Cutting Edge Eye Care

The Optos Daytona provides an unequaled 200 degree view of your retina in a single image. This view gives our doctors the opportunity to identify and follow **peripheral retinal pathology** much more easily. In many cases, we may be able to **avoid the strong dilating drops during the exam.**

The iWellness exam uses infrared light to produce cross sectional images of the retina, the back lining of the eye, comfortably and in a matter of seconds. The image produced is similar to an MRI of structures inside the eye.

To provide the highest level of care, we strongly recommend that all of our patients have these tests performed annually. It is especially important for people who have any one or more of the following:

1. Floaters, spots, or flashes of light in vision
2. Family (or personal) history of hypertension, high cholesterol, or diabetes
3. Family (or personal) history of glaucoma
4. Family (or personal) history of macular degeneration or retinal disorders
5. Change in history of headaches
6. Recent changes in vision
7. Vision not correctable to 20/20 with glasses or contact lenses
8. Would like to avoid dilating eye drops

If pathology or unusual anatomy is documented with this testing, these image studies can be billed to your insurance as part of your treatment plan. If the scans do not detect any unusual condition, then the photos will not be covered by insurance, and you are responsible for the **fee of $45.00.**

Our doctors think the Optomap testing is so valuable that we now provide it free of charge for children 16 years and under. Because of the nature of children's eyes and how the visual system works, a mild dilation will still be required.

Please check the appropriate line below and sign at the bottom.

- ◯ **I DO** want the procedure performed
- ◯ I decline or have questions about these tests

_____ _____

Signature (type initials for digital signature) Date

BLACKSBURG EYE ASSOCIATES

(please print)

Date:_____

Name:_____ SS#_____

Address:_____City:_____

State:_____ Zip:_____ Home#:_____

Work#:_____ Cell#:_____ e-mail:_____

Date of Birth:_____ Sex: Marital Status:

Race: Ethnicity:

Work place/School:_____ Occupation/Grade:_____

Name and phone# of a relative not living with you:_____

How did you hear about our office? _____

Last eye exam:_____ Doctor/Office:_____

Allergies to medication:_____

List of medications:_____

List all major injuries/surgeries:_____

Who is your primary care physician? _____ Date of last physical?_____

Are you pregnant? If yes, how far along? _____ Are you nursing?

Have you been prescribed glasses? Contacts? (brand/strength) _____

FAMILY HISTORY	**NO**	**YES**	
Blindness	○	○	Relation _____
Cataracts	○	○	Relation _____
Crossed eye / Lazy eye	○	○	Relation _____
Glaucoma	○	○	Relation _____
Macular Degeneration	○	○	Relation _____
Diabetes	○	○	Relation _____
High blood pressure	○	○	Relation _____
Heart disease	○	○	Relation _____
Thyroid disease	○	○	Relation _____
Cancer	○	○	Relation _____
Arthritis	○	○	Relation _____

SOCIAL HISTORY

Do you use the following?

Tobacco products	○	○	How long/amount _____
Alcohol	○	○	How long/amount _____
Illicit drugs	○	○	How long/amount _____

Review of Systems

Do you currently, or have you ever had any problems in the following areas: (If YES, please explain and/or list medications)

System	NO	YES	Unsure/ Borderline	MORE INFO / MEDICATIONS
GENERAL (weight gain / fatigue / etc)……	○	○	○	_____
EARS, NOSE, MOUTH, THROAT				
Allergies (chronic or recurrent)……..	○	○	○	_____
Sinus Congestion (chronic or recurrent)……..	○	○	○	_____
Cough (chronic or recurrent) ……..	○	○	○	_____
Dry Throat / Mouth (chronic or recurrent) ……..	○	○	○	_____
VASCULAR				
High Blood Pressure……..	○	○	○	_____
Vascular Disease……..	○	○	○	_____
RESPIRATORY				
Asthma……	○	○	○	_____
Chronic Bronchitis……..	○	○	○	_____
Emphysema……	○	○	○	_____
GASTROINTESTINAL				
Diarrhea (chronic or recurrent)……..	○	○	○	_____
Constipation (chronic or recurrent)……..	○	○	○	_____
GENITOURINARY (genitals / kidney / bladder)……	○	○	○	_____
BONES / JOINTS / MUSCLES				
Rheumatoid Arthritis……..	○	○	○	_____
Muscle Pain……..	○	○	○	_____
Joint Pain……..	○	○	○	_____
SKIN (Eczema / Rosacea / hair / nails)……..	○	○	○	_____
NEUROLOGIC				
Headaches……..	○	○	○	_____
Migraines……..	○	○	○	_____
Seizures……..	○	○	○	_____
PSYCHIATRIC (Anxiety / Depression)……..	○	○	○	_____
ENDOCRINE (Diabetes / Thyroid / other glands)……	○	○	○	_____
LYMPHATIC / HEMATOLOGIC				
Anemia……..	○	○	○	_____
Bleeding Problems……..	○	○	○	_____
ALLERGIC / IMMUNOLOGIC				
(Allergies, Lupus, Autoimmune disease, etc)……..	○	○	○	_____
EYES				
Loss of Vision (central or peripheral)……..	○	○	○	_____
Blurred Vision……..	○	○	○	_____
Distorted Vision / Halos……..	○	○	○	_____
Double Vision……..	○	○	○	_____
Dryness……..	○	○	○	_____
Mucous Discharge……..	○	○	○	_____
Redness……..	○	○	○	_____
Sandy or Gritty Feeling……..	○	○	○	_____
Itching……..	○	○	○	_____
Burning……..	○	○	○	_____
Foreign Body Sensation……..	○	○	○	_____
Excess Tearing / Watering……..	○	○	○	_____
Glare / Light Sensitivity……..	○	○	○	_____
Eye Pain or Soreness……..	○	○	○	_____
Chronic Infection of Eye or Lid……..	○	○	○	_____
Sties or Chalazion……..	○	○	○	_____
Floaters in Vision (chronic or new)……..	○	○	○	_____
Flashes of light in Vision……..	○	○	○	_____
Tired Eyes / Fatigue……..	○	○	○	_____
Pathology (glaucoma, macular degeneration, etc)……	○	○	○	_____
Eye Surgery (cataract, retina, lazy eye, LASIK)……..	○	○	○	_____

_____ _____

Doctor's Signature Review Date

BLACKSBURG EYE ASSOCIATES

(please print)

Additional Insurance Information

There are a few things you will need to do prior to your appointment to make sure you are seen on time and that you can fully use your insurance benefits. Feel free to call with any questions. 540.953.2020

1. Find out if you have routine vision coverage and find out who it is through. You can call the toll-free number on the back of your insurance card and ask. This process normally takes less than five minutes. For example, many (but not all) Anthem Blue Cross Blue Sheild plans have EyeMed for their vision coverage, but some may have VSP or Davis Vision.

2. If your insurance is through your parents/guardians there are a few important pieces of information we will need for you to use your benefits. Even if we have a copy of the card we will likely need their date of birth, home address, home phone and SSN. Payment (including all necessary insurance information) is required at the time of service and if you do not have this information readily available we can take payment and give you an insurance receipt that you may submit to the insurance company for reimbursement.

3. Come in the office early so we can finish any paperwork and address any concerns before your scheduled exam time. Don't forget to bring your card(s) with you.

Medical Insurance Carrier(Anthem, Aetna, Southern Health, etc): _____

Does your health insurance have a vision-care rider? (You may have to call to verify) _____

Name of vision carrier (Eye Med, Davis Vision, VSP, Spectera, etc): _____

Policy Holder's Name:_____ Policy Holder's DOB: _____

Policy Holder's Home Phone Number:_____ Policy Holder's SSN:_____

Policy Holders Home Address: _____

Don't forget to bring the insurance card(s) with you! Without all of the required information above, you may not be able to use your benefits at the time of your visit and will be required to pay out of pocket for services and products.

BLACKSBURG EYE ASSOCIATES

INSURANCE AUTHORIZATION AND BINDING FINANCIAL AGREEMENT

Providing the best possible care involves a mutual understanding between the patient and provider. Should you have any questions about the following policies, please ask for clarification. Our professional services are rendered to you, not your insurance company. Ultimately, payment for the services rendered to you is your responsibility.

- I authorize Blacksburg Eye Associates to bill my insurance companies for services provided to me and with payment made directly to the providing doctor's office and that such authorization is valid until written notice is provided to cancel that authorization.
- I may request services to not be billed to insurance, and that I would be solely responsible for payment.
- I may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, my right to access is suspended until the clinical trial is completed.
- In the event that I receive payment from my insurance company for services provided in this office, I agree to endorse any received payment to the doctor's office.
- I understand there may be medical findings during the course of my exam. I understand it is a violation of Blacksburg Eye Associate's provider agreement with my insurance to bill such medically related services to my vision wellness plan. In this event, my medical insurance will be billed and I understand I will be responsible for any applicable copays, cost-shares, and/or deductibles as per my agreement with my insurance company. I also understand that Blacksburg Eye Associates will not neglect medical findings in order to bill my vision wellness plan, as that would put Blacksburg Eye Associates in direct conflict with its ethical obligations to the Virginia Board of Optometry.
- I understand there is a $35 fee for all returned checks.

I understand and agree to all of the statements made herein and that this is a binding agreement.

Signature:_____ Date:_____

Printed Name:_____ Relationship:_____

NOTICE OF PRIVACY PRACTICES / HIPAA AUTHORIZATION

By signing below you attest that you have been informed of / offered this practice's privacy policy and the rights to privacy that you are afforded by federal legislation (HIPAA Privacy Act). The privacy policy outlines how your information is shared only for the purpose of performing service or collecting payment. I am free to refer to this policy at any time. These policies are subject to change or modification as legislation changes.

I give permission to Blacksburg Eye Associates to discuss or release health information identifying me to my insurance companies, referring / consulting physicians, and the following authorized people and entities: (names:)_____

Signature:_____ Date:_____