Medical History Questionnaire

TWO SIDES *required by your insurance provider*

Name_____ **Date of birth** _____**Today's Date**_____

Gender: o Male o Female **Social Security#** _____/_____/_____

Race: o Caucasian o Black or African American o Asian o American Indian

o Native Hawaiian or other Pacific Islander o Other Race o Unknown

Ethnicity: o Not Hispanic or Latino o Hispanic or Latino

Medical History

Do you have any allergies to medications? o No o Yes If yes, explain: _____

_____

List any medications you are taking: o I am on no prescription medications

_____

_____

_____

_____

Post Ocular History Circle any of the following that you have had

Cataract Lazy eye Glaucoma Macular Degeneration Retinal Detachment LASIK Injury

Other_____

Do you wear glasses? o No o Yes If yes, how old is your current pair? _____

Do you wear contacts? o No o Yes If yes, how old is your current pair? _____

Family History:	**NO**	**YES**	**Relationship to You**
Cataract	o	o	_____
Glaucoma	o	o	_____
Macular Degeneration	o	o	_____
Crossed Eyes	o	o	_____
Retinal Detachment	o	o	_____
Cancer	o	o	_____
Diabetes	o	o	_____
High Blood Pressure	o	o	_____
Heart Disease	o	o	_____
Thyroid Disease	o	o	_____
Other _____			_____

Social History

Do you use tobacco products? o No o Yes If yes, type/amount/how long:_____

Everyday _____ Occasional _____ Never _____ Former _____

Do you drink alcohol? o No o Yes If yes, type/amount/how long:_____

Everyday _____ Occasional _____ Never _____ Former _____

** Please turn this form over and complete side two **

Review of Systems

Do you currently have any of the following:

Eyes	NO	YES
Loss of Vision	o	o
Blurred Vision	o	o
Double Vision	o	o
Halos/Glare	o	o
Light Sensitivity	o	o
Dry Eye	o	o
Mucous Discharge	o	o
Redness	o	o
Sandy or Gritty Feeling	o	o
Itching	o	o
Burning	o	o
Foreign Body Sensation	o	o
Excess Tearing/Watering	o	o
Flashes/Floaters	o	o
Eye Pain or Soreness	o	o
Other_____	o	o
Constitutional		
Fatigue Syndrome	o	o
Cancer	o	o
Developmental Disabilities	o	o
Other _____	o	o
ENT		
Laryngitis	o	o
Dry Mouth	o	o
Sinusitis	o	o
Hearing Loss	o	o
Other_____	o	o
Neurological		
Multiple Sclerosis	o	o
Epilepsy	o	o
Cerebral Palsy	o	o
Tumor	o	o
Migraine	o	o
Other_____	o	o
Psychiatric		
Attention deficit	o	o
Anxiety disorder	o	o
Bipolar disorder	o	o
Depression	o	o
Other_____	o	o
Cardiovascular		
Stroke/CVA	o	o
High Blood Pressure	o	o
Vascular disease	o	o
Heart disease	o	o
Congestive Heart Failure	o	o
Other_____	o	o

Respiratory	NO	YES
Asthma	o	o
Bronchitis	o	o
Cigarette Smoker	o	o
Sleep Apnea	o	o
Chronic Obstruction	o	o
Emphysema	o	o
Other_____	o	o
Gastrointestinal		
Crohn's	o	o
Ulcer	o	o
Colotis	o	o
Acid Reflux	o	o
Celiac disease	o	o
Genitourinary		
Kidney disease	o	o
Pregnant/Nursing	o	o
Prostate disease/cancer	o	o
Herpes	o	o
Other_____	o	o
Musculoskeletal		
Gout	o	o
Osteoporosis	o	o
Arthritis	o	o
Muscular Dystrophy	o	o
Fibromyalgia	o	o
Integumentary		
Herpes Zoster/Shingles	o	o
Herpes Simplex/Cold Sores	o	o
Eczema	o	o
Other_____	o	o
Endocrine		
Type 2 Diabetes	o	o
Type 1 Diabetes	o	o
Thyroid dysfunction	o	o
Hormonal dysfunction	o	o
Other_____	o	o
Hemotologic/Lymphatic		
Anemia	o	o
Large-volume blood loss	o	o
High Cholesterol	o	o
Other_____	o	o
Allergic/Immune		
Sjogren's Syndrome	o	o
Lupus	o	o
Rheumatoid Arthritis	o	o
Environmental Allergies	o	o
Drug Allergies	o	o
Other_____	o	o

EYE CARE ASSOCIATES

Dr. Helaina Boulieris OD

12120 E. Mission Ave, Ste 2 Spokane Valley, WA 99206 P: 509-926-6800 F: 509-926-4041

Contact Lens Fitting and Evaluation Agreement

The fee for the contact lens fitting and evaluation by your eye care professional is not included in your comprehensive eye exam benefit. Fees vary based on the type of lens being evaluated and followed up required. The fee includes the initial visit and up to three subsequent visits directly related to contact lens wear and fit within a 60 day period. If you decide to change lens modalities during fitting, additional charges may apply.

POLICIES:

- Charges for fitting fees are due in full at the time of the fitting/evaluation.
- Progress checks and other contact lens-related services performed after your three follow-up visits are subject to normal office visit charge.
- Many insurance plans do not cover the full cost of contact lens fees. You will be responsible for any uncovered costs incurred.
- Professional fees for the contact lens fitting/ evaluation are non-refundable.
- You are responsible for scheduling and attending follow up visits to finalize your prescription. Your contact lens prescription expires after two years in the state of Washington.
- The fitting/evaluation fee does not include cost of your contact lens supply.
- Contact lenses may only be returned within 60 days of an initial order. All boxes must be unopened and in unmarked packaging.

Patient Name _____

Patient or Legal Guardian Signature_____Date_____

(Due to the health risks involved with contact lenses, we will require parental consent for all minor patients)

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

FINANCIAL POLICY

Our office will make every effort to collect payments from your insurance company. If, however, we are unable to obtain verification of benefits from your insurance company, our office does require payment at the time of services. If your insurance company then pays, a refund will be issued. For detailed information about your individual vision coverage, please contact your personnel office at work, or your insurance company. We are not responsible for knowing the details of your individual plan.

A down payment of one half of the total amount will be required when placing an order for glasses or contact lenses. The balance is required on dispense of eye-wear or contact lenses. Again, all efforts will be made to collect from your insurance company. If verification of benefits has been obtained, that amount will be deducted from the patient's personal total before figuring the amount of down payment.

Verification of benefits is not a guarantee of payment. If the insurance company should deny coverage for any reason, or, if they have not responded with payment within 90 days of billing, the patient will be held responsible for paying their balance in a prompt and timely manner. If payment is then received at a later date, a reimbursement check will be issued.

Signature_____ Date_____

Insurance Authorization

I request that payment of authorized insurance benefits for any services furnished me, be made on my behalf to EYE CARE ASSOCIATES

I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that I am responsible for changes not paid by the insurance plan.

Signature_____ Date_____

Retinal Photos

It is our office policy that every patient will have retinal photography as part of the eye health screening. Retinal photographs provide an image of the structures of the back of the eye. Here is why our patients are so happy that we take pictures:

- Most patients, if no eye disease is detected, may avoid having their pupils dilated with drops. The drops cause light sensitivity, blurred reading vision, and can sting when applied.
- It is fast, easy, and comfortable.
- Patients are able to view the image and are able to be better educated on their eye health.
- A permanent record is stored in the computer with the ability to monitor changes in eye health at each visit.
- It enhances the ability to detect diseases affecting the retina such as diabetes, high blood pressure, and macular degeneration.

Your insurance plan may provide basic vision examination coverage, but does not include coverage for retinal photos. The fee for the procedure is only $15.00. However, if pathology is detected, dilation may still be required. If you have any further questions, please ask the doctor or any member of our staff.

Initial: _____