Medical History Questionnaire

Name:_________________________________ Today's Date:______/____/______

Address:____________________________________ Phone:_________________________

City:______________________ Zip:__________ Occupation:______________________

Guardian(If applicable):___________________________ Last eye exam:____/_____/_______

Birth Date:___/____/___ Social Security #:____/___/_____ Name of medical Doctor:____________________

Email:______________________________

Medical History

Do you have any allergies to medications? [ ] no [ ] yes If yes, explain:____

____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

____

____

____

List all major injuries, surgeries and/or hospitalizations you have had:____

____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury:____

Are you pregnant and/or nursing?: [ ] no [ ] yes

Do you wear glasses? [ ] no [ ] yes If yes, how old is your present pair of lenses?__________________________

Do you wear contact lenses? [ ] no [ ] yes If yes, how old is your present pair of lenses?__________________________

Family History: Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following:

Blindness [ ] no [ ] yes [ ] ? Relationship to you:______________________________________

Cataract [ ] no [ ] yes [ ] ? Relationship to you:______________________________________

Crossed Eyes [ ] no [ ] yes [ ] ? Relationship to you:______________________________________

Glaucoma [ ] no [ ] yes [ ] ? Relationship to you:______________________________________

Macular Degeneration [ ] no [ ] yes [ ] ? Relationship to you:______________________________________

Retinal Detachment/Disease [ ] no [ ] yes [ ] ? Relationship to you:______________________________________

Arthritis [ ] no [ ] yes [ ] ? Relationship to you:______________________________________

Cancer [ ] no [ ] yes [ ] ? Relationship to you:______________________________________

Diabetes [ ] no [ ] yes [ ] ? Relationship to you:______________________________________

High blood pressure [ ] no [ ] yes [ ] ? Relationship to you:______________________________________

Other:____

Social History

This information is kept confidential. However, you may discuss this portion directly with the doctor if you prefer. [ ] yes, I would prefer to discuss my social history information directly with my doctor. (check box)

Do you drive? [ ] no [ ] yes If yes, do you have difficulty when driving? [ ] no [ ] yes If yes, please describe:________

____

Do you use tobacco products? [ ] no [ ] yes If yes, type/amount/how long:______________________________

Do you drink alcohol? [ ] no [ ] yes If yes, type/amount/how long:______________________________

Do you use illegal drugs? [ ] no [ ] yes If yes, type/amount/how long:______________________________

Have you ever been exposed or infected with: [ ] Gonorrhea [ ] Hepatitis [ ] HIV [ ] Syphilis

Review of Symptoms

Do you currently, or have you ever had any problems in the following areas?

	NO	YES	?		NO	YES	?
Fever, weight loss/gain	[ ]	[ ]	[ ]	Allergies/Hay fever	[ ]	[ ]	[ ]
Headaches/Migraines	[ ]	[ ]	[ ]	Sinus Congestion	[ ]	[ ]	[ ]
Seizures	[ ]	[ ]	[ ]	Runny nose	[ ]	[ ]	[ ]
Poor vision	[ ]	[ ]	[ ]	Cough	[ ]	[ ]	[ ]
Dryness	[ ]	[ ]	[ ]	Earaches	[ ]	[ ]	[ ]
Redness	[ ]	[ ]	[ ]	Dry throat/Mouth	[ ]	[ ]	[ ]
Itching	[ ]	[ ]	[ ]	Asthma	[ ]	[ ]	[ ]
Burning	[ ]	[ ]	[ ]	Wheezing	[ ]	[ ]	[ ]
Foreign body sensation	[ ]	[ ]	[ ]	Emphysema	[ ]	[ ]	[ ]
Tearing/Watering	[ ]	[ ]	[ ]	Diabetes	[ ]	[ ]	[ ]
Glare/Light sensitivity	[ ]	[ ]	[ ]	High blood pressure	[ ]	[ ]	[ ]
Eye pain/Soreness	[ ]	[ ]	[ ]	Vascular disease	[ ]	[ ]	[ ]
Thyroid/Other glands	[ ]	[ ]	[ ]	Stomach issues	[ ]	[ ]	[ ]
Stroke	[ ]	[ ]	[ ]	Genital/Kidney/Bladder	[ ]	[ ]	[ ]
Changing moles	[ ]	[ ]	[ ]	Rheumatoid Arthritis	[ ]	[ ]	[ ]
Muscle/Joint pain	[ ]	[ ]	[ ]	Anemia/Bleeding problems	[ ]	[ ]	[ ]
Allergic/Immunologic	[ ]	[ ]	[ ]	Psychiatric	[ ]	[ ]	[ ]

Other:______________________________________

______________________________________ **Date:**____________

OFFICE POLICIES

1) All payments and insurance co-pays are due at time of service.

2) Account balances older than 90 days are delinquent and subject to legal collection procedures. If your account Becomes delinquent, you are responsible for all reasonable fees incurred in the collection of your account.

3) A service charge of $35.00 will be added to any check returned due to insufficient funds, stop payment, or closed account. Failure to pay the check amount plus service charge, in cash, within 10 days of notification will result in immediate legal action.

ABOUT YOUR INSURANCE

There are two types of health insurance that help you pay for your eye care services and optical products. You may have both types. We accept most plans in both categories. 1) Vision plans (such as VSP, Eyemed, Superior and others) and 2) Medical insurance (such as BCBS, Medicare, Aetna, and others).

-Vision plans only cover ROUTINE wellness exams along with glasses or contact lenses.

-Medical insurance must be used for the diagnosis, treatment, and management of eye health problems.

-If you have both types of insurance plans, it may be necessary to bill some services to one plan and some to the other.

-While we work hard on your behalf with insurance companies, ultimately YOU are responsible for your account.

Please provide your insurance cards to our staff member so we can make a copy.

GLASSES AND SERVICES

Eyeglasses are custom made devices. For this reason, they are not refundable. We will be happy to correct and work with you should you experience any problems. Professional fees represent payments for services that were rendered and are not refundable.

When you request to reuse and old frame to manufacture and insert new lenses, we cannot be responsible for breakage. Although we use the utmost care if we accept a patient's frame, if a patient's frame breaks during handling, the purchase of a new frame is the patient's expense.

If our prescription is filled elsewhere and an RX change is needed, we will not be responsible for any charges incurred. For prescriptions by our doctor and filled with our labs, an office visit to recheck the RX will be provided and new lenses made at no charge within 30 days of dispensing. Recheck visits after 30 days will be charged the usual fee for a brief exam. Remakes due to the patient wanting a different frame will be done with a 20% discount. Prepackaged contact lenses may only be returned if the original packaging is not opened or written on.

I have read the above policies and agree to abide by them. I realize I am responsible for services and/or materials provided to my dependents and me. I authorize release of any information to third party payors. I authorize and request my insurance carrier to pay directly to the doctor insurance benefits otherwise payable to me. I understand my insurance may pay less than the actual billed amount for services and materials.

Patient/Legal Guardian:____________________________________ **Date:**____________________

Dr. Michelle Cooper's office offers secure viewing and communication as a service to patients who wish to view their records or communicate with our staff and physician.

How the secure patient portal works

Drmichellecooper.eyefinityehr.com

A secure web portal is a type of web page that uses encryption to keep unauthorized persons from entering. Secure messages and information can only be read by someone who knows the right username and password. Please note that your username will be your first initial, last name and year of birth-for example JSmith1970. Your password will be Password1. A representative portal is also available. The username will be the same as the patient's followed by the number 1-for example JSmith19701.

PLEASE CHANGE YOUR PASSWORD AS SOON AS YOU LOG IN!

Protecting your private health information and risks:

This method of communication and viewing prevents unauthorized persons from being able to access messages while they are in transmission. Keeping messages secure depends on making sure the secure message reaches the correct email address and making sure only the correct individual has access to the message. Only YOU can make sure these two factors are present. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it. It is imperative that our practice has your correct email address and that you inform us of any changes to your email address!

Online communication should never be used for an emergency or an urgent request. Please contact our office by phone in these situations.

Patient acknowledgement and agreement:

I acknowledge that I have read and fully understand this consent form regarding the patient portal. I understand the risks associated with online communications between my physician and me and consent to the conditions outlined herein. I agree to follow the instructions set forth in the log in screen as well as any other instructions my physician may impose to communicate with patients online. I understand and agree with the information I have been provided.

Patient name (print):_______________________________________ Date of birth:_____________

Patient/Legal guardian signature:__________________________________ Date:________________

PATIENT CONSENT FORM

(HIPAA)

Under Health Insurance Portability & Accountability Act of 1996 (HIPAA), you have certain right to privacy, which are outlined in the HIPAA form provided. This information will be used to:

1. Plan, conduct, and direct your treatment and follow-up among multiple health care providers involved in your treatment.

2. Obtain payment from third party payers.

3. Conduct normal healthcare operations such as quality assessment and physician certification.

4. Import medications from your pharmacy.

You have the right to review a NOTICE OF PRIVACY PRACTICES prior to signing this consent. This organization has the right to change its Notice of Privacy Practices from time to time and you may contact this organization at any time to obtain a copy of the Notice of Privacy Practices.

You may revoke this consent in writing at any time.

Patient name:____

Signature:____

Relationship to patient:_____________________________________

Date:________________

Eyeglasses/Outside Prescriptions

You have the right to your eyeglass prescription and as a patient of our office, you will always be provided with a copy. We hope you will obtain your eyeglasses from our office; we believe we provide the best value available when you consider service, quality and price. If you decide to shop elsewhere, we certainly understand and will be pleased to provide your ongoing eye and vision care.

Local opticians generally do a good job of filling prescriptions, but we have concerns with the use of eyeglass vendors over the internet. Fitting glasses involves precise measurements, unbiased advice based on your particular needs, as well as skillful adjustment of the frame and lenses. Since internet vendors do not actually meet with you in person, they cannot provide these services. We provide all the necessary optical services at no additional cost for patients who purchase eyeglasses at our office. Because we have no control in the fabrication, we cannot provide these services for glasses purchased elsewhere.

To avoid confusion and disappointment with glasses obtained outside our office, please refer to the following list:

We can only provide two technical services for eyeglasses purchased outside of our office.

1) P.D or pupillary distance. This measurement will be provided for a $15 dollar fee at your request.

2) Prescription verification. We will verify the basic lens parameters in new glasses to see if they match your prescription. This will be done at no charge. We cannot troubleshoot optical measurements taken by others. Visual problems may be a result if a correct prescription is made with inaccurate optical measurements. Correction or changes in the glasses will be up to you and the eyeglass vendor.

The following services cannot be provided for glasses purchased elsewhere:

-Seg height

-Vertical optical center

-Eye and bridge size

-Temple length

-Lens materials and index

-Base curve

-Multifocal design and brand

-Optional lens features

-Adjustments or minor repairs

-Education and training on lens and frame features and care

Patient Signature:____ **Date:**__________________

iWellness Exam

Your eyesight is priceless and we are here to protect it!

Vision threatening diseases such as glaucoma, macular degeneration and diabetic retinopathy often have no outward signs or symptoms in the early stages, so our practice has begun using state-of-the-art technology to assess the health of your eyes.

The iWellnessExam™ is a quick, non-invasive scan that allows our doctors to see beneath the surface of your retina. This unique technology can help our doctors detect vision threatening and systemic diseases in their very early stages, when they are most treatable.

As part of your pre-exam testing, our technician will perform the iWellnessExam which your doctor will review with you during your examination today. The $39 charge is not covered by your vision or medical insurance, so this will be added into the cost of your visit today. Any questions you have about iWellnessExam and the results of the test can be discussed with the doctor during your examination.

___ YES, I ________________________________ would like to have the iWellness scan done today.

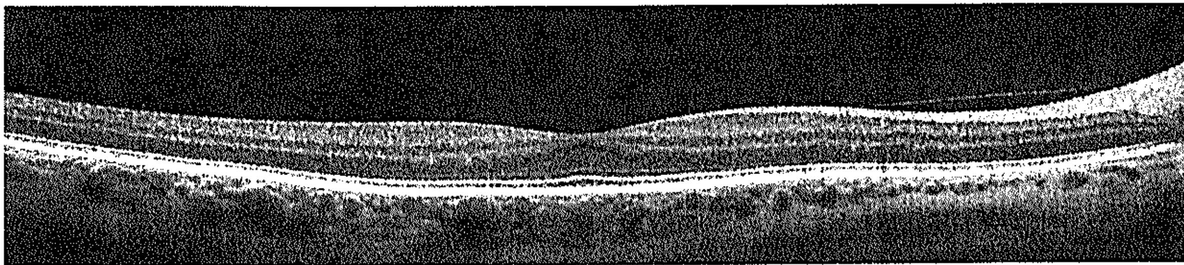
___NO, I _____________________________________ will not have the iWellness scan done today.

Date:___________

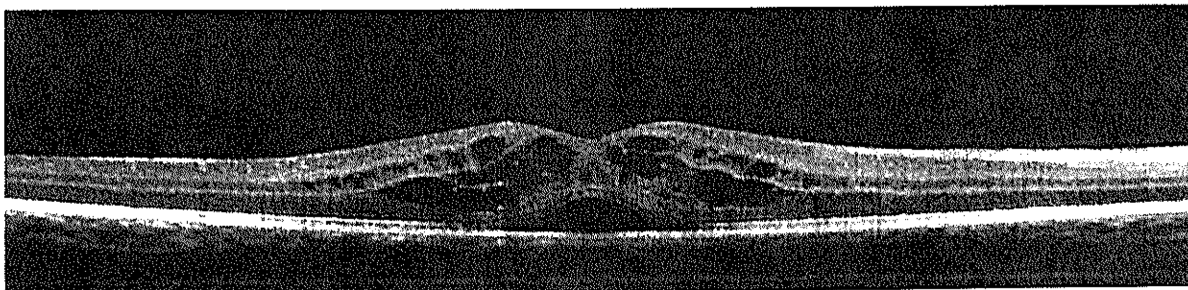
Thank you for choosing our practice to protect the health of your eyes!

iWellness Exam examples:

Healthy Retina



Unhealthy Retina



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A. Notifier: Dr. Michelle Cooper P.A

B. Patient Name: **C. Identification Number:** ________

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** refraction below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** refraction below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
92015 - Refraction (Determines your eyeglass prescription)	Non-covered service	$40

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** refraction listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** refraction listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** refraction listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** refraction listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).**

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

* MEDICARE PATIENTS ONLY *