Welcome to VISION SOURCE **CYPRESS**

Megan Stubinski, OD FAAO
Lora Mishler, OD

Patient Name: _____ Sex: _____ Birth Date: _____

Address: _____ City: _____ Zip: _____

Email: _____Cell phone: _____ Other phone: _____

Have we seen other family members or friends? If yes, who: _____

Responsible party information:

Name: _____ Social Security #: _____ Birth Date: _____

INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

In the course of providing Service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office. _____ **INITIAL**

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from other health professionals. Similarly, the use and disclosure of your health information for purposes of payment includes our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office and/or from our website.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. By signing you signify that you have no other health or vision insurance (or that you have provided us all insurance information) and agree that, since there is no guarantee of payment by an insurance company, you will be responsible for payment for services received in our office should the insurance not pay. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

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

Dated _____ Patient / Guardian Signature_____

If not patient, print name and relationship to patient_____

See other side →

VISION SOURCE CYPRESS

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Please read the following statements and initial on the line to indicate your agreement.

_____ I authorize Vision Source Cypress to **release any information** regarding my vision and ocular health through their **standard email**.

_____ I authorize Vision Source Cypress to **release glasses, contacts, or information** regarding my vision and ocular health including, but not isolated to, my glasses and/or contact lens prescription via phone call, fax or standard email to those listed (**OTHER THAN MYSELF**):

Name _____ Phone_____

Name _____ Phone_____

Name _____ Phone_____

IF PATIENT IS A MINOR: Guardian name: _____

_____ I am authorized to be the acting adult or guardian to sign on behalf of this minor patient.

optomap® ultra-widefield retinal imaging

Optomap Retinal Imaging: State-of-the art technology allows our doctors to thoroughly evaluate your general and eye health. We capture a digital image of your retina (Optomap) without the inconvenience of dilation.

Optomap provides:

- A digital map of the retina
- An in-depth view of the retinal layers where disease can start
- The ability to review the image with your doctor TODAY
- A permanent record in your medical files for yearly comparisons

Vision insurance will only fully cover an annual eye examination with dilation, not advanced diagnostic tools such as the Optomap. A charge of $29.00 will be your obligation in addition to co-payments that apply to routine vision.

_____ I elect to have Optomap (digital Image) of my retina for $29.00. Dilation may still be necessary in some circumstances

_____I only want a dilated exam (this will cause your vision to be blurry and you will be light sensitive for up to 6 hours)

If you decide to have neither the Optomap nor dilation, you are limiting your ability to have the health of your eyes accurately determined. You must initial and sign below.

_____I decline a thorough eye health examination

_____ _____ _____

Patient/Guardian Print Legal Name Patient/Guardian Signature Date

PATIENT FORM

EYE HISTORY

Date of Last Eye Exam

Currently Wear Glasses?

Currently Wear Contacts?

Reason for Today's Visit

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Cataracts	*yes*	*no*	*family*
Crossed Eye	*yes*	*no*	*family*
Glaucoma	*yes*	*no*	*family*
LASIK or RK	*yes*	*no*	*family*
Lazy Eye	*yes*	*no*	*family*
Macular Degeneration	*yes*	*no*	*family*
Retinal Detachment	*yes*	*no*	*family*

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ☐ Blurry Vision *near or distance*
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Infection
- ☐ Eye Pain or Soreness
- ☐ Floaters or Spots
- ☐ Halos
- ☐ Headaches
- ☐ Itching
- ☐ Light Flashes
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy or Gritty Feeling

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

AIDS/HIV	*yes*	*no*	*family*
Allergies	*yes*	*no*	*family*
Arthritis	*yes*	*no*	*family*
Asthma	*yes*	*no*	*family*
Blood/Lymph Disorder	*yes*	*no*	*family*
Cancer	*yes*	*no*	*family*
Diabetes	*yes*	*no*	*family*
Ears, Nose, Throat Conditions	*yes*	*no*	*family*
Gastrointestinal Conditions	*yes*	*no*	*family*
Heart Disease	*yes*	*no*	*family*
High Blood Pressure	*yes*	*no*	*family*
High Cholesterol	*yes*	*no*	*family*
Kidney Disease	*yes*	*no*	*family*
Lupus	*yes*	*no*	*family*
Neurological Conditions	*yes*	*no*	*family*
Psychiatric Disorder	*yes*	*no*	*family*
Seizures	*yes*	*no*	*family*
Skin Conditions	*yes*	*no*	*family*
Stroke	*yes*	*no*	*family*
Thyroid Dysfunction	*yes*	*no*	*family*

Current Medications (prescription and over-the-counter and dosage)

Medication Drug Allergies

Height **Weight**

Are you pregnant or nursing?

Do you smoke?

Have you ever smoked?