Patient Status: □ New □ Existing Date: _____

Patient's Name (Title, First Last, M.I.) _____ SSN: _____ – _____ – _____

Home Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ M / F Other:_____ Race/Ethnicity: _____

Cell Phone: _____ Home Phone: _____ Other Phone: _____

May we send you emails to remind you of your next appointment and/or to alert you of upcoming events or promotions? We will never give out your email address to anyone.

E-mail Address: _____ □ No email

What is your Occupation? _____ Pharmacy: _____

Primary Care Physician: _____ Date of last physical: _____

Address: _____ Phone: _____ Fax: _____

Patient Ocular and Medical History

Date of your last eye exam: _____ **Reason for your visit today?** _____

Have you ever experienced:

□ Spots/Floaters □ Eye Surgery □ Vision Training □ Eye Patching □ Eye Injury □ Flashing Lights □ Double Vision □ Lazy Eye
□ Head Trauma □ Distance Blur □ Near Blur □ Eye Pain/Ache □ Red Eye □ Sandy Feeling □ Focus Difficulty
□ Intense Light Sensitivity □Trouble Driving at Night

Do you currently wear Contact Lenses? □ Yes □ No, If no: Would you be interested in contact lenses □ Yes □ No

If yes: What type do you wear? □ Hard □ Soft □ Gas Permeable

How often do you replace each pair? _____ How many hours per day do you wear contacts? _____

What solution do you use to clean them? _____ How many hours have you been wearing them today? _____

Do you ever sleep with your lenses on? □ No □ Yes, how often? _____

Do you currently wear Glasses? □ Yes □ No

If yes: Would you like your lenses to be (check all that apply):

□ Thinner □ Lighter □ Glare-free □ Polarized □ More Impact Resistant □ Change in the sun (transition)

Do you wear glasses for: □ Distance □ Reading □ Constant Wear

Have you ever considered Laser Vision Correction (Lasik)? □ Yes □ No

Do you presently work with a computer? □ Yes □ No If yes, how many hours per day? _____

Are you experiencing any of the following: □ Eye Strain □ Back Aches □ Neck Strain □ Headaches

Do you participate in sports, recreational or outdoor activities especially around snow or water? □ Yes □ No

If yes, which? _____

Do you have any of the following (past and present)?

□ Cataract □ Macular Degeneration □ Glaucoma □ Diabetes □ High Blood Pressure □ Cholesterol □ Head Injury □ Heart Disease
□ Epilepsy □ Thyroid problems □ Neurological Disease □ Cancer □ Other (please explain or specify): _____

Are you taking any medications or pills (including birth control)? □ Yes □ No

If yes, please list and explain for what purpose: _____

Do you have any allergies? □ Yes □ No If yes, please list and explain: _____

Do you smoke? □ Yes, _____ cigarettes per day □ No, never smoker □ No, I've quit

Do you drink alcohol? □ Yes, _____ drinks per day □ No

Do you use recreational drugs? □ Yes □ No If yes, which drug(s)? _____

Have you been exposed to or infected with:

□ Gonorrhea □ Hepatitis □ HIV/AIDS □ Syphilis □ None □ Other (please specify): _____

Family Ocular and Medical History

Have any of your relatives, living or deceased, had any of the following conditions?

□ Blindness □ Cataract □ Crossed Eyes □ Glaucoma □ Macular Degeneration □ Retinal Detachment/Disease □ Lupus
□ Arthritis □ Cancer □ Diabetes □ Thyroid Disease □ Heart Disease □ High Blood Pressure □ Kidney Disease
□ Other (please specify): _____

CLEAR VIEW EYE ASSOCIATES

550 Main St. Woburn, MA 01801 Phone: 781–935–1025
8 Andover Rd. Billerica MA, 01821 Phone: 978–663–3100
www.clearviewi.com

Speed Questionnaire

Name: _____ Today's Date: _____

Date of Birth: _____

Do you have any of the following symptoms?

□ Dryness	□ Eye Fatigue	□ Fluctuating vision
□ Grittiness/Scratchiness	□ Soreness/Irritation	□ Contact lens discomfort
□ Burning/Stinging	□ Redness	□ Light sensitivity
□ Watering	□ Itching	□ Stringy mucus

Mark the **FREQUENCY** of the symptoms you are experiencing:

0 = Never 1 = Sometimes 2 = Often 3 = Constant

Symptoms	0	1	2	3
Dryness, Grittiness, or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

Mark the **SEVERITY** of your symptoms:

0 = No problems

1 = Tolerable – not perfect but not uncomfortable

2 = Uncomfortable – irritating but does not interfere with my day

3 = Bothersome – irritating and interferes with my day

4 = Intolerable – unable to perform my daily tasks

Symptoms	0	1	2	3	4
Dryness, Grittiness, or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

How often do you experience symptoms?

1) Every Day 2) Once per Week 3) Once per Month

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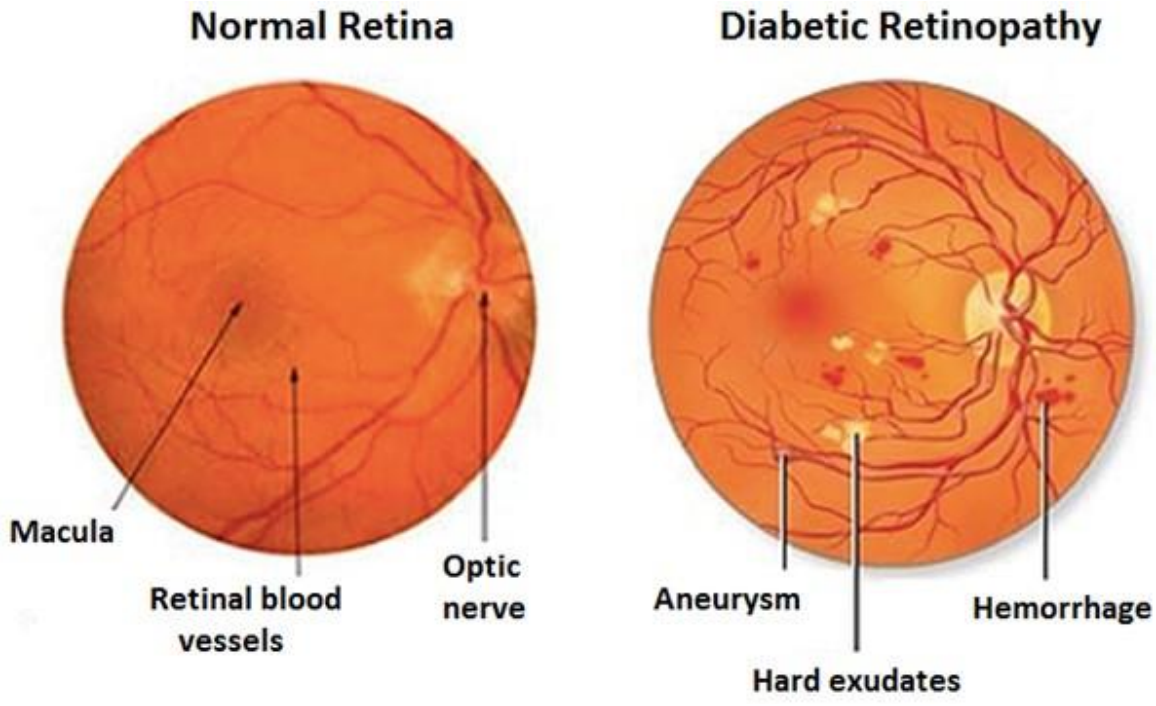
Retinal Imaging Consent Form

As part of your eye exam, we recommend a special diagnostic procedure called Retinal Photography. In this procedure a Retinal Camera is used to take a photograph of the back of the eye (the retina). This is not an X-ray or an ultrasound, nothing will touch your eye, it is simply a highly magnified photograph.

This permanent digital record is very valuable in assessing the health of your eyes presently and in monitoring the health of your eyes over the years. We are able to observe the retina, optic nerve, macula, and blood vessels and arteries of the eyes. It will also serve as an initial reference point with which to compare any changes as we monitor your health in subsequent years.

The fee for this additional part of your eye exam is **$36** which will be charged every year that photos are taken. Depending on your diagnosis, if there is a medical issue such as diabetes, glaucoma, etc., this procedure may be covered under your medical insurance. Retinal Photography is not covered under most vision plans such as VSP, EyeMed or Davis Vision. This office will advise you of your coverage.



_____ Yes, I want to have retinal photos taken of my eye for documentation.

_____ No, I do not wish to have retinal photos taken.

_____ _____

Patient Name (print) Patient Signature

Date _____

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Patient Responsibility Form

Thank you for choosing Clear View Eye Associates, P.C. (further referred to as CVEA) as your eye care provider. We are committed to providing you with the highest quality healthcare. Therefore, we ask that you read and sign this binding agreement to acknowledge your understanding of our patient policies.

1. Responsibility of Medical Care
    - All responsibility further described belongs to the Patient who is receiving medical services or the Responsible Party for all patients under the age of 18 (together further referred to as the PT/RP). **All persons under the age of 18 must be accompanied by a parent/legal guardian or by an adult who has obtained written consent for the child's treatment from the parent/legal guardian to be considered the Responsible Party.**

2. Financial Responsibility
    - **The PT/RP is ultimately responsible for the full payment for all treatments and services.**
    - **Complete payment of all charges is due at the time of service.**
    - As a courtesy, CVEA will check and bill the patient's insurance. The PT/RP is responsible to provide CVEA with all current and correct information regarding their insurance including presenting all current insurance cards prior to each visit. It is the responsibility of the PT/RP to know their plan coverages and benefits, it is impossible for CVEA to know this detailed information for every visit.
    - The PT/RP is responsible for payment of copayments, deductibles, and payments for all other procedures, treatments, services, and charges not covered by their insurance (including the refraction) at the time of service.
    - The PT/RP is responsible for the payment of co-insurances and deductibles within 30 days from receipt of the bill. CVEA accepts payment in cash, personal check, VISA, MasterCard. There is a $25 service charge for each returned check.
    - **If CVEA does not receive payment from the insurance company within 60 days from the date of service, the PT/RP will be expected to pay the balance in full.** After the balance is paid, CVEA will give the PT/RP an itemized receipt, it is the PT/RP's right to present this to their insurance company and request reimbursement from them. The outcome is solely dependent on the insurance company. This process is between the PT/RP and their insurance company.
    - PT/RPs with an outstanding balance of 60 days past-due must make arrangements to pay their balance in full prior to scheduling any future appointments.
    - PT/RPs with balances over 90 days past due will be considered seriously delinquent and will be filed with small claims court for immediate payment in full. The PT/RP is responsible for all costs of collection. At the discretion of CVEA, the PT/RP may be asked to leave the practice.
    - CVEA does realize that there are extenuating circumstances, and that people can have financial difficulties. We are willing to work with you to help you resolve any problems, please call our office if there is a problem.

3. Medical Records Transfers
    - If there is a request for medical records to be sent to the PT/RP or to another office CVEA reserves the right to charge an administrative fee of $15 (plus shipping where applicable). This is to be paid in full at the time of the request and is solely the responsibility of the PT/RP. Please allow up to two weeks for processing.

PT/RP Initials _____ Date _____

4. Responsibility of Referrals
    - The PT/RP's insurance may or may not require prior authorization (referral) from their Primary Care Physician (PCP) for the services which they are receiving. **It is solely the PT/RP's responsibility to know the policies of their insurance company.** CVEA is not required to know or provide any information regarding these policies.
    - **If necessary, it is solely the PT/RP's responsibility to obtain the referral prior to the date of the service and to present the referral to CVEA prior to or on the date services are rendered.**
    - If the PT/RP does not have a referral ready at the date of service and still chooses to receive services from CVEA they will be held responsible to pay any charges not covered by their insurance company for any reason.
    - If the patient is seen without a referral, it is the PT/RP's responsibility to obtain a back-dated (retroactive) referral as necessary per their insurance company. CVEA is not responsible for attaining this referral. Please also be aware that the PCP may refuse to issue a back-dated (retroactive) referral, this is their decision. In such cases, the PT/RP is responsible to pay any charges from CVEA for all services rendered.
    - If the insurance company chooses not to accept a back-dated (retroactive) referral for any reason, it is the PT/RP's responsibility to pay any charges from CVEA for all services rendered.

5. No-Shows/Late Cancellations
    - Our goal is to provide patients with the highest quality medical care in a timely manner. Appointments are in high demand and no-shows and late cancellations inconvenience other patients who need care, missed appointments are also a loss of revenue for our practice. As a courtesy, CVEA will attempt to confirm all appointments via automated email, text message, and/or phone call one day before the appointment but please understand that this is not always possible. At this time the PT/RP will have an opportunity to either confirm or make changes to the appointment. **It is ultimately the responsibility of the PT/RP to know and keep all appointments.**
    - If it is necessary to cancel or reschedule the appointment, **we require 1 business day advance notice**.
    - A no-show is any missed appointment without a minimum of 24-hour notice. **Cancellations less than 24 hours in advance are also considered as a no-show.** Arriving more than 15 minutes late without communication to the office will also be considered a no-show. All no-shows are recorded in the medical record of the patient.
    - **A no-show fee of $75.00 will be charged to the patient's account and is the responsibility of the PT/RP to pay in full.** All no-show fees must be paid in full before any future appointments can be scheduled.
    - CVEA reserves the right to discharge any patient with persistent (>3) no-shows in their record.

6. Outside Orders
    - If a complete pair of eyeglasses or sunglasses have been purchased online and the patient needs the frame adjusted, fitted, or repaired CVEA reserves the right to apply a $20 fee to be paid at the time services are rendered. If a Pupil Distance (PD) measurement or any measurement that is not part of the eyeglass prescription is requested at the discretion of the PT/RP a $15 charge will be applied. The Optician will inform the PT/RP of any charges. The PT/RP is responsible for all such charges that are applied prior to services being rendered.

7. Dilated Eye Examination
    - Dilation is a medical procedure that allows the doctor to use eye drops to temporarily enlarge the pupils for a more extensive view of the retina (back of the eye). With dilation, the doctor has the opportunity to evaluate and diagnose eye health problems often before symptoms occur. **It is recommended that all new patients are dilated and dilated again every 2-4 years thereafter unless certain conditions require closer monitoring.** Some patients may experience light sensitivity and blurred vision for 2-6 hours. CVEA will provide the patient with a disposable pair of sunglasses, if necessary, after the procedure. The patient may experience difficulty driving, if so, it is the responsibility of the patient to make appropriate transportation arrangements. In rare instances, patients may experience pain or other side effects. If this should occur, please seek medical attention immediately. **Please be certain to inform our doctors if you are pregnant or nursing at the time of the procedure. If you have any health conditions that may affect your response to this procedure or have any questions regarding dilation, please consult our doctors for additional information.**

PT/RP Initials _____ Date _____

Acknowledgment

I, the PT/RP, have read and fully understand the Patient Responsibility Form of Clear View Eye Associates, P.C., and agree to all the terms and conditions contained therein.

I hereby authorize and direct payment of my insurance benefits to Clear View Eye Associates, P.C. on my behalf for any service provided to me. I understand that I am fully responsible for payment of all charges not covered by insurance for any reason and agree to pay all charges as necessary.

I hereby authorize Clear View Eye Associates, P.C. to release medical and other information acquired in the course of my examination/treatment to the necessary insurance companies, governmental agencies, third-party payors, and/or other healthcare entities as needed to substantiate payment for all medical services as well as information required for precertification, authorization, or referral to other medical providers.

Clear View Eye Associates, P.C. respects patient confidentiality and will only release patient health information in accordance with the State and Federal Law.

This document is a binding agreement and does not expire. This agreement applies to all Clear View Eye Associates, P.C. locations.

To be completed by the **Patient (PT)**:

Name (print) _____ Today's Date _____

Signature _____

Date of Birth _____

To be completed by the **Responsible Party (RP)** if applicable:

Patient's Name (print) _____ Today's Date _____

Patient's Date of Birth _____

Name of the Responsible Party (print) _____

Signature of the Responsible Party _____

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HIPAA Consent: Consent to Use and Disclose Health Information

Permission to Use and Disclose My Health Information: By signing this form I give Clear View Eye Associates (further referred to as CVEA) permission to use and/or disclose my health information to provide treatment, obtain payment, and/or conduct health care operations.

Right to Refuse: I have the right not to sign this consent. If I refuse to sign this consent, CVEA has the right to refuse to treat me. However, treatment required by law- such as emergency care- can be provided to me whether or not I sign this consent.

Right to Review Notice of Privacy Practices: I have been given access to a copy of the Notice of Privacy Practices for CVEA which describes how CVEA may use and disclose my health information. I have the right to review this notice before signing this consent.

Changes to the Notice of Privacy Practices: CVEA may change the Notice of Privacy Practices as needed. I may obtain a current copy of the Notice of Privacy Practices for CVEA by contacting the office or going on the CVEA website at www.clearviewi.com

Right to Request Restrictions on Use/Disclosure: I have the right to request that the usage of my protected health information by CVEA be restricted in how it is used and/or disclosed for the purpose of providing treatment, obtaining payment, and/or conducting health care operations. However, CVEA is not required to agree to any restriction that I request. If CVEA does decide to agree to my request, the use and/or disclosure of my health information by CVEA must be restricted as I requested. If I wish to request restrictions, I must do so in writing by contacting CVEA at one of the above addresses. CVEA will notify me on whether my restrictions have been accepted or declined.

Right to Withdraw Consent: I have the right to withdraw consent at any time. I must do so in writing by contacting CVEA at one of the above addresses. My withdrawal of this consent will not be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then CVEA may refuse to provide me further treatment or follow-up, other than that required by law.

Effective Period: This consent is good unless and until I withdraw it in writing.

References to "I" or "me": References to "I" or "me" in this consent include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, it is because I am that person's parent, legal guardian, or agent under an active Power of Attorney for Health Care; and I am legally authorized to sign this consent on behalf of that person.

____ ________________________________
Name of Patient (print) Date

____ ________________________________
Signature of patient or authorized representative Name and relationship of authorized rep. if applicable

- -

FOR OFFICE USE ONLY

Complete this section if this form is not signed and dated by the patient or an authorized representative for the patient.
I have made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices for CVEA but was unable to for the following reason:

- ☐ Patient refused to sign
- ☐ Patient is unable to sign
- ☐ Other: ____

____ ________________________________
Name of Employee (print) Date

____
Signature of Employee