FRAMED EYECARE

BRUCE LUONG, OD – JESSICA LUONG, OD

1016 E HEBRON PKWY SUITE 150 – CARROLLTON TX 75010 – PHONE 469.480.6150

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____D.O.B:_____

Address:_____City:_____State: _____Zip:_____

Phone Number: _____ Last 4 Digits of Social Security #: _____

Email:_____Occupation:_____

List the names of people (e.g. spouse, parents, etc) you authorize us to release your health information to:

1._____ 2._____

SECTION B: TO THE PATIENT/GUARDIAN – PLEASE READ AND THE FOLLOWING STATEMENTS CAREFULLY

The purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to read our Practice Privacy Policy before you sign this consent. Our Practice Privacy Policy explains the use and disclosure we may make of your protected health information for treatment, payment activities, health care operations, along with other important matters concerning your health information. We advise you carefully and completely read before signing this Consent.

We reserve the right to change our privacy policies as described in the Practice Privacy Policy, but we will make those updates available for review. The changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this consent at any time. You are required to give us written notice of your revocation. Revocation of this consent will not affect any action FRAMED EYECARE PLLC had taken in reliance of this consent before we received your revocation. From that point, we hold the option to decline your treatment if you revoke this consent.

SIGNATURE AND DISCLOSURE

I HAVE READ AND UNDERSTOOD THE AFOREMENTIONED CONSENT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

All payments are due at the time services are rendered. You are responsible for all outstanding balances. By signing, you consent to paying all outstanding balances.

_____ _____

Signature Date

If this consent is signed by the patient's representative on behalf of the patient, please complete the following:

_____ _____

Representative's Name Relationship to Patient

INSURANCE INFORMATION

Medical Insurance: _____Subscriber ID:_____

Vision Insurance: _____SSN# (primary):_____

Primary Insurance Holder (name & date of birth): _____

How did you hear about us? _____ Whom may we thank for referring you to us? _____

REASON FOR TODAY'S VISIT

(Circle all that apply)

Annual Exam Glasses Contact Lens Other (explain): _____

I currently use or have used (circle one):	eyeglasses	contact lenses	both	none
I have noticed a blur in vision at (circle one):	near/reading	far/distance	both	none
I currently experience (circle all that apply):	itching	redness	dryness	pain
	sensitivity to light	tearing/discharge	eye strain	headaches

MEDICAL & VISION HEALTH HISTORY

Ocular Hx	Self	Family	None	Medical Hx	Self	Family	None
Eye injury/surgery	□	□	□	Diabetes	□	□	□
Lazy/Cross Eyes	□	□	□	Hypertension	□	□	□
Glaucoma	□	□	□	Heart Disease	□	□	□
Macular Degeneration	□	□	□	Thyroid Disease	□	□	□
Retinal Detachment	□	□	□	Cancer	□	□	□
Retinal Disease	□	□	□	Other	□	□	□

List of Medication: _____

Allergies to Medication: _____

REVIEW OF SYSTEMS

Please **Circle** if you have any of the following conditions:

Cardiovascular	Psychiatric	Ear, Nose, Throat	Respiratory	Neurological
Stroke	Depression	Sinus Infection	Asthma	Headaches
Heart Attack	Bi-Polar	Deaf (partial or full)	Emphysema	Migraines
Congestive Heart Failure	Anxiety		COPD	Multiple Sclerosis
Pacemaker	ADHD			
Irregular Heart Beat				

Integumentary	Gastrointestinal	Musculoskeletal	Genitourinary	Hematologic
Dermatitis	Hepatitis	Arthritis	Kidney Disorder	Anemia
			Bladder	Prostate

If you have a condition not listed, please explain:

_____
_____
_____

CONTACT LENS INFORMED CONSENT & COMPLIANCE AGREEMENT

If I already wear contacts, why do I have to be re-fit every year?

In February 2004, government passed a law called the "Fairness to Contact Lens Consumers Act" which states that all prescriptions for contact lenses need to be re-evaluated to ensure proper fit of the lens and health of the cornea, the front clear part of the eye. The fitting is a separate and distinct exam from a comprehensive exam, though both may be conducted at the same visit at the discretion of the optometrist. ***There is a separate fee for this exam which will be collected at the time of your visit.***

Risks of Contact Lens Wear

The use of contact lenses is not without risk. A small, but significant, percentage of individuals wearing contact lenses develop potentially serious complications which can lead to permanent eye damage and vision loss. Specifically, extended wear contact lenses pose the risk of complication 5 to 15 times greater than that of daily wear. Presbyopic contact lens corrections (monovision or bifocal contact lenses) can create vision compromises that may reduce visual acuity and depth perception for distance and near tasks. For extended wear patients, extra care is necessary to help prevent eye-health complications and for presbyopic patients, supplemental or alternative vision correction during hazardous activities is advised.

Contact Lens Disinfection, Wearing and Replacement Schedule, and Follow-up:

The solutions prescribed are specific for your eyes and lenses. Since solution contents vary significantly from one manufacturer to another and cross-reactions are possible between different brands, do not change or substitute solutions unless you check with your doctor first. Use of improper products may result in lens damage or eye irritation. Abuse and improper contact lens wear and replacement may put your eyes at risk of infection, irritation, decrease in vision, restricted contact lens wear, etc.

You are responsible after the initial eye exam to follow-up and finalize the contact lens prescription within the allotted follow-up period. *Any visit beyond the follow-up period will result in an additional $35 reassessment fee.* The follow-up period will vary on the type of fitting performed. For more information on follow-up periods, please ask a member of the office for further details.

Compliance Agreement

Your doctor at FRAMED EYECARE PLLC reserves the right to terminate the agreement upon non-compliance of prescribed wearing times or follow-up visits.

A printed copy of your contact lens prescription will be provided to you upon completion of the contact lens medical management services. Any extra copies of the contact lens prescription will be an additional charge.

By signing below, I acknowledge that I have read, understand, and have received a copy of this agreement. I am aware of the potential risks, side effects and adverse reactions due to contact lens wear. I agree to wear my contacts no longer than prescribed by the doctor, agree to properly care for my contact lenses as instructed and agree to return for recommended follow-up visits.

_____ _____

Patient's Signature (guardian, if a minor) Date

For Office Use Only

I, the patient listed above or their guardian, confirm with my signature that upon completion of the Contact Lens Fitting and any follow ups required, I received a copy of my contact lens prescription.

Patient Name:_____ Date:_____

DILATION POLICY

The doctor highly recommends this test as part of the comprehensive eye examination. Dilation allows the doctor to fully assess the interior health of the eye with a 360 degree field of view. This procedure is important in diagnosing complications within the eye such as diabetes retinopathy, glaucoma, retinal tears or holes, macular degeneration, and more. Dilation leaves the eyes slightly sensitive to light with blurred vision for a few hours. Distance vision is rarely affected. Any additional questions can be answered by the doctor.

Please check one: _____ **YES**, I consent to dilation. _____ **NO**, I decline dilation.

RETINAL PHOTO CONSENT FORM

"What are retinal photos?" ↓

In addition to your exam and dilation, the doctor also recommends the retina/fundus camera which is a new digital retinal imaging system that now allows us to take photographs of your retina (the back of the eye). This assists the doctor in the early detection of many disorders such as glaucoma, diabetic retinopathy, macular degeneration, retinal detachments, and other vision threatening conditions. These digital images are stored in the computer and can be used to help better evaluate the optic nerve, macula, and blood vessels of the retina on a year to year basis. This allows the doctor to observe even the smallest change from the previous exams. The retinal photo is strongly recommended if any of the following apply:

1. If you are a new patient to this office.
2. If you have never had retinal photos in this office.
3. If you are 65 or older.
4. If you have or have a family history of high cholesterol, elevated blood pressure or any circulatory disorder.
5. If you have or have a family history of diabetes or elevated blood sugar.
6. If you have headaches or visual disturbances suggestive of a neurological problem.
7. If you have or have a family history of elevated eye pressure or glaucoma.
8. If you have any retinal disorder such as a detachment, tear, floaters, veils, flashing lights, bleeding, or macular degeneration.
9. If your vision is not correctable to 20/20 in one or both eyes.
10. If you were told by your previous eye doctor of some changes in the back of your eyes.

Retinal photos are a recommended part of your eye exam if you fall into any of the above categories and does not replace the dilation. ***The charge for this procedure is $30.00.***

Please check one: _____ **YES**, I want this procedure _____ **NO**, I do not want this procedure

_____ By initialing, I acknowledge that I have read and understand the retinal photo consent.