BISSELL Eye Care

Date:_____ Social Security # _____

Name:_____ Date of Birth:_____ Age: _____

Address:_____ City:_____ State:_____ Zip: _____

Home#:_____ Cell#:_____Work#:_____

E-mail:_____ Status: Married Single Divorced Widowed

Work Place/School:_____ Occupation/Grade: _____

Emergency Contact (Name/Phone): _____

Primary Language:_____ Race:_____ Ethnicity:_____ Gender: _____

How did you hear about our office? _____

Primary Care Doctor:_____ Last exam:_____ Pharmacy:_____

Last Eye Exam:_____ Last Eye Doctor: _____

Do you wear glasses?_____ How often do you wear sunglasses? _____

How old are your glasses?_____ Do you wear Contacts? (Brand/Power) _____

How many hours/day do you use the computer? _____ Do you get strain from computer work? _____

Social History: Tobacco: Type/Frequency? _____ Alcohol: Frequency? _____

Ocular History – please check all that apply

- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Diabetic Retinopathy
- ☐ Dry Eye
- ☐ Eye infection, Inflammation, Allergy
- ☐ Floaters/Flashes of light
- ☐ Iritis or Uveitis
- ☐ Retinal Defects or Degenerations
- ☐ Other: _____
- ☐ None

Vision and Eye Concerns

- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Tearing
- ☐ Discharge
- ☐ Blurred Vision
- ☐ Eye Strain
- ☐ Eye Pain
- ☐ Severe Light Sensitivity
- ☐ Headache
- ☐ Poor Night Vision
- ☐ Night Glare
- ☐ Double Vision
- ☐ Total Loss of Vision
- ☐ Other: _____
- ☐ None

Immediate Family History – Please list Father, Mother, Brother, Sister or Children

- ☐ Blindness _____
- ☐ Lazy Eye _____
- ☐ Glaucoma _____
- ☐ Macular Degeneration _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ High Blood Pressure _____
- ☐ Heart Disease _____
- ☐ Thyroid _____
- ☐ Other_____

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Medical History

Please list all prescription and over the counter medications that you currently are taking:

_____

_____

_____

Allergies to medications? _____

Please list any major injuries/surgeries:

Constitution

- ☐ Weight gain/loss
- ☐ Fatigue
- ☐ Cancer
- ☐ Other:_____

Ears, Nose, Throat, Mouth

- ☐ Seasonal Allergies
- ☐ Dry Mouth
- ☐ Hearing Loss
- ☐ Other:_____

Neurologic

- ☐ Migraine
- ☐ Stroke
- ☐ Autism spectrum
- ☐ Seizures
- ☐ Other:_____

Psychiatric

- ☐ Depression
- ☐ Anxiety
- ☐ Other:_____

Cardiovascular

- ☐ High blood pressure
- ☐ Heart Disease
- ☐ Other:_____

Respiratory

- ☐ Asthma
- ☐ COPD
- ☐ Sleep apnea
- ☐ Other:_____

Gastrointestinal

- ☐ Crohn's disease
- ☐ Celiac disease
- ☐ Other:_____

Genitourinary

- ☐ Kidney disease
- ☐ Pregnant/Nursing
- ☐ Other:_____

Muscular/Skeletal

- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Other:_____

Skin

- ☐ Rosacea
- ☐ Other:_____

Endocrine

- ☐ Diabetes
- ☐ Thyroid
- ☐ Other:_____

Hematologic/Lymphatic

- ☐ High cholesterol
- ☐ Anemia
- ☐ Other:_____

Allergy/Immunologic

- ☐ Lupus
- ☐ Rheumatoid arthritis
- ☐ Sjogrens syndrome
- ☐ Other:_____

BISSELL Eye Care

To be seen in a timely manner, please find out which vision insurance company you carry. Come to the office early to insure we have all necessary information, along with your insurance cards.

Vision Insurance: _____ ID#_____
(VSP, VBA, Davis, EyeMed, etc.) (Some vision plans have no card)

Policy Holder's Name: _____ DOB:_____

Policy Holder's Phone #: _____ SS#:_____

Policy Holder's Address:_____ _____
(With some insurance, we need the SS# to get the authorization)

Medical Insurance: _____ID#_____
(Highmark, UPMC, CIGNA, United HealthCare, Medicare, etc.)

Policy Holder's Name: _____ DOB:_____

Policy Holder's Phone #: _____ SS#:_____

Policy Holder's Address:_____

Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents to any third payer and/or other health care practitioner involved in my care.

I authorize and request my insurance company to pay Bissell Eye Care, LLC directly for services rendered.

I understand my insurance plan may pay less than the actual bill for services; therefore, I agree to be responsible for any payment beyond what my insurance company determines to be the maximum benefit provided. If for whatever reason my insurance company denies payment to Bissell Eye Care, LLC, I understand that I am responsible for the balance.

_____ _____

Patient/Guardian Signature Date

BISSELL Eye Care

OCULAR HEALTH SCREENING TOOL

A new, highly sophisticated computerized instrument now allows us to take high quality digital images of the retina and other structures inside your eye. This procedure assists the doctor in early detection of many disorders, including glaucoma, diabetic retinopathy, macular degeneration, retinal detachments and many other vision threatening conditions. The images are stored in our computer and can be compared with images in the future, allowing us to observe even the smallest amount of change. The images can also be printed and shared with your family physician or specialist if necessary.

We strongly recommend that *all* patients have this procedure performed and it is especially important for people who have:

1. Headaches
2. See spots or flashes
3. Family history of diabetes
4. Family history of glaucoma
5. High blood pressure
6. High cholesterol
7. Reached the age of 40
8. Sudden vision change
9. Your vision is not correctable to 20/20
10. Never had the procedure previously
11. Have had retinal disorders such as a detachment, tear or floaters
12. Would like a “baseline” image for future comparison

Screening retinal photography is a **NECESSARY** part of your eye exam if you fall into **ANY** of the above categories. There is an additional charge of $35.00 for this screening procedure and it is **NOT COVERED** by insurance if the screening does not detect any unusual condition. If pathology or a risky condition is documented with these photos, or more are needed, this "photographic study" can be billed to your health insurance as part of your treatment plan, **deductibles may apply**.

Please check the appropriate line below and sign at the bottom.

_____ **I ACCEPT** having the procedure done

_____ **I DECLINE** having the procedure done

_____ _____

Patient/Guardian Signature Date

_____

Print Name

BISSELL Eye Care

HIPAA AUTHORIZATION FORM

I, _____, give permission to Bissell Eye Care to discuss or release health information identifying me to my insurance company/companies, to any referring or consulting physicians or entities, and to the following.

List of authorized people and entities (suggestions: parents, spouse, caretakers):

_____

_____

_____

Description of information to be produced: medical and financial (amount billed, payments, etc).

This authorization is being made voluntary and at my request.

I understand that:

If the above listed person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations (e.g. If you release your information to your spouse we have no control of what your spouse may do with the information).

I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

I may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, my right to access is suspended until the clinical trial is completed.

Bissell Eye Care has a comprehensive Notice of Privacy Practices available that describes these uses and disclosures in detail. I am free to refer to this Notice at any time.

Finally, I may revoke this authorization in writing at any time by notifying the office. My notice will not apply to actions taken prior to the date they receive my written request to revoke authorization.

I have read and understand the above information.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name Relationship/Authority

If you would like this authorization to expire note here (date/event):_____

Bissell Eye Care Contact Lens Evaluation & Fitting Agreement

Understanding the contact lens exam

A contact lens evaluation is an additional procedure to a comprehensive eye exam. It is required annually to ensure your eyes remain healthy, the lenses fit correctly and your prescription is accurate.

- **Comprehensive Eye Exam**: Assesses eye health and updates glasses prescriptions.
- **Contact Lens Evaluation**: Assesses how lenses fit, cornea health and updates contact lens prescriptions.

Financial Policy

- **Not Always Covered:** Most vision insurance plans do not cover the full cost of contact lens evaluations, treating them as an “elective” service.
- **Payment Due at Time of Service:** The fee is due in full at the time of the exam.
- **Non-Refundable:** Professional fitting fees are non-refundable.
- **Validity:** Prescriptions are valid for one year from the date of the evaluation.

Fee Structure

- **Established Wearer:**
  - **Simple** $65.00, **Toric** $85.00, **Multifocal/Gas Perm** $110
- **New Wearer/Fitting/Training:**
  - **Simple** $80.00**, Toric** $100, **Multifocal** $140.00, **Gas Perm** $180.00

Patient Acknowledgement

Please Check One:

[ ] **YES**, I would like a contact lens evaluation today. I understand this is an additional fee, potentially not covered by my insurance, and is due today.

[ ] **NO**, I do not want a contact lens evaluation today. I understand I will not receive a contact lens prescription; therefore, I will be unable to order contact lenses.

Patient Name: _____

Signature:

_____

Date:

_____