THIRD AVENUE EYECARE

Name: _____ Sex: Male / Female

Social Security #:_____ Birth Date:_____ Age: _____

Phone Home:_____ Work: _____ Cell:_____

Mailing Address:_____ City/State/Zip: _____

Email Address:_____

Would you like to receive text message notifications? Y / N

Race: (circle) American Indian Asian Black/African American Caucasian Hispanic Pacific Islander Other Decline

Occupation:_____Employer:_____

How were you referred to our office:_____

Primary Care Physician:_____ Phone:_____ Last Visit:_____

Previous Eye Dr.:_____ Phone:_____ Last Visit:_____

Do you wear **glasses: YES / NO** how long _____ ***and*** full-time / part-time ***for*** near / far / both

Do you wear **contact lenses**: **YES / NO** how long _____ soft / gas perm / specialty _____

Do you want a Contact Lens Exam today for a new Contact Lens Prescription? **YES / NO**

PATIENT **EYE** HEALTH HISTORY

	YES	NO
Amblyopia (lazy eye)	☐	☐
Strabismus (eye turn)	☐	☐
Macular Degeneration	☐	☐
Keratoconus	☐	☐
Blindness	☐	☐
Cataracts	☐	☐
Cataracts Removed?	☐	☐
Glaucoma	☐	☐
Retinal Detachment	☐	☐
Retinal Hole or Tear	☐	☐
Dry Eye Syndrome	☐	☐
Floaters	☐	☐
OTHER?	☐	☐

Please List _____

FAMILY **HEALTH** and **EYE** HEALTH HISTORY

	YES	NO	**RELATIONSHIP**
Glaucoma	☐	☐	_____
Amblyopia (lazy eye)	☐	☐	_____
Blindness	☐	☐	_____
Keratoconus	☐	☐	_____
Cataracts	☐	☐	_____
Macular Degeneration	☐	☐	_____
Other Retinal Disorder	☐	☐	_____
Strabismus (eye turn)	☐	☐	_____
Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Thyroid Disorder	☐	☐	_____
High Cholesterol	☐	☐	_____
Hypertension	☐	☐	_____

Do you have any **CURRENT EYE** issues:

Blurred vision	☐	☐	Halos	☐	☐
Dryness	☐	☐	Sandy/Gritty feeling	☐	☐
Burning	☐	☐	Glare	☐	☐
Itching	☐	☐	Eye Pain	☐	☐
Floaters	☐	☐	Eye Fatigue	☐	☐
Flashes of light	☐	☐	Double vision	☐	☐

Other Symptoms not listed? _____

Have you had any **EYE** surgeries? **YES / NO** (If ***yes***, what, which eye, when): _____

Have you had any other surgeries? **YES / NO** (If ***yes*** what and when): _____

REVIEW OF SYSTEMS

Do **you** currently, or have you ever had any problems in the following area:

SYSTEM	YES	NO
CONSTITUTIONAL		
Developmental Disability	☐	☐
Cancer	☐	☐
Type_____		
How treated: _____		
When:_____Where:_____		
EARS, NOSE, THROAT, MOUTH		
Hearing Loss	☐	☐
Sinusitis	☐	☐
Dry throat/mouth	☐	☐
NEUROLOGICAL		
MS	☐	☐
Epilepsy	☐	☐
Cerebral Palsy	☐	☐
Tumor	☐	☐
Migraines	☐	☐
Autism Spectrum Disorder	☐	☐
Head Trauma	☐	☐
If yes what and when: _____		
PSYCHIATRIC		
Depression	☐	☐
Attention Deficit	☐	☐
Anxiety Disorder	☐	☐
Bi-Polar Disorder	☐	☐
Dementia	☐	☐
CARDIOVASCULAR		
Hypertension	☐	☐
Heart Disease	☐	☐
Vascular Disease	☐	☐
Congestive Heart Failure	☐	☐
Stroke	☐	☐
If yes when:_____		
RESPIRATORY		
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
COPD	☐	☐
Sleep Apnea	☐	☐
GASTROINTESTINAL		
Crohn's Disease	☐	☐
Colitis	☐	☐
Ulcer	☐	☐
Hepatitis (**circle**) A B C	☐	☐
IBD	☐	☐
GENITOURINARY		
Kidney Disease	☐	☐
Prostate Disease	☐	☐
Herpes	☐	☐
Chlamydia	☐	☐

SYSTEM	YES	NO
MUSCULOSKELETAL		
Arthritis	☐	☐
Osteoarthritis	☐	☐
Fibromyalgia	☐	☐
Muscular Dystrophy	☐	☐
Ankylosing Spondylitis	☐	☐
Osteoporosis	☐	☐
INTEGUMENTARY		
Eczema	☐	☐
Rosacea	☐	☐
Psoriasis	☐	☐
Herpes Simplex/Cold Sores	☐	☐
Herpes Zoster/Shingles	☐	☐
ENDOCRINE		
Diabetes Type 1	☐	☐
Diabetes Type 2	☐	☐
Thyroid Dysfunction	☐	☐
Hormonal Dysfunction	☐	☐
LYMPHATIC/HEMATOLOGIC		
Anemia	☐	☐
Large Volume Blood Loss	☐	☐
Hypercholesterolemia	☐	☐
ALLERGIC/IMMUNOLOGIC		
HIV or AIDS (**if yes**, circle)	☐	☐
Drug Allergies	☐	☐
Seasonal Allergies	☐	☐
Rheumatoid Arthritis	☐	☐
Lupus	☐	☐
Sjogren's Syndrome	☐	☐

Other condition not listed? _____

_____

_____

ARE YOU CURRENTLY **PREGNANT**? Y / N

ARE YOU CURRENTLY **NURSING**? Y / N

Do you take any **medications** or **supplements**? **YES / NO** (if ***yes*** please list):

_____

_____

Do you have any known **allergies? YES / NO** (if ***yes*** please list, including medications, food, and environmental):

_____

_____

SOCIAL HISTORY

This information is kept strictly confidential, however you may discuss this portion directly with your doctor if you prefer.

CIRCLE THE FOLLOWING that apply to you:

1. **SMOKING**: CURRENT everyday/someday / FORMER SMOKER year quit: _____ / NEVER SMOKER
2. **DRINKING**: NON / TRIVIAL (less than 1 a day) / LIGHT (1-2 a day) / MODERATE (3-6 a day) / HEAVY (6+ a day)

FINANCIAL POLICY/INSURANCE AGREEMENT

VISION INSURANCE _____ **MEMBER NUMBER** _____
MEDICAL INSURANCE _____ **MEMBER NUMBER** _____

Financial Policy

We are committed to providing you with quality and affordable health care. As a courtesy, Third Avenue Eyecare verifies your benefits with your insurance company. A quote of benefits is not a guarantee of those benefits or payment. If we are a participating provider with your insurance plan, all payments are due at the time of service including but not limited to copays, overage or any other balance not paid by your insurance. **PLEASE NOTE:** retinal imaging is a part of Third Avenue Eyecare's standard of care. It helps your Optometrist find certain diseases and checks the health of your eyes. **Since most insurance plans do not contribute to the cost of retinal imaging, your cost will never exceed $46.** Payment for any materials such as glasses or contacts is due upon receipt of those materials. A deposit is required on glasses upon ordering. Should you write a check from an account with non-sufficient funds, it will be subject to a $60 returned check fee, applied per occurrence.

PLEASE HELP US HELP YOU! It is impossible for us to know every insurance company plan and contract. Therefore, each patient is responsible for understanding their own insurance policy. The insurance contract is between you and the insurance company NOT the physician and the insurance company. Our fees are not contingent on insurance allowances or slow payment and the patient is ultimately responsible to assure fee payment personally or by the insurance company. It is necessary that you provide us with your most current insurance card so we may keep a copy of it on file. Without an insurance card we may be unable to file a claim. We will not re-file a claim if the information given to us was incorrect. When purchasing materials such as glasses or contact lenses we must have the correct insurance information when an order is being placed. If you are picking up materials and the proper insurance information was not given to us at the time of the order it is your responsibility to file the claim privately.
PLEASE BE SURE WE HAVE YOUR MOST CURRENT INFORMATION ON FILE.

The following is a list of insurances we accept for ROUTINE AND/OR MEDICAL: MEDICARE, CIGNA (most plans), ANTHEM BLUE CROSS BLUE SHIELD, UNITED HEALTH CARE, GREAT-WEST, HUMANA, VSP, AARP MEDICARE COMPLETE, MEDICARE ADVANTAGE, UMR
Medical insurance **DO NOT accept**: CIGNA CONNECT, CIGNA LOCAL PLUS, BCBS CU EXCLUSIVE, FRIDAY HEALTH, MEDICAID, SELECT HEALTH
***The above list is not exhaustive, please call the office if you have questions regarding medical insurance coverage**

By signing below, **I HAVE READ THE ABOVE INFORMATION AND AGREE TO THE CONDITIONS AS OUTLINED IN REGARD TO PAYMENT OR FEES FOR SERVICES RENDERED BY THIRD AVENUE EYECARE**. In the event that I default, I agree to pay, whether or not legal proceedings are instituted, all collection costs, including but not limited to collections agency fees, court costs, and attorney fees.

PATIENT OR GUARDIAN SIGNATURE: _____ **DATE:**_____

Optomap Retinal Imaging

Your doctor believes that Optomap Retinal Imaging is essential in detecting eye diseases including glaucoma, macular degeneration, retinal detachment, and diabetic retinopathy. Retinal imaging also allows your provider to assess risk for conditions such as hypertension, diabetes, cancer, and stroke.

The added benefit of the doctor being able to view last year's image and this year's image side-by-side for comparison is an invaluable tool in providing comprehensive eye care. Without the Optomap and/or dilated examination, the doctor will only be able to see approximately 30% of the internal part of the eye

PLEASE NOTE: THERE IS AN ADDITIONAL CHARGE OF **UP TO $46.00** DEPENDANT ON INSURANCE THAT WILL NEED TO BE COLLECTED ON DATE OF SERVICE. THE OPTOMAP RETINAL IMAGE IS NOT COVERED BY VSP

☐ I want the Optomap Retinal Imaging and agree to pay the $46.00 fee

☐ I decline the Optomap Retinal Imaging (Dilation encouraged for full ocular health assessment)

HIPAA Notice of Privacy Practices
Third Avenue Eyecare
800 3rd Ave Longmont, CO 80501

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

1. 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 our office that are involved in your care and treatment for the purposes of providing health care services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law. 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.

2. Your Rights (The 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. 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 purpose of treatment, payment or healthcare 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 a 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 health care professional.

You have the right to request or 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. You may have the right to have your physician amend your protected health information.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

3. 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.
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 to our HIPAA Compliance Officer in person or by phone.

I have received and/or read notice of this office's HIPAA Notice of Privacy Practices

PATIENT OR GUARDIAN SIGNATURE: _____ **DATE:**_____

EMERGENCY CONTACT

Please list a person to contact **in the case of an emergency**

Name _____ Relationship_____ Phone number_____

AUTHORIZED INDIVIDUALS

I authorize the disclosure of my personal health information to the **persons listed below**:

Name: _____ **Relationship:**_____

Phone:_____

Name: _____ **Relationship:**_____

Phone:_____

I understand that I have the right to revoke this consent at any time by sending a written statement to Third Avenue Eyecare, except to the extent Third Avenue Eyecare has already made a disclosure in reliance upon my prior consent.

PRINT NAME _____

SIGNATURE _____

DATE _____