Price Optical
FOR THE FINEST IN EYEWEAR

PATIENT INFORMATION

NAME (FIRST, MIDDLE, LAST, SUFFIX) _____ DATE _____

D.O.B _____ SSN (REQUIRED) _____

PHONE #_____ EMAIL_____

ADDRESS _____

_____

CONTACT PERSON (IN CASE OF EMERGENCY) _____Phone #_____

PARENT OR GUARDIAN FULL NAME AND SSN (REQUIRED, IF APPLICABLE) **NAME**_____

SSN _____

EXPLANATION OF EYE EXAM AND CONTACT LENS FITTING FEES

Please be advised that the comprehensive eye exam and contact lens fitting are two separate services with two separate fees. Both fees are non-refundable.

PLEASE CHECK BELOW

_____ YES I would like a contact lens evaluation today in order to update my contact lens prescription which will allow me to purchase contact lenses for the next 12 months. I understand that the fitting fee **MUST** be paid at the time of service.

_____ NO I would not like to have a contact lens evaluation today. I understand that I **WILL NOT** be able to purchase contact lenses without an updated contact lens prescription.

Patient Signature _____ Date _____

INSURANCE AND ATTENDANCE POLICY

Please be advised that **ALL PATIENTS** are required to provide proof of insurance including medical, vision, primary and secondary insurances **AT EVERY VISIT,** regardless if medical/primary insurance covers routine vision services. If this information is not provided, patient will be charged for the full amount due for eye exams, glasses, contact lenses, etc. or will be asked to reschedule their examination. If a patient does not call to cancel an appointment they cannot attend three times, Price Optical will not reschedule that patient. Patient will only be seen on a walk-in basis **IF** there is an opening on the schedule.

I HAVE READ AND UNDERSTAND THIS POLICY

_____ _____

Patient (or Guardian) Signature Date

MEDICAL HISTORY QUESTIONNAIRE

Name _____ Birth Date ___ / ___ / _____

Address _____ Today's Date _____ / _____

Last Eye Doctor _____ Last Eye Exam (Month/Year) _____ / _____

Current Medical Doctor _____ Last Medical Exam (Month/Year) _____ / _____

MEDICAL HISTORY

Do you have any allergies (to medications)? ☐ Yes ☐ No If yes, explain _____

_____

List any medications you take (including oral contraceptives, aspirin, over-the-counter medications and home remedies) _____

_____

_____

Have you had any of the following: ☐ **Reading Difficulty** ☐ **Crossed Eyes** ☐ **Lazy Eye** ☐ **Glaucoma** ☐ **Retinal Disease** ☐ **Cataracts** ☐ **Eye Injury**

Are you pregnant and/or nursing? ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No If yes, how old is your present pair? _____ How many pairs of glasses do you currently use? _____

Do you wear contact lenses? ☐ Yes ☐ No If yes, how old is your present pair? _____ Are they comfortable? ☐ Yes ☐ No

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other _____

Have you had refractive surgery? (Example: cataract surgery, lasik vision correction) ☐ Yes ☐ No

At work: Do you perform fine or close-up work? ☐ Yes ☐ No

Are you outdoors all or part of the time? ☐ Yes ☐ No

Is safety protection a concern at work? ☐ Yes ☐ No

Do you have trouble reading signs when driving at night? ☐ Yes ☐ No

Are you bothered by the glare from: Overhead lighting? ☐ Yes ☐ No

A computer screen? ☐ Yes ☐ No

Oncoming headlights at night? ☐ Yes ☐ No

Are you sensitive to bright sunlight? ☐ Yes ☐ No

What hobbies or recreational sports do you enjoy? _____

FAMILY HISTORY

Have any of your relatives, living or deceased, had any of these diseases or conditions?

OCULAR	Yes	No	Not Sure	Relationship to You
Blindness	☐	☐	☐	
Cataract	☐	☐	☐	
Crossed Eyes	☐	☐	☐	
Glaucoma	☐	☐	☐	
Macular Degeneration	☐	☐	☐	
Retinal Detachment	☐	☐	☐	
Retinal Disease	☐	☐	☐	

SYSTEMATIC	Yes	No	Not Sure	Relationship to You
Arthritis	☐	☐	☐	
Cancer	☐	☐	☐	
Diabetes	☐	☐	☐	
Heart Disease	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Lupus	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Other _____	☐	☐	☐	

Please turn this form over and complete side 2

SOCIAL HISTORY *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

☐ Yes, I would prefer to discuss my Social History information with my doctor (Check box)

Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty while driving? ☐ Yes ☐ No If yes, please describe _____

_____

Do you use tobaccco products? ☐ Yes ☐ No If yes, type/amount/how long _____

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

Do you use recreational drugs? ☐ Yes ☐ No If yes, type/amount/how long _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐ No, I have not

REVIEW OF SYSTEMS Do you currently, or have you ever had any problems in the following areas:

	Yes	No	Not Sure
CONSTITUTIONAL			
Fever, Weight Loss/Gain	☐	☐	☐
SKIN (Integumentary)	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Stye or Chalazion	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
ENDOCRINE			
Thyroid	☐	☐	☐
PSYCHIATRIC DISORDERS	☐	☐	☐

	Yes	No	Not Sure
EAR, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR/CARDIOVASCULAR			
Diabetes	☐	☐	☐
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
Brain Injury / Stroke	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals/Kidney/Bladder	☐	☐	☐
BONES/JOINT/MUSCLES			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC/HEMATOLOGIC			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐

DO NOT WRITE BELOW THIS LINE

_____

_____

_____

_____

_____

I have reviewed this history with the patient: _____ *(Doctor's Signature & Date)*

Price Optical Co.
567 E. Third Street
Williamsport PA 17701

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you: We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable 1Du Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on or before **April 14. 2003**. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number. 570-323-8000

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Signature: _____ **Date:** _____

Price Optical
FOR THE FINEST IN EYEWEAR

Optomap® Retinal Scan

What is the **Optomap®** Retinal Scan, and why is it necessary and superior to other examination methods?

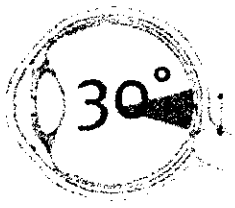
This retinal scan is state-of-the art scanning laser technology that allows your doctor to examine a digital image of your retina (similar to a photograph). Signs of sight- and life-threatening diseases such as macular degeneration, glaucoma, retinal detachments, cancerous tumors, diabetes and high blood pressure are but a few of the conditions that can be detected with this technology. When complemented with (and sometimes without) pupil dilation, our retinal scan improves your doctor's ability to assess the health of your eyes –something that is important even if you are healthy.

Parents: the retinal scan is especially useful for children, who can sometimes be difficult to thoroughly examine. The retinal scan is quick, painless, and will be saved as a permanent part of your patient record.

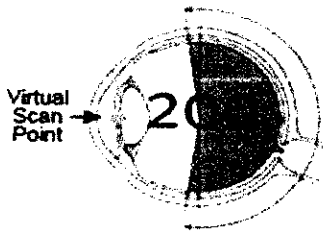
Because of the advanced disease detection:

Our doctors recommend that you obtain a retinal scan every year. The retinal scan may be covered by your insurance, based on factors such as family history, ocular health history and patient's medical history.

If not covered by insurance, The **Optomap®** retinal scan is provided for a fee of **$ 40.00**



Conventional non-dilated exam



Optomap® Retinal Scan

The **Optomap®** retinal scan produces a single 200° ultra-wide field image of the retina, allowing our doctor to see more of your retina at once than ever before.

☐ **Yes,** I would like a retinal scan performed today.

☐ **Unsure,** please tell me more.

☐ **No –** I would not like a retinal scan done at this time. I understand that having a retinal scan greatly enhances my doctor's ability to comprehensively examine my eyes and that early detection of potentially threatening disease is an important part of my thorough eye health evaluation.

Signature: _____ Date ___/___/_____

MEDICAL INSURANCE BILLING POLICY

Please be advised that Price Optical/Price Optometric Group is a medical facility. When a patient is seen for an eye exam, there may be a medical diagnosis made during their exam. It is required by your insurance company that we submit diagnosis codes documented by this provider. Pricing for a medical exam/procedure will differ from the pricing of a routine vision exam. If there is a coinsurance, copay, or if the cost of the exam is applied to the patient's deductible, we are required by the insurance companies to charge the patient the allowed amount that is determined by the insurance.

To learn what your insurance will cover, the amount of your deductible, or any copays/coinsurances you may incur, please contact your medical insurance provider.

I have read and understood the Medical Insurance Billing Policy.

Patient/Guardian Signature _____ Print Patient Name _____ Date _____