ADDITIONAL INFORMATION:_____

Dilation of the Eyes

It will be necessary to dilate your pupils in order to perform a complete and thorough eye examination. This allows the doctor to obtain a better view of the back of the eyes. The dilating drops typically last 3-4 hours. During this time you may find it difficult to focus at near and less commonly at distance. You may be sensitive to light. You will be provided with post-dilation glasses.
We strongly recommend caution when driving or operating equipment or machinery after dilaton.
If you feel you would not be able to drive or return to work, we recommend Digital Retinal Photography and OCT in place of dilation.
Signing this section signifies that you have been informed of the risks and benefits of dilation.

Please select one of the options below, indicating your choice for Dilation:

☐ I wish to have Dilation performed today ☐ I do not wish to have Dilation performed today
☐ I wish to to discuss Dilation with the Doctor.

Signature (Patient or Guardian)_____ Date:_____

Acknowledgment Notice of Privacy Practices

Signing in this section signifies that you have received a copy of our Notice of Privacy Practices

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for these services, and to conduct healthcare operations involving our offices.
The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

Signature (Patient or Guardian)_____ Date:_____

Digital Communication

I give permission to be in contact via text message or e-mail

Signature (Patient or Guardian)_____ Date:_____

Optic Gallery

Date_____ Please Print

PATIENT INFORMATION

Patient Name_____ Sex (M/F)_____ Date of Birth___/___/___ Age_____

Address_____City_____State_____Zip_____

CIRCLE ONE

Primary Phone #_____(Home/Work/Cell) Place of Employment:_____

CIRCLE ONE

Alternate Phone #_____Home/Work/ Cell) Occupation:_____

Social Security #_____ E-mail Address_____

INSURED INFORMATION

Insured's Name_____ Insured S.S.#_____Insured's DOB_____

Medical Insurance_____ Medical Insurance#_____Vision Insurance_____

VISIT INFORMATION

Reason for today's visit_____

Last eye exam_____Drs. Name_____Last Medical Exam_____Drs. Name_____

List Activities and Hobbies_____

Does your work require any special vision needs?_____

Do you wear sunglasses?_____

Do you wear contact lenses?____ Type_____ Do you want to wear contact lenses?_____

How were you referred to our office?_____

OCULAR HISTORY

☐ I Have No Ocular Conditions.

Blindness	☐	Eye Trauma	☐
Blurred Vision	☐	Eye Turn/Lazy Eye	☐
Cataracts	☐	Eye Watering	☐
Double Vision	☐	Flashes	☐
Eye Fatique	☐	Floaters	☐
Eye Itching	☐	Glaucoma	☐
Eye Redness	☐	Macular Degeneration	☐

Eye Surgery(LASIK ect.) Type:_____

MEDICAL HISTORY

☐ I Have No Medical Conditions.

Do you have (Past or Present)?

		medication			medication
Allergies	☐	_____	High Blood Pres.	☐	_____
Asthma	☐	_____	High Cholesterol	☐	_____
Cancer	☐	_____	Kidney Disease	☐	_____
Diabetes	☐	_____	Lung Disease	☐	_____
Headaches	☐	_____	Sinus Problems	☐	_____
Heart Disease	☐	_____	Thyroid Problems	☐	_____

Medications:_____

Are you pregnant or nursing?_____

Allergies?_____ (Please use the back of this form for additional medications)

Do you? / Frequency Drink_____Smoke_____Use Drugs_____

FAMILY HISTORY Does anyone in your family have? Who?

Blindness_____Glaucoma_____Macular Degeneration_____Eye Disease_____Diabetes_____

Cancer_____High Blood Pressure_____Heart/Lung Disease_____Other_____

In the event that it becomes necessary for us to release your records to or request from another healthcare professional, I authorize Optic Gallery to release and/or request these records. If applicable, I request payment of authorized Medicare or other insurances be made either to me or on my behalf to Optic Gallery, for any service rendered to me. I authorize pertinent medical information about me to determine insurance benefits and billing to be released to the health care financing or other insurance agencies.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE COMPANY

It is the policy of this office to require: (1) Payment in full or at least one-half deposit made before an order can be placed. (2) The balance of the fee must be paid at the time the order is dispensed. (3) All orders are final when placed. I furthur acknowledge and agree that all accounts past 30 days shall bear a compounding interest rate of 1.5% per month. I also acknowledge and agree that in the event I do not pay for services rendered "Optic Gallery" may place my account with a collection agency. I agree to pay reasonable collection fees, attorney fees and court cost incurred in collection of my overdue account.

Signature X Witnessed By X Date

WE THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM AND CHOOSING OPTIC GALLERY FOR YOUR EYECARE NEEDS

OPTIC GALLERY
Family Eye Care

Eye Wellness / Preventative Care

OCT Retinal Scan/ Digital Retinal Photography

Sight threatening diseases such as Glaucoma, Macular Degeneration, Diabetic Retinopathy, and others often have no outward signs of symptoms. That is why eye exams, including a thorough retina evaluation are important to protect vision. In an effort to provide a more advanced comprehensive eye exam. Optic Gallery has incorporated the **Wellness Exam OCT Retinal Scan & Digital Retinal Photography** as part of your complete eye exam today.

Our technician will perform these two tests before you go into the exam room and the Doctor will review these results with you during your examination today. These two tests will become a part of your permanent patient records. Any questions about these tests can be discussed during your exam with the Doctor.

While these tests are recommended for preventative eye care for all patients, they are of particular importance for those patients with any of the following:

- Flashes / Floaters
- Cataracts
- Over the age of 40
- Personal or Family History of Diabetes
- Personal or Family History of Glaucoma
- High Nearsightedness
- Frequent or Severe Headaches
- High Blood Pressure

The $49.00 charge is typically not covered by your medical or vision insurance.
This cost will be added to the price of your exam copay today.

Please Check One :

- ☐ I wish to have the OCT Retinal Scan / DRP done today
- ☐ I do not wish to have the OCT Retinal Scan / DRP done today
- ☐ I wish to have the OCT Retinal Scan / DRP scheduled for another day
- ☐ I wish to discuss the OCT Retinal Scan / DRP with the Doctor

Signature: _____ Date: _____

OPTIC GALLERY
Family Eye Care

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 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 the information but the practice does not 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 was signed by(Print Name Please): _____

Signature: _____ Date: _____

Witness: _____ Date: _____

OPTIC GALLERY
Family Eye Care

Optic Gallery Contact Lens/ Eyeglass Communication

In accordance with the fairness to contact lens consumer act,and the eyeglass rule. We are required to present you with your finalized eyeglass and/or contact lens prescription following your evaluation. Please print and sign below that you have received your prescription for our files.

I, _____

attest that I have received my finalized eyeglass and/or contact lens prescription from my eye care professional at Optic Gallery.

_____ _____

Signature **Date**

OPTIC GALLERY
Family Eye Care

NO SHOW POLICY

We schedule our appointments so that each patient receives the appropriate amount of time to be seen by our Doctors and staff. Therefore, it is very important to keep your scheduled appointment and arrive on time as instructed.

As a courtesy and to help patients remember their scheduled appointments, we send text reminders 24 hours before the scheduled exam and another text reminder 30 minutes prior to the scheduled appointment time.

If your schedule changes and you are unable to keep your appointment, please contact us at least 24 hours prior to your scheduled appointment to avoid a no-show fee.

Monday-Friday appointments canceled or rescheduled with less than 24 hours notice will be charged a $25.00 no-show fee.

Saturday appointments canceled or rescheduled with less than 24 hours notice will be charged a $50.00 no-show fee due to the high demand and limited availability of Saturday appointments.

No-show fees are not reimbursable by your insurance company and will be billed directly to you. All outstanding no-show fees must be paid prior to scheduling another appointment in our office.

I understand the no-show policy of Optic Gallery Ann and agree to pay the applicable fee for appointments canceled or rescheduled with less than 24 hours notice.

I understand that I cannot schedule another appointment until any outstanding no-show fee has been paid.

Print Name:_____

Sign:x_____

Date:_____