CONSENTS & INFORMATION

HEALTH CARE SERVICES:

• I authorize consent for medical treatment at C-Luminous Eye Care, INC. (CLE)

• (HIPAA) Health Insurance Portability and Privacy Act of 1996 requires that CLE (this practice) provide you a copy of, or access to, our notice of privacy practices. I acknowledge that I have been presented the opportunity to read the notice of privacy practices and that I do not wish to have any exceptions.

If you have any medical conditions or findings relating to your vision such as headaches, floaters, dry eye, cataracts, diabetes, etc., your major medical insurance will be billed for the exam and you will be responsible for copay at the time of service. If we do not participate with your medical carrier, you will be responsible for the medical exam fee at the time of service.

FOR MINORS ONLY:

_____ I give permission for my child to have any diagnostic drops or contact lens service which may be required for an eye exam or contact lens fitting.

FINANCIAL RESPONSIBILITY / INSURANCE COVERAGE:

• **Valid** insurance must be presented at the time of visit to be applied to the current visit only. It is your responsibility to know your insurance information in order for (CLE) to file a claim on your behalf. **If no insurance is presented or found at the time of visit (CLE) is not responsible for filing claims at a later time. You will be responsible for all fees associated with the visit.**

• Payment is required at the time of service. If services are billed to an insurance carrier, I authorize that payment of any insurance benefits either to me or on my behalf be made to (CLE) for any services furnished to me or my dependents. **I understand that if my insurance company does not provide payment to (CLE), I will be billed for the non-covered services and that I am responsible for payment when I receive the bill**. If payment is not made within 30 days from the date the bill was mailed from (CLE), I understand that a **5%** charge will be added to my bill after each 30 days.

• You may be contacted by the CLE or a collections agency by any telephone number associated with your account, including wireless telephone numbers[charges may apply], to discuss and collect owed balances. Methods of contact may include using pre-recorded or artificial voice messages and/or use of an automatic dialing device, as applicable.

• There will be a **20% restocking fee** upon the cancellation or return of any contact lens materials.

MEDICARE/MEDICAID MEMBERS: I understand that the doctors at CLE are **NOT** Medicare/Medicaid Providers and that CLE/nor I will be able to submit a claim for today's eye exam.

NOTICE: The optometrist **recommends** the examination to include dilation **AND** Optomap (Retinal Photo). Without dilation, it is not a **COMPLETE** comprehensive exam. Dilation is **included** in the standard comprehensive exam. IF **unable** to dilate, then the Optomap is recommended.

DILATION: Every **comprehensive exam INCLUDES** dilating drops to dilate or enlarge the pupils of the eye to **allow the optometrist a better view of the inside of your eyes**. They frequently blur vision for a length of time which varies **4-6 hours** and may also make bright lights bothersome. Thus, it is best to have a designated driver. Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This reaction is extremely rare and is treatable with immediate medical attention.

_____ I **understand** the side effects and benefits of dilation and hereby authorize administering the dilating eye drops.

_____ I **understand** that I am opting **against** what is recommended for my comprehensive ocular health by the optometrist.

IF you wish to opt out, Please list medical reason(s):_____

OPTOMAP (Retinal Photo): Acquires a digital image of the inside of the eye to allow the optometrist to look for diseases and track changes over time. **Retinal imaging does not require dilating drops** nor have the other ocular side effects of dilation. **Not recommended** for those with seizures or epilepsy due to intense, flashing lights.

_____ I **will** have an OPTOMAP (retinal photo) taken today for a payment of $34.00, which will not be covered by insurance.

_____ I **understand** that I am opting **against** the Optomap and what is recommended for my ocular health by the optometrist.

If you elected **NOT to have your eyes dilated **OR** have the OPTOMAP taken today, then we **recommend** that you make an appointment with an ophthalmologist at UVA or with Dr Schauer or Dr Collins at Blue Ridge Ophthalmology.

If you do not dilate or have a retinal photo taken today, then it is **REQUIRED to dilate or have a retinal photo taken at your **NEXT** comprehensive examination.

I acknowledge that I have read this form and understand its content. I am the patient or the person duly authorized either by the patient or otherwise, sign this agreement, consent to, and accept its terms. I am responsible for the payment and/or co-payment that is due at the time of service, and I have been given the option for a copy of the CLE HIPAA Policy.

Patient's Signature (or person authorized to sign for patient): **Date:**

_____ _____

NAME:	BIRTH DATE:	GENDER:	AGE:	SOCIAL SECURITY #
ADDRESS:	CITY:	STATE:	ZIP:	EMAIL:
EMERGENCY CONTACT: NAME/PHONE#	PATIENT PHONE NUMBER:			PATIENT OCCUPATION:

What is the main reason for your visit?

GUARDIAN OF PATIENT (If under 18)

Name:(Last)_____(First)_____(MI)__

DOB_____/_____/_____

Address:_____

City:_____ State:_____ Zip: _____

Relationship to Policy Holder: ____Child ____Spouse ____Parent

INSURANCE INFORMATION

Policy Holder's Name_____

Policy Holder's DOB _____/_____/_____

Policy Holder's ID #: _____

Insurance:_____

Policy Holder's Employer_____

Do you wear glasses? □Y □N
If yes, do you wear them for:
DISTANCE | NEAR | BOTH
Do you wear contact lenses? □Y □N
Date of your last eye exam? _____

Date of your last medical exam? _____
Allergies to medications? □Y □N

_____

Do you suffer from seasonal allergies? □Y □N
Are you taking any medications? □Y □N
Are you Pregnant? □Y □N
Are you nursing? □Y □N
Do you smoke? □Y □N
Former smoker? □Y □N
Do you drink alcohol? □Y □N
Do you have frequent headaches? □Y □N
Any flashes of light in your eyes? □Y □N
Any floating objects in your eyes? □Y □N
Any blackouts of your vision? □Y □N

CURRENT MEDICATIONS:

_____

_____

_____

EYE MEDICATIONS:

_____

Please select if you have any of the following conditions:

❑ **NONE**
❑ Cancer
❑ Diabetes
❑ Cholesterol
❑ Hypertension
❑ Heart Disease
❑ HIV/AIDS
❑ Rheumatoid Arthritis
❑ Thyroid
❑ STI
❑ Other_____

Please select if you have any of the following eye conditions:

❑ **NONE**
❑ Amblyopia (lazy eye)
❑ Cataracts
❑ Cataract Surgery
❑ Diabetic Retinopathy
❑ Dry Eyes
❑ Glaucoma
❑ Eye injury_____
❑ Lasik/PRK
❑ Macular Degeneration
❑ Retinal Detachment
❑ Retinal Disease
❑ Strabismus (eye turn)
❑ Strabismus surgery
❑ Other _____

Please select family members who suffer from the following conditions:

(M=Mother, F=Father, GM=Grandmother, GF=Grandfather, SIB=Sibling)

	M	F	GM	GF	SIB
❑ **NONE**					
❑ Cancer					
❑ Diabetes					
❑ Cholesterol					
❑ Heart Disease					
❑ Hypertension					
❑ Thyroid					

❑ Other _____

Please select family members who suffer from the following eye conditions:

	M	F	GM	GF	SIB
❑ **NONE**					
❑ Blindness					
❑ Glaucoma					
❑ Mac Degen.					
❑ Amblyopia					
❑ Strabismus					
❑ Eye Cancer					

❑ Other _____