Epic Vision Eye Centers

888-749-7755

PATIENT INFORMATION:

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____

PATIENT DOB: _____ PATIENT SSN: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

HOME PHONE: _____ EMAIL: _____

CELL PHONE: _____ EMPLOYER/SCHOOL: _____

WORK/OTHER: _____ POSITION: _____

SEX	MARITAL STATUS	JOB STATUS	PREFERRED LANGUAGE	RACE	COMMUNICATION PREFERENCE
___MALE	___ SINGLE	___ FULL TIME	___ ENGLISH	___ CAUCASIAN/WHITE	___ CELL PHONE
___FEMALE	___ MARRIED	___ PART TIME	___ SPANISH	___ HISPANIC/LATINO	___ HOME PHONE
	___ OTHER	___ RETIRED	___ OTHER _____	___ AFRICAN AMERICAN/BLACK	___ TEXT MESSAGE
		___ UNEMPLOYED		___ ASIAN	___ EMAIL
		___ STUDENT		___ MIDDLE EASTERN	___ OTHER_____
		___ OTHER		___ OTHER _____	

PERSON RESPONSIBLE FOR ACCOUNT (INSURED) :

NAME OF INSURED – LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

INSURED DATE OF BIRTH: _____ INSURED SSN: _____

HOME PHONE: _____ EMAIL: _____

CELL PHONE: _____ EMPLOYER/SCHOOL: _____

WORK/OTHER: _____ POSITION: _____

I HEREBY AUTHORIZE EPIC VISION TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS, AND ASSIGN TO PHYSICAN ALL PAYMENTS CONCERNING MEDICAL SERVICES FOR MYSELF AND DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURNACE.

SIGNATURE: _____ DATE: _____

MEDICAL QUESTIONNAIRE:

WHEN/WHERE WAS LAST EYE EXAM? _____ DATE OF LAST MEDICAL EXAM?_____

ARE YOU INTERESTED IN EYEGLASSES TODAY? ___ YES ___ NOT AT THIS TIME LIST OF MEDICATIONS: _____

DO YOU CURRENTLY WEAR CONTACT LENSES? ___ YES ___ NOT AT THIS TIME _____

DO YOU HAVE ANY MEDICATION ALLERGIES? ___ YES ___ NO_____ _____

CONDITIONS: CHECK CONDITIONS YOU HAVE OR HAD IN THE PAST.

___ BLURRED VISION ___ HEADACHES ___ WEARING CONTACTS

___ CATARACTS ___ HYPERTENSION TYPE OF LENSES _____

___ CROSSED EYES ___ LOSS OF VISION HOURS PER DAY_____

___ DIABETES ___ RETINAL DISEASE DAYS WEARING CURRENT CONTACT LENS _____

___ DOUBLE VISION ___ SEEING FLASHES

___ EYE INFECTION ___ SEEING HALOS

___ EYE INJURY ___ SENSITIVITY TO LIGHT

___ EYE SURGERY

___ FLOATERS PREGNANT OR NURSING? ___ YES ___ NO

___ GLAUCOMA SEXUALLY TRANSMITTED DISEASE? ___ YES ___ NO _____

TOBACCO PRODUCTS:

___NEVER SMOKED

___FORMER SMOKER

___CURRENT SMOKER

___YEARS ____PACKS PER DAY

ALCOHOL:

___ SOCIAL USE ONLY

___ 1-2 DRINKS DAILY

___ ABOVE AVERAGE

___ NONE

HEIGHT _____ WEIGHT _____

CHECK IF YOU BLOOD RELATIVES HAD ANY OF THE FOLLOWING:

___ MACULAR DEGENERATION RELATIONSHIP TO YOU_____ ___ DIABETES RELATIONSHIP TO YOU _____

___ CATARACTS RELATIONSHIP TO YOU_____ ___ GLAUCOMA RELATIONSHIP TO YOU _____

Epic Vision Eye Centers

DILATION

We recommend that your pupils be dilated so that we may more thoroughly evaluate the health of the inside of your eyes under the best conditions. Dilating the pupils is necessary for the best evaluation of many eye conditions, such as cataracts, glaucoma, macular degeneration, retinal detachment, and other potentially sight-threatening conditions. It is necessary for the earliest detection of these serious conditions. Without dilation, it is often not possible to detect these conditions. Drops will be placed in your eyes to enlarge your pupils.

When the pupils are enlarged, you will likely find:

- Increase sensitivity to light. Please bring your sunglasses to wear home. We may also provide dilation sunglasses for your comfort.
- Blurred vision, especially close up. You may have difficulty reading or doing desk work.
- Difficulty driving because of increased glare, sensitivity to light, and blurred vision. It is best to have someone drive you.
- The effects of dilation will usually last from 2 to 6 hours.

Please ask us any questions you may have. We provide dilation for the best care of your eyes and your vision. If you experience any problems after dilation, please feel free to call us. We have a doctor on call at all times for our patient's needs.

I agree to have the dilation procedure during this appointment with no increase in cost.

Signature: _____ Date: _____

I have read and do decline the dilation process. I understand that should I require or decide to have this procedure done at a later date, there will be a charge for the service.

Signature: _____ Date: _____

CONCENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

In the course of providing service to you, we create, receive, and store health information the identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purpose of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices changes. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline service if you elect not to sign this consent form.

You have the right to ask us to restrict the uses or disclosures made for purpose of treatment, payment or heath care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us.

I Have Read this Consent and Understand it.

Signature: _____ Date: _____

Imaging Technology

In our continued efforts to bring the most advanced technology available to our patients. Epic Vision Eye Centers is proud to announce the inclusion of Digital Retinal Images (DRI) and Ocular Coherence Tomography (OCT) as an integral part of your eye exam today. Many eye diseases can lead to serious visual problems including loss of vision, missing areas of vision, or blindness. Eye Diseases often develop without warning signs and progress with no symptoms. Previously, dilation of the eyes and hand drawn sketches were the only way to screen for many conditions and to track changes overtime. Fortunately, times have changed and digital imaging with electronic medical records have replaced antiquated written records.

Digital Retinal Imaging (DRI)

Digital retinal imaging is a high-definition photography of the microscopic structures in the back of the eye. A specialized camera allows for a clear picture of the entire back surface of the eye without the need for dilating drops.

Ocular Coherence Tomography (OCT)

Ocular coherence tomography is state of the art technology that represents the latest in eye disease detection and prevention. The OCT image is a 3-D ultrasound of precise locations in the seeing tissue of you eye, called the retina. In particular, high resolution images of the macula and optic nerve have allowed doctors to visualize structures too small for the naked eye. This ability allows for the earliest detection of disease and changes in these very sensitive tissues. Early detection of retinal abnormalities is crucial to protect your vision now and in the future.

Who Do Recommend These Test For? And what are the benefits?

- ✔ For all first time patients, including children, baseline images should be acquired.
- ✔ Every 1-2 years afterwards a follow-up is recommended to monitor change over time
- ✔ For all patients with a history of eye disease in the family (e.g. macular degeneration, glaucoma, ect)
- ✔ You should be tested annually if you have been diagnosed with any of the following:
  - Diabetes
  - High blood pressure
  - Macular degeneration
  - Glaucoma
  - Other retinal diseases
- ✔ No dilation is necessary to perform these tests
- ✔ The doctor immediately analyze and review the test results with you
- ✔ Images are stores for future reference and comparison
- ✔ Peace of mind knowing the health of you eye and your vision are okay

These procedures are not covered by basic vision insurance. The fee for **DRI imaging is $15.00** and for **OCT imaging is $30.00**. Medical insurance typically does **not cover** any advanced screening technology as part of a comprehensive eye examination (however, if a medical condition is diagnosed, then the images can be billed to insurance). Our Doctors know the benefits of these new technologies and would like to make DRI and OCT available to all of our patients. The Doctor will review the images with you, explain any relevant findings, and make further recommendations if necessary.

I have read the above information and choose:

____**Yes**, I chose to have **DRI & OCT** images performed ____**Yes**, I choose to have only **DRI** images performed

____**Yes**, I choose to have only **OCT** images performed ____**No**, I choose to defer the tests at this time.

Patient Signature: _____ Date: _____