibility of the patient to understand the difference between medical and vision issues.** Please contact your insurance provider for specific details on these benefits.

- **All copays and deductibles are due at the time services are rendered.** However, any monies collected at time of visit are an estimate. Insurance companies offer no guarantee of payment upon filing a claim, regardless of coverage. Any remaining balance as defined by your insurance will be your financial responsibility.

- In the event a charge must be billed to the patient after insurance has finalized a claim, **the balance is due in 30 days.** If no payment is received after three statements, communication with the patient will be attempted via letter and phone, after which the account will be turned over to a collection agency. It is the patient's responsibility to provide our office with accurate and up-to-date contact information. **No further visits will be permitted until the account is paid in full.**

- Any testing performed during a patient's visit may process through insurance differently than a regular exam. Please contact your insurance provider if you are unsure of how your plan determines benefits for testing services.

- **Refractions are typically not covered under medical insurance. This fee is the patient's responsibility and will be due at time of service.**

- If an appointment cannot be confirmed with the patient at least 24 hours in advance, **Advanced Laser Center reserves the right to cancel the patient's appointment** and reschedule only at the clinic's discretion.

- While we offer free LASIK screenings, this offer is valid only once per patient. If you wish to determine if you are a candidate futher after an initial screening, your option will then be to use your insurance or pay out of pocket.

I have read and understood the above policies and agree with its terms. I agree that these policies apply as long as I am a patient at Advanced Laser Center.

_____ _____

Signature (or parent signature for minor) Date

_____

Print Name

REFRACTION FEE POLICY

Refraction is the process of determining the eye's refractive error, need for corrective lenses/materials, or possible medical eye-related issues. However, it is considered a **non-covered service** by Medicare and most medical insurance plans; thus, it becomes the responsibility of the patient to pay for the refraction charge. Our fee for the refraction is $25.00 and is **due at time of service in addition to any copayment, deductible, or other balance.**

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service.

Print Name _____ Date _____

Patient Signature (or parent signature for minor) _____