WELCOME TO OUR OFFICE!

PLEASE PRESENT ALL VISION AND MEDICAL INSURANCE CARDS AND PHOTO ID TO RECEPTIONIST

Please Print

Patient's Legal Name: _____

Guardian Name: _____ **Marital Status** ❑ **M** ❑ **S** ❑ **D** ❑ **W**

DOB _____/_____/_____ **SSN#** _____/_____/_____

Address _____

City/St _____ **Zip** _____

Home Phone _____

Cell Phone _____

Occupation _____

Email _____

Primary Insured _____

DOB _____/_____/_____

SSN# _____/_____/_____

Insurance Company _____

Member ID# _____

Miscellaneous

Last Eye Exam _____/_____/_____

Are you followed by an Ophthalmologist? ❑ **Yes** ❑ **No**

If so, Whom? _____

Do you wear glasses? ❑ **Yes** ❑ **No**

***Do you wear contact lenses?** ❑ **Yes** ❑ **No**

***Are you interested in contact lenses?** ❑ **Yes** ❑ **No**

*Additional fee for evaluation

How did you hear about us? _____

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

If Applicable:

Are you Pregnant? ❑ **Yes** ❑ **No**

Are you Breastfeeding? ❑ **Yes** ❑ **No**

Review of Systems

Do you currently have, or have you ever had, any of the following problems or conditions?

	Yes	No
Constitutional		
Fever, Weight Loss/Gain	❑	❑
Cardiovascular		
Heart Disease	❑	❑
High Blood Pressure	❑	❑
High Cholesterol	❑	❑
Stroke	❑	❑
Vascular Disease	❑	❑
Ears/Nose/Mouth/Throat		
Allergies	❑	❑
Sinus Congestion	❑	❑
Hearing Loss	❑	❑
Respiratory		
Asthma	❑	❑
Chronic Bronchitis	❑	❑
Emphysema	❑	❑
Sleep Apnea	❑	❑

	Yes	No
Gastrointestinal		
Crohn's Disease	❑	❑
Ulcer/Reflux	❑	❑
Genito-Urinary		
Kidney Disease	❑	❑
Prostate	❑	❑
Musculoskeletal		
Joint Pain	❑	❑
Osteo Arthritis	❑	❑
Rheumatoid Arthritis	❑	❑
Integumentary (skin)		
Skin Cancer	❑	❑
Herpes Zoster/Shingles	❑	❑

	Yes	No
Neurological		
Headaches	❑	❑
Migraines	❑	❑
Multiple Sclerosis	❑	❑
Gout	❑	❑
Seizures	❑	❑
Psychiatric		
Anxiety	❑	❑
Depression	❑	❑
Endocrine		
Diabetes Type I	❑	❑
Diabetes Type II	❑	❑
Thyroid	❑	❑
Lymphatic - Hematologic		
Anemia	❑	❑
Eczema	❑	❑
Hives	❑	❑
Lupus	❑	❑
Organ transplant	❑	❑

Please Complete Both Pages of the Form ⟶

Ocular History

Age-related macular degeneration	❑ Yes	❑ No
Amblyopia (Lazy eye)	❑ Yes	❑ No
Cataracts	❑ Yes	❑ No
Cataract Surgery	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No
History of refractive surgery	❑ Yes	❑ No
Strabismus (Crossed eyes)	❑ Yes	❑ No
Tear film insufficiency (Dry eyes)	❑ Yes	❑ No

Other _____

_____

Family Health History

(Mark yes or no to each entry. If yes, list which family member including, mother, father, brother, sister, maternal/paternal grandmother or maternal/paternal grandfather.

Amblyopia (Lazy eye)	❑ Yes	❑ No _____	Strabismus (Crossed eyes)	❑ Yes	❑ No _____
Blindness and/or vision impairment	❑ Yes	❑ No _____	Arthritis	❑ Yes	❑ No _____
Cataract	❑ Yes	❑ No _____	Cancer	❑ Yes	❑ No _____
Macular Degeneration	❑ Yes	❑ No _____	Diabetes	❑ Yes	❑ No _____
Glaucoma	❑ Yes	❑ No _____	Hypertension (High blood pressure)	❑ Yes	❑ No _____
Retinal disorder	❑ Yes	❑ No _____	Cardiovascular disease	❑ Yes	❑ No _____
			Stroke	❑ Yes	❑ No _____

Social History (check one for each question)

Are you a drug user? ❑ Yes ❑ No

Are you a: ❑ Non-drinker ❑ Social drinker

Tobacco Use (mark which one applies)

❑ Heavy tobacco smoker ❑ Light tobacco smoker

❑ Never a smoker ❑ Former smoker

Medications

- ❑ Permission given to pull Medication List from Pharmacy
- ❑ Taking over the counter medications
- ❑ No Prescribed Medications

Medication Allergies

List any medication allergies you may have:

_____

_____

❑ **No Medication Allergies**

I hereby authorize KORRECT OPTICAL / THE DOCTORS to furnish information to insurance carriers on my behalf and I hereby assign to the doctor all payment for routine/ medical services pertaining to my dependents or myself. I understand that I am responsible for any amount not covered by my insurance. I understand that I am responsible for any fees or charges for services and/or materials. **Payment is requested at time of service. We accept cash, check, CareCredit™ and all major credit cards.**

Signature _____ Date _____

Routine eye exams are typically not covered under your medical Insurance and therefore will need to be billed to a separate Vision Plan or paid in full at the time of service. Medical eye exams must be billed to your Health Insurance carrier. Any deductibles, refraction fees and co-pays will be billed to you.

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I,_____, understand that as part of my health care, Korrect Optical & the Doctors (Providers) originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations. I understand that Providers are not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance theron. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by section 164.506 of the Code of Federal Regulations.

I further understand that Providers reserve the right to change their notice and practices prior to implementation in accordance with Section 164.520 of the Code of Federal Regulations. Should Providers change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health infomation:

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity. I consent to such disclosure for these permitted uses including disclosures via fax.

I understand that I must give written permission for Providers to disclose any information to my spouse or a family member. I hereby, give Providers permission to disclose my personal health information to:
List of names we can call

Name _____ Phone _____

Name _____ Phone _____

I fully understand and ❑ Accept ❑ Decline the terms of this consent

Patient Name (Please Print)_____

Patient Signature _____ Date_____

Korrect Optical **Seth J. Summers, O.D., PSC**

Today's Date: _____

Patient Financial Responsibility and Assignment of Benefits

1. Financial Responsibility: I agree to pay **Korrect Optical & the Doctors (Providers)** and its assigns, for any and all services rendered or expenses incurred as the responsible person on this account. I understand that bills are payable in full upon the rendering of treatment, however, Providers will bill any applicable insurance as a courtesy. I assign Providers all benefits due me for services rendered and expenses incurred under any applicable policy of insurance. I understand that I am financially responsible to Providers for all charges and services not covered by this assignment, and promise to pay any remaining balance.

2. Collection Policy: An account is considered delinquent when insurance has not paid within 30-45 days after Providers billing, or if payment in full has not been received within 30 days of the final insurance payment. Delinquent accounts will be assessed penalties and interest at the annual rate of 12%, and may be turned over to a collection agency. I further agree that in the event legal action is required in order to enforce payment on this account, I will pay all court costs, expenses, attorney's fees and other costs incurred and/or expended as a result of such proceeding.

3. Continuing Services: I understand that Providers may create a separate account for each time services or expenses are incurred on this account. I acknowledge and agree that the terms and conditions in this Financial Responsibility and Assignment of Benefits as outlined above shall be effective for continuing and additional services incurred after execution of this form.

Policyholder is defined as the employee who subscribes to the insurance plan through their employer.

Patient Name	Policy Holder (employee)
Patient Signature	Policy Holder Address (if different)
Parent or Legal Guardian Signature	Place of Employment

❑ Self ❑ Spouse ❑ Child

optomap®

Annual eye exams are vital to maintaining your vision and overall health. The doctors offer the **opto**map® Retinal Exam as an important part of our eye exams. The **opto**map® Retinal Exam produces an image that is as unique as your fingerprint and provides the Doctors with a wide view look at the health of your retina. The retina is the part of your eye that captures the image of what you are looking at, similar to film in a camera.

Many eye problems can develop without you knowing. You may not even notice any change in your sight. Diseases such as macular degeneration, glaucoma, retinal tears or detachments, and other health problems such as diabetes and high blood pressure can be seen with a thorough exam of the retina.

The **opto**map® Retinal Exam is fast, easy, and comfortable for all ages. To have the exam, you simply look into the device one eye at a time and you will see a soft flash of light to let you know the image of your retina has been taken. The **opto**map® image is shown immediately on a computer screen so we can review it with you.

An **opto**map® Retinal Exam provides:

- A scan to show a healthy eye or detect disease.
- A view of the retina, giving your doctor a more detailed view than he/she can get by other means.
- The opportunity for you to view and discuss the **opto**map® image of your eye with your doctor at the time of your exam.
- A permanent record for your file, which allows the Doctors to view your images each year to look for changes.

I understand the benefits of the annual **opto**map® Retinal Exam as:

- Fast, easy and comfortable.
- A permanent record to compare and track potential eye diseases.
- An in depth view of nearly the entire retina.
- Educational tool for your doctor to discuss your health and wellness.

I understand that a wide field view of the retina is an important part of a comprehensive eye exam and that **I ACCEPT** the doctor's recommendation to obtain a comprehensive view of my retina for an additional fee of **$35.00** that I will be responsible for at the time of service.

Patient Signature _____ Date _____