TRIO EYECARE
THE RIGHT CHOICE IN OPTOMETRY

Name

Medical History:

Have you ever been diagnosed or treated for any of the following health problems?

- ❑ Allergies
- ❑ Arthritis
- ❑ Blood/Lymph
- ❑ Cancer
- ❑ Cholesterol
- ❑ Diabetes
- ❑ Digestive/Gastric
- ❑ Ears/Nose/Throat
- ❑ Endocrine
- ❑ Fatigue
- ❑ Fevers
- ❑ Heart disease
- ❑ High Blood Pressure
- ❑ Immune
- ❑ Integumentary (Skin disease)
- ❑ Kidney
- ❑ Muscle Bone
- ❑ Neurological/Headaches
- ❑ Psychological
- ❑ Respiratory
- ❑ Sinus
- ❑ Stroke/Seizures
- ❑ Throat Infections
- ❑ Thyroid
- ❑ Unusual Weight Loss/Gains

Current Medications with Dosage:

_____

_____

_____

Allergies:

_____

_____

_____

Surgical History: _____

Social History:

Do you use cigarettes/alcohol? Y/N Freq: _____

Ocular History:

Date of Last Eye Exam: _____

Have you ever experienced, been diagnosed or treated for any of the following?

- ❑ Blurry
- ❑ Burning
- ❑ Cataracts
- ❑ Corneal Abrasions
- ❑ Crossed eye/Eye turn
- ❑ Double Vision
- ❑ Eye Infections
- ❑ Eye Injury
- ❑ Flash of light
- ❑ Floaters/Spots
- ❑ Glaucoma
- ❑ Grittiness
- ❑ Headaches
- ❑ Iritis/Uveitis
- ❑ Itchiness
- ❑ Lazy Eye
- ❑ Macular Degeneration
- ❑ Occasional dryness
- ❑ Retinal Detachment
- ❑ Sunlight Sensitivity
- ❑ Tearing
- ❑ Night vision hard

Family Ocular History:

Is there a family medical history of the following?

Blindness _____ y/n
Cataracts _____ y/n
Corneal Problems _____ y/n
Diabetes _____ y/n
Glaucoma _____ y/n
Heart Disease _____ y/n
Lazy Eye _____ y/n
Macular Degeneration _____ y/n
Retinal Problems _____ y/n

Visual Needs Assessment:

Hours of computer usage: _____
Hours of outdoor activity: _____
Hobbies: _____
Eyestrain/neck strain/headaches: _____
Sports: _____
Hours before reading fatigue? _____

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Medical vs. Vision

Medical insurance DOES NOT cover vision related issues such as routine exams, glasses, and contact lenses. Many people with medical insurance have a separate rider policy to cover routine eye exams. Most vision plans do not cover ANY medical testing, diagnosis, consultation or treatment. Vision insurance covers ONLY routine eye exams for purchasing glasses or fitting and purchasing contact lenses. Regardless of your vision insurance, most plans do not cover 100% of expenses, and thus you should expect some out-of-pocket costs. There may be co-pays, deductibles or a percentage of costs that you will pay out-of-pocket as required by your insurance policy. As with most doctors, at TRIO Eyecare the patient's portion must be paid before materials (glasses or contacts lens) can be ordered. And all co-pays are due at the time services are rendered.

MEDICAL concerns (Glaucoma, Dry Eyes, Macular Degeneration, Red-Eyes, Floaters, Allergic Conjunctivitis) take priority and as such will be treated first or concurrently with a vision problem. Sometimes a medical condition has to be treated and corrected before vision can be accurately evaluated. Medical insurance companies usually separate the components of an eye exam, one being the comprehensive exam and the other being the refraction. (**The refraction determines the prescription for eyeglasses and contacts**.) Typically, VISION insurance policies usually cover both the ROUTINE EXAM and REFRACTION, while MEDICAL policies cover the EXAM only. You are responsible for the cost of the refraction if your insurance is medical only. If the presence of disease is detected that require additional testing, the doctor will provide you information regarding the condition and the testing required.

Unfortunately, they do not differentiate between "medical refractions" and refractions performed for the purpose of providing glasses or contact lenses. We are required to charge for this service regardless of whether your insurance company will cover the service as a benefit of your insurance plan.

There is a fee of **$50.00** for this test. You will be asked to pay at the time of your visit. **This fee will be charged to you approximately one time per year.** This is a routine charge at all medical, optometric and surgical ophthalmology practices.

_____ I understand that a refraction is a non-covered service and request an updated prescription and evaluation to properly assess my best corrected vision.

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Notice of Privacy Practices Patient Acknowledgement

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- ✓ A statement that this practice is required by law to maintain the privacy of protected health information.
- ✓ A statement that practice is required to abide by the terms of the notice currently in effect.
- ✓ Types of uses and disclosures that this practice is permitted to make for each of the following purposes: Treatment, payment and health care operations
- ✓ A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- ✓ A description of uses and disclosures that are prohibited or materially limited by law.
- ✓ A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- ✓ My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated and that no retaliatory
    - The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information
    - The right to amend protected health information
    - The right to receive an accounting of disclosures of protected health information
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Patient: Name: _____ Date of Birth_____

Signature: _____Date: _____

Relationship to patient (if signed by a personal representative of patient):

_____

I authorize my records to be released to the following individual(s):

_____