

ISSAQUAH EYEWORKS - ANNUAL UPDATE

PATIENT INFORMATION

Name _____ Date of Birth _____
Last First Middle Initial

EYE HEALTH HISTORY

Since your last visit have you experienced any of the following.....

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Amblyopia (lazy eye) | <input type="checkbox"/> Drooping Eyelid | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Loss of Vision - Side |
| <input type="checkbox"/> Blurred Vision - Far | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Glare / Light Sensitivity | <input type="checkbox"/> Mucus / Discharge |
| <input type="checkbox"/> Blurred Vision - Near | <input type="checkbox"/> Eye Surgeries | <input type="checkbox"/> Headaches | <input type="checkbox"/> Redness |
| <input type="checkbox"/> Burning Eyes | <input type="checkbox"/> Eye Turn | <input type="checkbox"/> Infection of Eye / Lid | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Floaters / Spots | <input type="checkbox"/> Itchy Feeling | <input type="checkbox"/> Tearing / Watery Eyes |
| <input type="checkbox"/> Double /Distorted Vision | <input type="checkbox"/> Fluctuating Vision | <input type="checkbox"/> Loss of Vision - Central | |

MEDICAL HISTORY

Changes to your medical history since your last visit: _____

CONCERNS TO DISCUSS WITH THE DOCTOR

GENERAL VISION QUESTIONNAIRE

- Do you have trouble driving at night? Yes No
- Do you experience blur, headaches or eyestrain with computer use? Yes No
- Are you interested in laser (refractive) surgery to correct your vision? Yes No I have questions

CONTACT LENS WEARERS

- Do you wear contacts? Yes No If Yes, What Type? _____
- Are your contact lenses comfortable? Yes No
- How frequently do you replace your contacts? _____
- What type of contact lens solution do you use? Opti-Free - GP Boston Advance
- Boston Simplus RevitaLens Clear Care Opti-Free Bio-true
- Do you have any concerns about your current contacts? _____

As a contact lens wearer, you should have an annual contact lens exam. During this exam, the doctor will access the contact lens fit, check parameters and look for any medical issues arising from contact lens wearing. A written prescription good for one year will be written. If you do not elect to have a contact lens exam, you will not have a current prescription to purchase contacts.

- Do you wish to have a contact lens exam today?
 Yes No, I do not wish to have a current contact lens prescription.

The fees associated with a contact lens exam are particular to each patients needs, and are in addition to your comprehensive eye exam. The insurance coverage of these fees is unique to each insurance plan. Please feel free to ask our staff for more information. **Please Initial:** _____

Soft Spherical Range: \$49-\$69 Soft Toric Range: \$54-\$90 Soft Bifocal Range: \$64-\$100 Soft Bifocal/Toric Range: \$74-\$120

RGP Spherical Range: \$49-\$85 RGP Toric Range: \$74-\$125 RGP Bifocal Range: \$94-\$154 RGP Bifocal/Toric Range: \$110-\$170

CRT \$1500 Initial fitting fee w/CRT lenses CRT Range: \$99-\$300

DIGITAL RETINAL SCREENING OPTIC

PLEASE READ THE FOLLOWING INFORMATION THOROUGHLY

Issaquah Eyeworks is committed to providing the best patient care possible. We recommend high resolution Digital Retinal Screening. This new method of examining and documenting retinal findings often without the use of the dilation eye drops, is more detailed and accurate than conventional hand drawn documentation. This test should be done every year since the health of the eye can change at any time, often without symptoms. Depending on each patient's specific medical needs, the doctor may recommend both Digital Retinal Screen and Dilation

Digital Retinal Screening

- Vision is unaffected
- Digital screening provides permanent documentation of eye disease and establishes baseline images to compare against any future changes
- Both patient and doctor view images together, providing the best in patient education.

Dilated Exam

- Blurred vision and sensitive to bright light
- Conventional hand drawn documentation of the retina is not as accurate
- Patient cannot see the retina

The doctors at Issaquah Eyeworks strongly recommend the Digital Retinal Screening. The fee for the Digital Screening is \$20.00 when performed as part of the routine exam and is paid in full by the patient. Please feel free to ask the staff any questions regarding this procedure, associated fees or insurance coverage.

_____ I elect to have the Digital Retinal Screening

(I understand that the doctor may recommend both the digital screening and dilation depending on my individual needs)

_____ I Decline the Digital Retinal Screening and elect to have a dilated exam.

NOTICE OF FINANCIAL POLICES

I AM RESPONSIBLE FOR MY BALANCE IF ANY OF THE FOLLOWING OCCURS:

- The treatment goes over my yearly maximum.
- Any treatment denied by my insurance company.
- I am not eligible for insurance.
- I prevent or delay payment by not complying with requests for insurance forms or signatures.
- I receive my insurance check and do not send it to your office.
- My insurance company does not pay within 60 days of service.

Please also note that your insurance company will determine final insurance benefits after claims are submitted. You may request a copy of our complete Financial Policy from an office staff member. Patient changes to our Financial Policy will not be acknowledged.

There will be a \$25.00 charge for any returned checks. A finance fee of 1.5 % along with a \$15.00 late fee for any outstanding balance that requires a second statement.

Further, in the event that you do not show up for a scheduled appointment or if you must cancel an appointment without giving 24-hour notice, you will be charged a \$50.00 cancellation fee. In order to maintain patient fluency within the office, late arrivers are not guaranteed to be seen by the doctor and may be subject to the \$50 cancellation fee as determined by the doctor's schedule and availability.

I authorize the release of any medical or other information necessary to process any claims. I authorize payment of medical and vision benefits to Issaquah Eyeworks and accept all financial responsibility for services and materials not covered by my insurance company, including Medicare. I acknowledge that I have read and can request a copy of Issaquah Eyeworks, LLC Notice of Privacy Practices.

Signature: _____ Date _____
Patient or Guardian

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