New Optix
OPTOMETRY

PATIENT'S NAME: _____

PATIENT INFORMATION: *(NEW PATIENTS, or for ESTABLISHED PATIENTS only if your contact information has CHANGED)*	**INSURANCE:** *(NEW PATIENTS, or for ESTABLISHED PATIENTS only if your insurance has CHANGED)*
Email:	Name of Insurance:
Phone:	Insured's name:
Address:	Insured's ID# or SS#:
City/State/Zip:	Insured's Birth Date:
Birth Date: SS#:	Insured's phone:
Occupation:	Relationship to patient:

Main reason for today's visit: _____

What TYPE of GLASSES do you wear? _____ How old are your GLASSES? _____

If you are not happy with your GLASSES, please explain the problem: _____

Are you interested in discussing LASIK VISION CORRECTION with the doctor? Yes/No

If you wear CONTACT LENSES, do you sleep in your contacts? Yes/No How often do you throw them away? _____

If you are having any problems with your contacts, please explain:_____

For NEW PATIENTS, what is your current contact lens prescription? Right: _____ Left: _____ Brand/Type:_____

Hobbies:_____ Referred by:_____

*Have **YOU** or any **FAMILY MEMBERS** (blood relatives only) ever been diagnosed as having any of the following? (Please check all that apply)*

	Self	Family		Self	Family		Self	Family		Self	Family		Self	Family
Glaucoma	☐	☐	Blindness	☐	☐	Eye trauma/injury	☐	☐	Diabetes	☐	☐	High blood pressure	☐	☐
Cataract	☐	☐	Retinal Disease	☐	☐	Lazy/Crossed Eyes	☐	☐	Autoimmune Disorder	☐	☐	Heart disease	☐	☐
Macular Degeneration	☐	☐	Corneal Disease	☐	☐	Thyroid disease	☐	☐	Cancer	☐	☐	High cholesterol	☐	☐

Are there any other medical conditions or eye disorders that the doctor should be aware of (please list)?_____

Please list any MEDICATIONS/SUPPLEMENTS that you take: _____

_____

Do you have ALLERGIES to any medications, materials, or substances? Yes/No If yes, please list: _____

If you are a DIABETIC, is your diabetes currently under control? Yes/No What was your last Hemoglobin A1C Count %? _____

AUTHORIZATION TO RELEASE INFORMATION: I/We hereby grant New Optix Optometry to release any medical or incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This includes but is not limited to my Insurance Company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.

CONSENT FOR TREATMENT: I/We hereby authorize New Optix Optometry to administer diagnostic and medical procedures as may be necessary for proper health care.

OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges/co-pays in full on the date of service. As a courtesy, my vision insurance will be billed for me. It is my responsibility to pay any deductible, co-pay, or any other balance not paid for by my insurance company. I authorize insurance benefits to be paid directly to the provider.

Signature: _____ **Date:** _____

New Optix
OPTOMETRY

INFORMED CONSENT FORM

Patient's Name: _____

Retinal Examination

The doctor recommends a thorough retinal evaluation with digital retinal photography and dilation for everyone, especially if you have any of the following conditions:

- Diabetes, High Blood Pressure, High Cholesterol
- Frequent or severe headaches, light sensitivity
- High nearsightedness
- Flashes, Floaters, or Loss of side vision
- Personal or family history of eye disease
- Over the age of 40 or 1st time patient

DILATION (Dilated Retinal Exam):
Dilating the pupil allows the Doctor to better view the inside of the eye to screen for potentially vision threatening conditions. Without dilating the eyes, the doctor has a limited view of the interior of the eye and would not be able to view the peripheral portions of the retina to detect tears, holes, hemorrhages, or abnormalities in the back of the eye. In order to dilate the eyes, the doctor or technician will put eye drops into the eyes, which will take effect after 10-20 minutes.

Common side effects include light sensitivity for 4-6 hours and blurred vision especially at near distances. We recommend that you have a driver present for dilation, although in most cases you can drive yourself. It is possible to reschedule the dilation (within 30 days) if today is not convenient. Side effects from the drops are rare, but if you experience eye pain, headache, or nausea, please contact our office immediately. The charge to have your eyes dilated is $25 in addition to your eye exam. For most insurances, that cost is completely covered.

RETINAL PHOTOGRAPHY:
A retinal camera takes a quick and painless digital image of our retina, the tissue responsible for allowing you to see. This technology assists in determining the health of your eyes and can help identify diseases like diabetes, glaucoma, macular degeneration, and many more conditions that may affect the health of your eyes.

Retinal photography is NOT a substitute for dilation, but together, can provide an objective assessment of your overall eye health. The doctor will also use the retinal photos as a digital medical record for your retina, and can compare photos from one year to the next to check for slight changes that could indicate the beginning or progression of any eye diseases. This is a preventative screening test, and is available for $39. We are also happy to email you copies of your retinal photos, at your request.

☐ I do want my eyes dilated

☐ I do NOT want my eyes dilated

☐ I do want to have my retinal photos taken

☐ I do NOT want to have retinal photos taken

I have been informed by Dr. Tran and the staff at New Optix Optometry of the need for a dilated fundus examination of my eyes. It has been explained to me and I understand that a condition with potential loss of vision may exist and without dilation, it may go undetected. Being advised of the above, I hereby decide the checked services offered above. By checking the left column, I understand the information and risks, and agree for any fees associated with these procedures.

Patient/Guardian Signature: _____
Date:_____

New Optix
OPTOMETRY

CONTACT LENS PATIENT AGREEMENT

A contact lens is a medical device in contact with the tissues of your eye; therefore, it must fit appropriately to maintain the health of your eyes. A contact lens prescription can only be determined by the careful observation of the lens on the eye and the eye's response to the lens on follow-up visits. Since follow-up care is essential, it is your responsibility to keep all appointments and follow all lens care instructions.

Before a person can be fit with contact lenses, a complete medical and refractive eye examination is necessary. This exam is critical to assure the good health of your eyes and to rule out the possibility of any unsuspected, underlying condition that may prevent contact lens use.

The goal of contact lens fitting is to find the most appropriate contact lens for each patient's optimal vision and comfort. Although many people will need only one fitting session, sometimes this process requires several appointments. We will not finalize the contact lens prescription until both the individual being fit for contacts lenses and the doctor are satisfied with the fit and visual acuity of the contact lens. We will provide one set of trial lenses. Any patient who is changing lens brands must have a new fitting and there may be an additional fitting charge.

Follow-up appointments are necessary to assure:

1. The contact lenses are fitting and moving well

2. The prescription is providing the best possible vision

3. The eyes are remaining healthy

4. There are no problems with insertion or removal

5. The patient understands and complies with the recommended wearing schedule

6. Prescriptions will NOT be written for patients who do not keep follow up appointments. There is no charge for follow-up visits during the first 60 days or first three follow up visits, whichever comes first.

By law, a contact lens prescription is valid for only one year.

All patients are required to come in for an annual contact lens exam. This is necessary to assure that the patient's eyes are healthy and the contact lenses are still fitting well. Contact lens prescriptions cannot be renewed without an annual exam.

Contact lens exams have a separate charge that is NOT included in your medical exam. There will be NO refund of the exam, fitting, or annual contact lens examination fee.

Patient/Guardian Signature_____ Date_____

New Optix
OPTOMETRY

RETURN POLICY FOR EYEGLASSES & CONTACT LENSES

All sales of prescription and non-prescription eyeglasses and sunglasses are final, but patients are welcome to return to the office ***as many times as needed*** before the final purchase is made. If there are any discrepancies between the Doctor's prescription and the lenses manufactured by the lab, or the actual prescription, any adjustments to the prescription lenses are included at NO CHARGE within 90 days.

All name-brand eyeglass frames are under manufacturer warranty for any manufacturing defects for up to **one year** from the date of purchase. This does **not** include accidental damage or breakage that has been incurred to the frames.

Even though the eyeglass frame is under warranty by the manufacturer, the manufacturer does not pay for the shipping and handling for the exchange of the defective frames for the new frames. **The patient will be responsible for the two-way shipping costs involved ($20.00).** Keep in mind that, as a courtesy to our patients, we: (1) exchange the frames; (2) order the proper lenses for those frames; (3) surface and edge those lenses; and (4) physically remount the lenses into the new frames with NO ADDITIONAL FEE.

With regard to sales of **non-specialty** soft contact lenses, any **unopened & unmarked boxes** may be returned for a full refund, or exchanged, within 90 days. However, all sales of **specialty gas permeable (rigid) and hybrid (containing both rigid and soft components) contact lenses are final.** If there are any discrepancies between the Doctor's prescription and the actual prescription, any exchanges for the appropriate contact lens prescription will be honored at NO CHARGE as long as enough time is given for the lenses to be mailed and physically received by the manufacturer, in order to meet the manufacturer's 90-day exchange policy.

POLICY FOR PICKING UP EYEGLASSES & CONTACT LENSES

All eyeglasses and contact lenses that have been prescribed, fitted, and purchased by the patient will be kept in the office for a total of **one year** from the date of purchase. If the patient does not pick up his/her eyeglasses or contact lenses within that year, we will subsequently donate them to charity.

POLICY FOR ACCEPTING PERSONAL CHECKS & BOUNCED CHECKS

Any bounced personal checks are subject to a fee of **$20.00**, which is to be paid, in addition to the original amount on the check, within 90 days.

I have read and understood all aspects of the above policies and HIPAA/Notice of Privacy Practices. It has been made known to me that if any or all parts of the above policies are not fully understood by me, for any reason at all, that further explanation is available and has been provided to me at the time of signing.

Name:_____ Signature:_____ Date:_____

New Optix Optometry HIPAA - Notice of Privacy Practices

Right to Notice: As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPAA), New Optix Optometry can use your protected health information for treatment, payment and health care operations.

1. Treatment - We may use or disclose your health information to a physician or other healthcare provider providing treatment to you
2. Payment - We may use and disclose your health information to obtain payment for services we provide you.
3. Health care operations - We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: Most uses and disclosures that do not fall under treatment, payment, health care operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

Emergency Situations: In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your healthcare.

Marketing: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may also use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health or safety.

National Security: We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders via phone, e-mail or letter.

Your Rights as a Patient: You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or health care operations.

- You have the right to receive confidential communications regarding your protected health information.
- You have the right to inspect and copy your protected health information.
- You have the right to amend your protected health information.
- You have the right to receive an account of disclosures of your protected health information.
- You have the right to a paper copy of this notice of privacy practices.

Legal Requirements: New Optix Optometry is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are posted to this site, or are available within our office.

Complaints: If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint.

Contact Information:

New Optix Optometry
4898 Convoy St. Suite 103
San Diego, California 92111
Phone: 858-565-1001
Fax: 858-565-1004

Name: Signature: Date:

New Optix
OPTOMETRY

COVID-19 Pandemic Essential Eye Exam and Treatment Consent Form

Patient Name: _____ DOB: _____ Date: _____

Please read the following statements and initial next to the following statements to indicate your agreement. If you cannot positively affirm to all of these questions, you will be asked to postpone or reschedule your visit to a later date.

_____ I do not currently, nor have I had in the last two weeks, a fever, cough, shortness of breath or difficulty breathing, sore throat, chills, muscle ache, headache, loss of smell/taste or other cold symptoms.

_____ To the best of my knowledge, I do not have, nor have I been in direct contact with someone who has a confirmed diagnosis of COVID-19 or a presumptive positive COVID-19 test result in the last 30 days.

_____ Neither I, nor anyone living in my immediate household, have traveled outside of the state in the last 30 days.

On March 16, 2020, The Centers for Disease Control and Prevention (CDC) issued the following Public Health Reminder:

Healthcare facilities and clinicians should prioritize urgent and emergency visits and procedures now and for the coming several weeks. The following actions can preserve staff, personal protective equipment, and patient care supplies: ensure staff and patient safety; and expand available hospital capacity during the COVID-19 pandemic:

- Delay all elective ambulatory provider visits
- Reschedule elective and non-urgent admission
- Delay inpatient and outpatient elective surgical and procedural cases
- Postpone routine dental and eyecare visits

I have read the above states Public Health Reminder and have answered the health questions above honestly and to the best of my knowledge. I understand that New Optix Optometry, its doctors and staff are taking precautions to limit any potential exposure I may have to the COVID-19 virus. I also understand that there is no definitive way to eliminate potential exposure by one hundred percent.

By signing this form below, I agree that I will not hold New Optix Optometry or any of its doctors or staff personally responsible should I, or someone I come in contact with, become positive or presumptively positive diagnosed with the COVID-19 virus. There are certain inherent risks associated with an eye exam during a pandemic and I assume full responsibility for personal illness that may result and further release and discharge New Optix Optometry and its doctors and staff for injury, loss, or damage arising out of my visit. I understand that COVID-19 infection can lead to illness, disability, or even death and knowingly take the risk of exposure as I deem my eye exam to be essential to the maintenance of my vision.

_____	_____	_____
PRINT LEGAL NAME	**SIGNATURE**	**DATE**