PATIENT RECORD OF DISCLOSURES / HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing the Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, if you revoke this Consent it shall not affect any disclosure we have already made in reliance on your prior Consent.

The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices, and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Release of Information

□ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information can be released to:

- □ Spouse _____
- □ Child(ren) _____
- □ Other _____
- □ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call □ my home □ my work □ my cell Number: _____

If unable to reach me:

- □ you may leave a detailed message
- □ please leave a message asking me to return your call
- □ _____

Signed: _____ Date: _____

Please Print Name: _____

**Sign below to acknowledge that you are provided with a copy of your glasses and/or contact lens prescription as a part of your refractive examination.

Signature: _____ Date: _____

QUESTIONNAIRE

Name: _____ **Date:** ____/____/____ **Sex:** M F (Circle) **DOB:** ____/____/____

For the Standardized Patient Evaluation of Eye Dryness (SPEED) Questionnaire, please answer the following questions by checking the box that best represents your answer. Select only one answer per question.

1. **Report the type of SYMPTOMS you experience and when they occur:**

	At this visit		Within past 72 hours		Within past 3 months	
Symptoms	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

2. **Report the FREQUENCY of your symptoms using the rating list below:**

Symptoms	**0**	**1**	**2**	**3**
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

0 = Never **1** = Sometimes **2** = Often **3** = Constant

3. Report the SEVERITY of your symptoms using the rating list below:

Symptoms	**0**	**1**	**2**	**3**	**4**
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

1. = No Problems
2. = Tolerable - not perfect, but not uncomfortable
3. = Uncomfortable - irritating, but does not interfere with my day
4. = Bothersome - irritating and interferes with my day
5. = Intolerable - unable to perform my daily tasks

4. Do you use eye drops for lubrication? ☐ **YES** ☐ **NO** **If yes, how often?** _____

For office use only | Total SPEED score (Frequency + Severity) = ____/28

Financial Agreement for Oconee Vision Group

Our office and doctors are providers for numerous vision/medical insurance plans. Your responsibility will be for any co-payment or other charges your insurance does not cover. Our office will help you receive your maximum benefits, if you have provided us with the necessary current insurance information at the time of examination, or before the time your eyewear is ordered. Otherwise, you will be responsible for all costs incurred. If your insurance plan requires a co-payment/co-insurance, you are expected to pay this at the time of service.

If we do not accept your vision/medical insurance, then you will be responsible for all fees and charges that you incur. Payment is due on the date of service. Our office will provide you with an itemized statement, upon request, that you can submit to your insurance company for reimbursement.

We are happy to verify insurance eligibility and benefits. However, this is never a guarantee of benefits as some insurance companies arbitrarily select certain services that they will not cover and/or must be medically necessary. It is your responsibility to understand the scope and limitations of your insurance policy and you are financially responsible for all charges rendered whether paid by your insurance. We are happy to discuss insurance coverage in more detail with you regarding your specific vision and/or medical plan.

Our office is not a party in divorce settlements, therefore, the parent who brings a minor child for care will be the one responsible for payment to us. If the other parent needs to reimburse you, we will give you a receipt as proof of your payment.

Refraction Services

The refraction service is vital to calculating the most accurate prescription to help your vision, however, it is considered routine vision and is normally only covered by Vision plans. Medicare and most other medical insurances do not cover refraction as part of their medical policies, therefore, if we are only filing Medical insurance, the $35 refraction fee will be due from the patient on the date of service.

Uninsured Patients

If you do not have insurance, a 15% administrative discount will be given on the exam only. Glasses, contacts and other eyewear are 10% off.

Payment

We accept cash, check, Visa, MasterCard, AMEX and Discover. We also accept CareCredit, HSA or FSA. There is a $30.00 returned check fee that will be assessed for any returned checks.

Eyewear/Contact Lenses

We strive to provide you a truly custom product, tailored to your individual prescription. Therefore, frame and lenses are non-refundable. However, in-house credit will be honored within 30 days of being dispensed should you experience any problems that can't be resolved by our optician and/or doctor. Our office requires 50% down payment on all glasses or contact lens orders and the balance is due when they are dispensed.

We are grateful for all our patients and the opportunity to serve them. We appreciate your assistance in helping us complete our work in an efficient and accurate manner.

We reserve the right to terminate a patient from the practice in those rare cases when a patient may be verbally or physically abusive, refuse to give necessary information, or is non-compliant with ocular instructions, treatment, and advice.

☐ I acknowledge that I have had the opportunity to read over the patient care agreement of Oconee Vision Group and understand the financial policy and agree to be bound by the terms. This policy is effective the date it is signed and for future services/purchases.

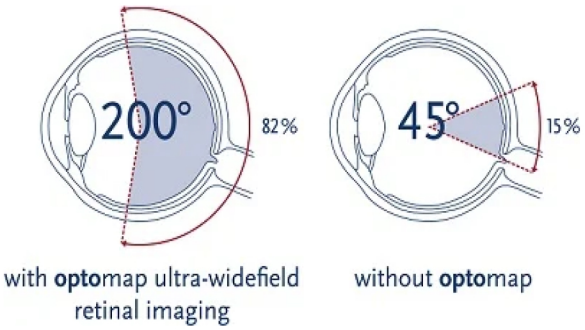
_____ _____ /_____/_____

Patient signature Date

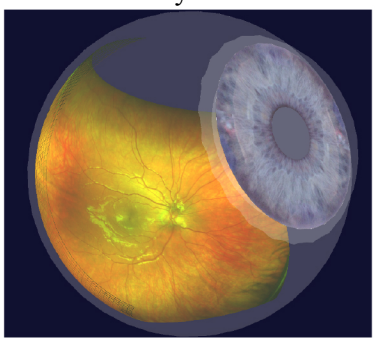
During a comprehensive eye exam, our doctors may utilize the **optomap® ultra-widefield retinal exam** to monitor for complications including macular degeneration, diabetic retinopathy, glaucoma, and retinal holes or detachments. ***These problems can develop without warning and sometimes with no signs or symptoms.***

This state-of-the-art technology allows your doctor to see small details that can assist with detecting systemic problems unrelated to the eye such as diabetes, hypertension, cancer/tumors, auto-immune disorders, and others earlier than with traditional methods.

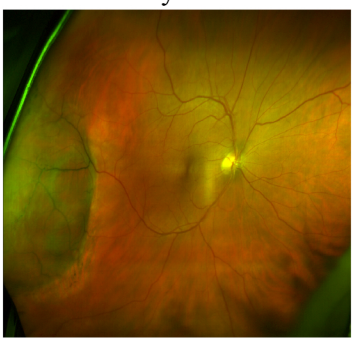
Early detection means successful treatments can be administered and reduces the risk to your sight and health.



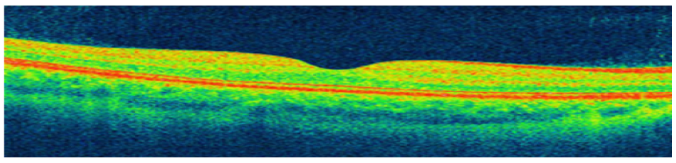
Healthy Retina



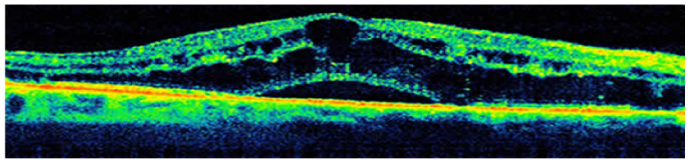
Unhealthy Retina



Normal Retina Scan



Diseased Retina Scan



The optomap® Retinal Exam:

- ✔ Is as fast as taking a picture.
- ✔ **DOES NOT REQUIRE DILATING DROPS. You may not need to be dilated today, potentially eliminating a 30-minute wait and avoiding side effects such as blurry vision and light sensitivity.**
- ✔ Photos are SAVED in your file each time enabling our doctors to make important comparisons during your annual eye exam.

There is a $ 59.00 fee for the optomap® Retinal Exam.

____ I prefer to have the **optomap® Retinal Exam** performed today and understand that this is a "non-covered" elective service with my health and/or vision plan, meaning I am responsible for the charges.

____ I prefer to be **dilated** and have no additional health screenings.

Signature: _____ Date: _____