MEDICAL VISION INSTITUTE OCULAR/MEDICAL HISTORY FORM

PATIENT NAME: DATE OF BIRTH:

OCULAR HISTORY:(CIRCLE ALL THAT APPLY)	**MEDICAL HISTORY:(CIRCLE ALL THAT APPLY)**
PAST EYE CONDITIONS? YES / NO / Details: PAST EYE SURGERIES? YES / NO / Details:	ARTHRITIS ASTHMA CANCER (Type:_____) STROKE COPD DIABETES (Last A1C? _____) HEARING LOSS HIGH BLOOD PRESSURE HEART DISORDER-(Details:_____ _____) HIGH CHOLESTEROL HYPER/HYPO-THYROIDISM SLEEP APNEA
CURRENT OR PAST USE OF EYE DROPS? YES / NO / Details: DO YOU WEAR CORRECTION? NO/ BIFOCALS/ DISTANCE ONLY/ PRESCRIPTION READING/ OVER THE COUNTER READING/COMPUTER CONTACT LENSES	**HAVE YOU EXPERIENCED ANY OF THE FOLLOWING IN THE LAST YEAR? (CIRCLE)** Headache Anxiety/depression Allergies Angina Shortness of breath Uncontrolled blood sugar Angina (chest pain) Change in bowel habit Weight loss/gain Dry mouth Stuffy nose Joint pain
DOES ANYONE IN YOUR FAMILY HAVE A HISTORY OF EYE DISEASE? e.g. glaucoma, macular degeneration	**PLEASE LIST ANY OTHER MEDICAL CONDITIONS:**
HOW WOULD YOU DESCRIBE YOUR TOBACCO USE? Never Smoker Former Smoker Current Smoker	**PLEASE LIST ANY PAST MAJOR SURGERIES:**
MEDICATIONS (PLEASE LIST)—or attach sheet 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____	**ALLERGIES (CIRCLE & DESCRIBE REACTION)** ADHESIVE _____ LATEX _____ IODINE/BETADINE _____ LIDOCAINE(or other anesthetic) _____ FLUORESCEIN_____ EYE DROPS _____ OTHER (Please list): _____ _____ _____ _____

MEDICAL VISION INSTITUTE OCULAR/MEDICAL HISTORY FORM

PATIENT NAME: DATE OF BIRTH:

WHAT IS YOUR PROFESSION?	**PLEASE LIST A FEW OF YOUR HOBBIES/PASTIMES:**

Please indicate if you are experiencing the following symptoms:

Circle the number that corresponds to your answer.

	Always	**Usually**	**Often**	**Seldom**	**Never**
1. Eyes that are sensitive to light?	**4**	**3**	**2**	**1**	**0**
2. Eyes that feel gritty?	**4**	**3**	**2**	**1**	**0**
3. Painful or sore eyes?	**4**	**3**	**2**	**1**	**0**
4. Blurred vision?	**4**	**3**	**2**	**1**	**0**
5. Excess tearing?	**4**	**3**	**2**	**1**	**0**
6. Reduced side vision?	**4**	**3**	**2**	**1**	**0**
7. Double vision?	**4**	**3**	**2**	**1**	**0**
8. Glare/halos around lights?	**4**	**3**	**2**	**1**	**0**

Have problems with your eyes limited you in performing any of the following during the last week?

Circle the number that corresponds to your answer.

	Always	**Usually**	**Often**	**Seldom**	**Never**
1. Reading?	**4**	**3**	**2**	**1**	**0**
2. Driving at night?	**4**	**3**	**2**	**1**	**0**
3. Working on a computer?	**4**	**3**	**2**	**1**	**0**
4. Watching TV?	**4**	**3**	**2**	**1**	**0**
5. Seeing at night or in dim conditions?	**4**	**3**	**2**	**1**	**0**

Are there any other concerns that you would like to address at this visit?

_____

_____

_____

_____

_____

PATIENT DEMOGRAPHICS INFORMATION

PATIENT NAME:_____ **TODAY'S DATE:**_____

SSN:_____ DOB:_____ SEX: _____ CAREGIVER NAME (if applicable) _____

ADDRESS:_____**CITY:**_____**ST:**_____**ZIP:**_____

CELL PHONE:_____**HOME PHONE:**_____**MAY WE LEAVE A MESSAGE?** YES NO

EMAIL:_____ HOW DID YOU HEAR ABOUT US?_____

PRIMARY CARE DOCTOR: _____ **ANY OTHER DOCTORS?** _____

_____

PHARMACY: _____ **PHARMACY CITY & STREET:** _____

PRIMARY MEDICAL INSURANCE NAME: _____

SECONDARY MEDICAL INSURANCE NAME (if applicable): _____

VISION INSURANCE NAME (if applicable): _____

PATIENT ACKNOWLEDGEMENT

PRIVACY NOTICE-"I have read and understand the Notice of Privacy Practices for Medical Vision Institute, PSC and would like the following person(s) to have access to my account information: _____ (optional). I understand that I can rescind this permission at any time with written notice to Medical Vision Institute."

INSURANCE PATIENTS-"I authorize my health insurance company to utilize my medical information as reasonably necessary for the proper administration of the health plan. I hereby assign MVI any payments of medical benefits for services rendered to myself or dependents." Copayments: MVI is required by your insurance to collect your copayment. Your copayment is due at the time of service. If you do not have your copayment, your appointment may be rescheduled. "I have read and understand that I am responsible for paying the annual deductible, copayment, coinsurance and any charges for non-covered services as determined by my insurance."

REFRACTION/CONTACT LENS FITTING FEE: "I have read the MVI fee schedule for refraction and contact lens fitting and understand these services may not be covered by my insurance plan. I understand if they are covered services, it would be under my vision plan, not medical insurance."

ACCEPTANCE OF FINANCIAL RESPONSIBILITY: "I acknowledge full financial responsibility for services rendered by MVI, regardless of insurance coverage and whether or not there was an accident with another party at fault. "

OUTSTANDING BALANCES- "Any patients having an outstanding balance with a collection agency will not be able to make an appointment until the balance is paid in full. Any third-party costs associated with collecting past due accounts will be added to the patient's account. MVI will charge 2% interest on any balances over 90 days old. I AGREE TO THE TERMS AND CONDITIONS ABOVE."

E-PRESCRIBING- "I have read the Medical Vision Institute (MVI) e-Prescribing consent form in its entirety and would like to enroll in the e-Prescribing program. I agree that Medical Vision Institute may request and use my prescription medication history from other healthcare providers
or pharmacies for treatment purposes."

Responsible Party Signature: _____ **(required)**

For more information regarding MVI policies and procedures, please visit our website at www.medicalvision.com

MEDICAL VISION INSTITUTE NOTICE OF PRACTICE POLICIES AND PATIENT ACKNOWLEDGEMENTS

Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. We are required by law to maintain the privacy of your PHI (private health information) and to provide you the notice of our legal duties and our privacy practice with respect to PHI. It is our intention to abide by the terms of the current Notice of Privacy Practices (which can be provided to you upon request) and HIPAA Regulations currently in effect.

If you would like to give access to your information to anyone other than yourself (you can rescind permission at any time), **list their name here**:_____

Other Office Policies/Procedures

Arrival Policy

Patients who are 10 or more minutes late for appointments may be asked to reschedule.

Missed Appointments and Termination

More than 3 "no-shows" or "late cancellations" without justified reason in any 6-month period may result in practice termination. MVI reserves the right to discretion when determining justifiable cause.

Electronic Prescribing

All patients are automatically enrolled in electronic prescribing and access to their preferred pharmacy and medications for their convenience. They can be unenrolled at any time per their request.

Updating Your Contact Information

In the event that your contact information has changed, you should notify us as soon as possible. You may do this by logging into your Patient Portal account. If you do not have a Patient Portal account, please contact our office. If you fail to update invalid contact information, you must understand that any communications (including billing statements, appointment changes, etc.), shall nevertheless be deemed to have been provided to you.

Minors

Any patient under the age of 18 must have an accompanying adult throughout the entire examination process.

Dilation

Most medical eye exams require dilation. Dilation is the use of eye drops to make the pupils larger. Dilation can cause blurry vision, particularly near vision, and light sensitivity that lasts several hours afterward. Most of our patients are comfortable driving after dilation, but you may want to bring a driver if you have concerns.

Emergency Coverage

In the event you have an ocular emergency and our physician is not on site, the office is closed, or for some reason we are not able to respond within an hour, it is your responsibility to seek care elsewhere. You should visit an urgent care center or your closest emergency room to have your condition evaluated.

Obtaining a Copy of Your Records

Medical vision will provide a paper copy of your records with us in their entirety free of charge one time only. Any additional paper copies will require processing fees.

Communications

We may contact you electronically, by phone, in writing, or with a combination thereof. MVI will follow the privacy policy above and make all attempts to be respectful of your time. However, we cannot predict every circumstance for which we may need to contact you. You may choose to inform us of your preferred contact method and have the option to opt out of some electronic communications.

Financial Policy

Payments: You will be held accountable for all unpaid balances by your insurance plan and any non-covered service charges incurred. Note: The adult accompanying a minor patient is responsible for payment for all services rendered. For your convenience, we accept cash, check, money order, VISA, Discover, MasterCard and American Express. We participate with most major insurance companies and will bill those plans with which we have an agreement and will collect any required co-payment, co-insurance, and/or deductible at the time of service unless other arrangements have been made in advance.

Insurance: As a courtesy, MVI verifies your coverage and benefits with your insurance company. Accepting your insurance does not place all financial responsibilities onto this practice and a quote of benefits is not a guarantee of benefits or payment. Although we are contracted with most insurance carriers, some of our services may not be covered

by your particular insurance plan. In the event your insurance plan determines any service to be “non-covered,” you will be responsible for the complete charge.

Medical Insurance vs. Vision Insurance: Medical eye exams include the diagnosis and treatment of eye disorders. Vision exams are just a basic eye check and include the refraction service (required to generate an updated glasses prescription; see more information below regarding this service). Many medical insurances include a *vision benefits package* but this is still through a completely separate insurance company and their rules do not allow both to be billed on the same day.

Refraction Service and Fee: The refraction test is not covered under Medicare guidelines or any other medical insurance and is not reimbursed. The extra service is time-consuming, carries liability, and is a legal requirement for issuing a prescription. Please note: we are not charging for the prescription paper itself, but for the service required to generate it. Even if you are seeing well with your current glasses, refraction testing is required to determine your best corrected visual acuity. We can measure the approximate prescription in your current glasses, but these readings are not enough to write a valid prescription without a refraction test, even if you are seeing well. Note: If you decline to have a refraction performed, you will not receive a new prescription.

Contact Lens Fitting / Maintenance Fees: Contact lens wearers are charged a yearly renewal fee which covers the evaluation of fit, power, and any other concerns related to contact lens wear before the patient can receive an updated contact lens prescription. This fee does not include the cost of the eye examination, refraction, contact lens supply, or contact lens solution. Fees vary depending on the complexity of the fit, type of lens, and prescription. Important: The refraction service is required for the renewal of your contact lens prescription to ensure proper evaluation of your refractive error correction in your contact lenses. This means even if you do not want an updated glasses prescription, you will be required to pay for both the refraction service and contact lens fitting service.

Non-insured Patients: If you do not have insurance coverage, a deposit may be required prior to seeing the physician and you are 100 percent responsible for all services. MVI will provide a quote for the self-pay pricing, but cost will vary based on the services provided. We are not able to predict all services that may be required for your care but will make all attempts to have open communication and help prevent surprise charges.

Outstanding Balances: Patients that have an outstanding balance may receive a billing statement by mail. If payment is not received within 30 days, a service charge may be applied to the patient account. If no payment is received within 60 days, the account may be sent to collections without further notice unless arrangements are made by the responsible party. Overdue accounts may also incur monthly interest in addition to processing fees until the account is settled in full. Any patients having an outstanding balance with a collection agency will not be able to make an appointment until the balance is paid in full. Any third party costs associated with collecting past due accounts (court costs, legal fees and collection charges) will be added to the patient's account. If your appointment is urgent in nature or extenuating circumstances prevent you from paying your balance, a payment plan may be requested. If a payment plan becomes delinquent, it will be subject to the interest and billing fees stated above.

Returned Checks/NSF: Accounts with checks returned due to insufficient funds may be charged a processing fee. The balance due must be paid by cash or credit card. In the event that MVI receives a second returned check from the same patient or client, checks will no longer be accepted for services provided.

No-Show / Late Cancellation Policy: Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, MVI may charge a fee for missed appointments (“no-show”) and appointments which, absent a compelling reason, are not canceled with a 24-hour notice (“late cancellation”). Procedure cancellations require at least 5 business days advance notice. These fees will be billed to the patient and are not covered by insurance.

*You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with our office and with the Department of Health and Human Services, Office of Civil Rights. In the event you wish to seek additional information regarding our policies, feel free to contact the Practice Compliance Officer in person or in writing.

By signing below, you acknowledge that you have received this notice and understand the above policies:

_____ _____

Signature Date

_____

Printed Name