PINE CREEK VISION CLINIC

NEW PATIENT

Legal Name: _____ Date: _____

Nickname: _____Date of Birth: ____/____/____ Sex: _____SSN: _____

Street Address: _____ City: _____ State: ____ Zip Code: _____

Email: _____Primary Phone #: _____Secondary #: _____

Optomap ($39) OR **Dilation** (Please circle one)

Preferred Language: ☐ English or ☐ Other ☐ Decline to Answer

Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Caucasian ☐ Native Hawaiian or other Pacific Islander ☐ Other ☐ Decline to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Employer or School: _____ Occupation or Grade: _____

Referred by: _____#_____

Release of Information

I authorize the release of information (including the diagnosis, records, examination rendered to me and claims information) to be released to the following*: _____

*The release information will remain in effect until terminated by me in writing.

Insurance Information

Payment Policy: **Payment is required when services are rendered, or materials are ordered**. Quotes of insurance coverage are based on information from the insurance company and are not guaranteed. Although we will gladly bill insurance for you, patients remain responsible for their charges even after insurance has been billed. If payment has not been received from insurance after 60 days, the patient will be expected to pay Pine Creek Vision Clinic. Pine Creek Vision Clinic does not bill Secondary Insurance, if the claim does not cross over it is the patient's responsibility to bill insurance.

Vision Insurance: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____

Subscriber's SSN: _____

ID#: _____

Group#:_____

Employer: _____

Medical Insurance: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____

Subscriber's SSN: _____

ID#: _____

Group#:_____

Employer: _____

COVID-19 Pre-screening

Are you experiencing ANY of the following emergency symptoms: severe shortness of breath and difficulty breathing, persistent chest pain or pressure, new confusion or inability to arouse, bluish lips or face, loss of consciousness, slurred speech, and/or severe, constant dizziness or lightheadedness?

- ○ Yes
- ○ No

Are you experiencing any of the following symptoms? Please select all that apply.

- ○ Fever, chills or sweating
- ○ New or worsening cough
- ○ Fatigue
- ○ Body aches
- ○ Diarrhea
- ○ Reduced sense of smell and/or taste
- ○ Mild to moderate difficulty breathing
- ○ Sore throat
- ○ Runny nose
- ○ None of the above

Have you been told by a health official that you may have been exposed to COVID-19 (coronavirus)?

- ○ Yes
- ○ No

Have you been around someone who is known to have COVID-19?

- ○ Yes
- ○ No

Have you been tested before for COVID-19?

- ○ Yes, results negative.
- ○ Yes, results positive.
- ○ No

How many people do you currently live with?

- ○ 0, I live alone.
- ○ 1
- ○ 2
- ○ 3+

In the last 14 days, have you been in an area of high-risk for COVID-19?

- ○ Yes
- ○ No
- ○ I don't know

In the last 14 days, have you traveled internationally?

- ○ Yes
- ○ No

In the last 14 days, have you traveled on a cruise ship?

- ○ Yes
- ○ No

In the last 14 days, have you been around someone who recently traveled to a high-risk area and is also sick?

- ○ Yes
- ○ No
- ○ I don't know

Do you live or work in a care facility (This includes a hospital, emergency room, other medical setting, or long-term facility)?

- ○ Yes
- ○ No

Are you currently working in an industry providing critical services that require you to work on location (this includes industries such as grocery, banking, childcare, etc.)?

- ○ Yes
- ○ No

Over the last 14 days, have you and the people you live with been practicing social distancing of 6-feet or more?

- ○ Yes
- ○ No

Over the last 14 days, have you or the people you live with congregated with groups of more than 10 people?

- ○ Yes
- ○ No

COVID-19 affects various ages differently. How old are you?

_____

Do you have any of the following? Please select all that apply.

- ○ Asthma
- ○ Cancer
- ○ Diabetes
- ○ Extreme obesity
- ○ Heart disease
- ○ High blood pressure
- ○ Kidney disease
- ○ Liver disease
- ○ Lung disease
- ○ None of the above

COVID- 19 can affect people who have weaker immune systems from things like chemotherapy, HIV/AIDS, organ transplant, being pregnant, or prolonged steroid use. Do you have a weakened system from a known cause?

- ○ Yes
- ○ No

Referring Provider: _____

Location: _____

Address: _____

Phone number: _____ Fax number: _____

PCP (Primary Care Physician): _____

Location: _____

Address: _____

Phone number: _____ Fax number: _____

Signed: _____ **Date**: _____

* This authorizes the release of information to be released to the above providers

PINE CREEK VISION CLINIC
MEDICAL QUESTIONNAIRE

Name:_____ Date:_____

Reason for Visit:

- ☐ General Eye Exam
- ☐ Contact Lens Fitting/ Evaluation
- ☐ Evaluation after Trauma/Brain Injury/ Concussion/ Stroke/ Neurological Reason
- ☐ Referral From-_____
- ☐ Other_____

Do you wear glasses? Yes No Do you wear Contacts? Yes No Type of Contacts: Soft Other_____

Date of Last Eye Exam:_____ Eye Doctor:_____

Last Medical Exam:_____ Primary Care Physician:_____

Medical History:
Current Medications and Dosage- including contraceptives, over the counter, supplements, vitamins:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies to Medications? Yes No If yes, _____

List any major injuries/motor vehicle accidents/concussions/ surgeries/ hospitalizations with dates:

_____

_____

Are you pregnant or nursing? Yes No

Social History
Do you drive? Yes No Is driving difficult? Yes No
Do you use any tobacco products (circle one)? > 1 year 1-5 years <5-10 years Occasional Never
Do you consume alcohol (circle one)? Occasional Frequent Never
Do you use any recreational drugs (circle one)? Occasional Frequent Never
Have you ever been exposed to or infected with: AIDS/HIV Gonorrhea Hepatitis Syphilis
Hobbies/Sports:_____
Occupation:_____

- ☐ I would prefer not to discuss my social history

Review of Systems

Do you currently, or have you ever had problems in the following areas?

Constitutional
Yes No Fever, weight gain/loss

Ear/Nose/Throat
Yes No Sinus Congestion
Yes No Dry mouth/throat

Cardiovascular
Yes No Heart Pain
Yes No High blood pressure
Yes No Vascular Disease
Yes No Heart Surgery

Respiratory
Yes No Asthma
Yes No Chronic Bronchitis
Yes No Emphysema

Genitourinary
Yes No Dialysis/kidney failure

Gastrointestinal
Yes No Diarrhea
Yes No Constipation

Musculoskeletal
Yes No Rheumatoid arthritis
Yes No Muscle Pain
Yes No Joint Pain

Integumentary (Skin)
Yes No Eczema
Yes No Skin cancer

Neurological
Yes No Headaches
Yes No Migraines
Yes No Concussion
Yes No Stroke

Psychiatric
Yes No Depression
Yes No Anxiety

Endocrine
Yes No Diabetes
Yes No Hyper/Hypo thyroid

Hematologic/ Lymphatic
Yes No Anemia
Yes No Bleeding problems

Allergic/ Immunologic
Yes No Lupus
Yes No Hay fever/ allergies

Please explain if you have answered yes to any of the conditions above or have any conditions not listed:

_____

_____

Ocular History

Yes No Glaucoma
Yes No Cataracts
Yes No Diabetic Retinopathy
Yes No Retinal Disease
Yes No Eye Injury
Yes No Blindness
Yes No Cross/turned eye
Yes No Lazy eye/ amblyopia
Yes No Keratoconus

Yes No Decreased vision
Yes No Dry eye
Yes No Burning eyes
Yes No Itching eyes
Yes No Double vision
Yes No Eye pain
Yes No Floaters
Yes No Flashes of light
Yes No LASIK/ Other eye surgeries

Please explain if you have answered yes to any of the conditions above or have any conditions not listed:

_____

_____

Family History

			Relationship
Blindness	Yes	No	_____
Cataract	Yes	No	_____
Glaucoma	Yes	No	_____
Macular Degeneration	Yes	No	_____
Retinal Degeneration	Yes	No	_____
Cancer	Yes	No	_____
Diabetes	Yes	No	_____
Heart Disease	Yes	No	_____
High Blood Pressure	Yes	No	_____

☐ **UNKNOWN FAMILY HISTORY**

PINE CREEK VISION CLINIC
INJURY INFORMATION

Patient Name: _____ Date:_____

Date of Accident: _____ State: _____

Please briefly describe the injuries or accident that have led to your current vision problems:_____

_____

_____

_____

_____

Did you lose consciousness? Yes No

If so, for how long?_____

Please circle if this was a:

Motor Vehicle Accident Sports Concussion Other_____

If this was a motor accident:

Were you a: Driver Passenger Pedestrian

Were you on a: Highway Street Parking Lot

If you were on a highway:

Were you: Entering Exiting On the Highway

Were you: Moving Stopped

When did you begin to notice difficulties with your vision?_____

Please list all previous injuries, concussions, surgeries, or motor vehicle accidents including the year of the occurrence:_____

_____

_____

_____

Has a vision/eye exam been performed since the injury? Yes No

If yes, by whom?_____ Date:_____

Doctor Recommendations?_____

Your name: _____ **your age** ____ **today's date**: _____

☐ I have had a medical diagnosis of brain injury (check box if true). My brain injury was: ___ years ago
☐ I suffered a brain injury without medical diagnosis (check box if true)
☐ I have NOT had a previous brain injury (check box if true)

Please check the most appropriate box, or circle the item number that best matches.

Circle a number below:

Please rate each behavior. **How often does each behavior occur?** (circle a number)	**Never**	**Seldom**	**Occasionally**	**Frequently**	**Always**
Clarity of vision changes or fluctuates during the day	0	1	2	3	4
Eye discomfort / sore eyes / eyestrain	0	1	2	3	4
Headaches or dizziness after using eyes	0	1	2	3	4
Eye fatigue / very tired after using eyes all day	0	1	2	3	4
Feel "pulling" around the eyes	0	1	2	3	4
Print moves in and out of focus when reading	0	1	2	3	4
Normal indoor lighting is uncomfortable – too much glare	0	1	2	3	4
Indoors fluorescent lighting is bothersome or annoying	0	1	2	3	4
Clumsiness / misjudge where objects really are	0	1	2	3	4
Lack of confidence walking / missing steps / stumbling	0	1	2	3	4
Side vision distorted / objects move or change position	0	1	2	3	4
What looks straight ahead--isn't always straight ahead	0	1	2	3	4
Avoid crowds / can't tolerate "visually-busy" places	0	1	2	3	4
Short attention span / easily distracted when reading	0	1	2	3	4
Difficulty / slowness with reading and writing	0	1	2	3	4
Poor reading comprehension / can't remember what was read	0	1	2	3	4
Confusion of words / skip words during reading	0	1	2	3	4
Lose place / have to use finger not to lose place when reading	0	1	2	3	4

Predictive score = ≥ 28

total score for all 18-items: _____

Payment Policy: **Payment is required when services are rendered, or materials are ordered**. Quotes of insurance coverage are based on information from the insurance company and are not guaranteed. Although we will gladly bill insurance for you, patients remain responsible for their charges even after insurance has been billed. If payment has not been received from insurance after 60 days, the patient will be expected to pay Pine Creek Vision Clinic.

"I understand that I am personally responsible for payment of my account even if I have insurance. If it becomes necessary to use a collection agency for any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses including reasonable attorney's fees. Accounts assigned to collections will be charged a $50 collection fee."
Signed: _____ **Date**: _____

"I hereby authorize release of information to my insurance company or to any health care professional or educational professional when necessary for my healthcare or billing." (This allows us to bill your insurance.)
Signed: _____ **Date**: _____

Pine Creek Vision Clinic Colorado Springs, CO
ACKNOWLEDGEMENT OF RECEIPT OF SUMMARY NOTICE OF PRIVACY PRACTICES
Revised April 1, 2020

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains participant rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office at (719) 594-2020.

You have the right to request that we restrict how protected information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke the Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Dr.
Thomas A. Wilson O.D., Michael H. Saxerud, or Steven P. Clancy at Pine Creek Vision Clinic, Colorado Springs, CO provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The participant understands that:
Protected health information may be disclosed or used for treatment, payment or health care operations.
-Pine Creek Vision Clinic, Colorado Springs, CO has a Notice of Privacy Practices and that the participant has the opportunity to review this notice.
-Pine Creek Vision Clinic, Colorado Springs, CO reserves the right to change the Notice of Privacy Practices.
-The participant has the right to request restrictions to the uses of their information but Pine Creek Vision Clinic, Colorado Springs, CO will not have to agree to those restrictions.
-The participant may revoke this Consent in writing at any time and full disclosures will then cease.

Pine Creek Vision Clinic, Colorado Springs, CO may condition receipt of treatment upon the execution of this consent.

I have received a copy of the Summary Notice of Privacy Practices. I understand that I may also request a copy of the practice's complete Notice of Privacy Practices if I so desire.

Signed: _____ **Date**: _____

Office Policies

Thank you for choosing Pine Creek Vision Clinic for your vision care. In order to provide the best care possible for all our patients we request that you take the time to carefully review our office policies. Listed below, you will find our policies concerning COVID-19, scheduling, appointments, financial arrangements, and missed appointments.

NOTE: Some of these policies are new, we highly suggest you take the time to read this form in its entirety. Services cannot be provided until this agreement is signed by the patient or patient's legal guardian. By signing this agreement, you acknowledge that you are responsible for all charges/fees that may apply. Thank you for your cooperation.

COVID-19 Safety Protocol:

As a healthcare organization we must comply with safety, health standards and regulations. Therefore, safety and care of our staff and patients is an obligation and top priority for the practice.

PCVC will maintain a strict cleaning and disinfecting protocol. We want to assure our patients that the exam lanes, equipment and office will be continually sanitized and handled with the most caution. In order to keep a safe environment, we require all patients, children included, and employees to wear masks at all times when in the office. Due to limited supply, we will not be providing masks for patients in the office and if the patient chooses to arrive without a mask, the appointment will be rescheduled. Employees will be continually washing their hands and sanitizing throughout the day. PCVC requests that you wash your hands prior to entering the office and avoid any unnecessary touching.

In an effort to prevent the spread, we ask that if you have any fever or respiratory symptoms, you or someone you live with have traveled domestically or internationally within the last month, or have been in the presence of someone with COVID-19, that you cancel and wait to schedule your appointment for an additional two weeks.

In an effort to maintain a low number of patients and employees in the office at a time. PCVC will only allow the patient and, if necessary, their caretaker to attend the appointment. The waiting room is no longer available, and any family or company is required to wait in their car. PCVC also requires patients to wait in their car until their appointment time. If patients arrive more than 5 minutes prior to their appointment we will ask them to wait in their car. This applies to multiple family member appointments. Once the appointment has been concluded, patients will be expected to wait for their family in their car.

PCVC requires all paperwork to be filled out and submitted to the office the day before the patient's exam. To minimize viral spread, paperwork will be sent by email or text prior to your appointment in an electronic format. If you experience any difficulties with the electronic format, please contact the office. Forms can also be printed off our website at pinecreekvision.com and emailed to frontdesk@pinecreekvisionclinic.org or faxed to the office at (719)694-8562. Patients will not be able to fill out forms in the office and if we do not receive the forms prior to the appointment we will have to reschedule for a later date.

PCVC requires patients to check their temperature the morning of their exam. If the temperature is higher than 98.9 degrees, we require you to call and reschedule your appointment and the cancellation fee will be waived. At designated appointment time, patients will be welcomed into the office. Staff will verify that the patient is wearing a mask and an employee will check the patient's temperature, and if applicable, the caretaker. If the temperature is over 98.9 degrees, the patient's appointment will be rescheduled and advised to speak with their primary care physician. We advise all patients to remain at least 6 feet from one another.

PCVC will be avoiding paper transactions as much as possible. At check out, patients will be emailed a link to their patient portal. On the portal, the patient will have access to their exams, receipts and prescriptions. If you would like this information prior, please call our office to get set up.

PCVC Optical will no longer be available on a walk-in basis. All visits to Optical will have to be scheduled prior to visiting the office. Patients can schedule themselves through their patient portal at RevolutionPHR.com or call the office to be scheduled. This includes all patient pick ups, adjustments and orders.

PCVC will have protocols in place for ordering glasses, adjustments and troubleshooting. Patients coming in for optical will also be required to wear a face mask, wash their hands and check their temperature.

Cancellation and No-Show Policy: Exam slots are limited and valuable. To serve our patients better, we ask for proper notice for any cancellations. All patients are required to provide **at least 24 hours** advance notice when cancelling an appointment so that we may provide other patients with care. We understand that you may miss your appointment due to an emergency, for this reason we also reserve the right to asses each situation on a case by case basis. While we do provide reminders the day before the appointment it is the *patients responsibility* to remember the appointment.

Patients failing to provide at least a **24-hour notice** ("Same Day Cancellation") or giving no notice at all ("No Show") will be charged a **$30.00** fee for a missed appointment. After three (3) missed appointments, the practice may at its discretion, choose to discontinue your care.

All fees must be paid before a new appointment can be scheduled.

Late policy: All patients are asked to wait to enter the office until 5 minutes prior to their scheduled appointment time. In order to maintain social distancing and a timely schedule, if you arrive more than 10 minutes late to your appointment you will be asked to reschedule your appointment, unless the doctor's schedule can accommodate you.

Priority will be given to patients who arrive on time and you may have to be worked in between them. This may mean you will have a considerable wait time.

Insurance: As a practice we participate in most major insurance plans, including Medicare and Medicaid. It must be understood that if you are insured by a plan we are not in network with or we cannot verify coverage, payment in full will be expected at the time of your appointment. Knowing your insurance is your responsibility. Please contact your insurance company prior to your appointment with us to clarify your coverage/benefits.

Co-payments, Deductibles, and Co-insurance: All co-payments must be paid at the time of service. This arrangement is part of your agreement with your insurance company. Failure on our part to collect co-payments, deductibles, and co-insurance from patients can be considered fraud. Please assist us in upholding the law by paying your insurance costs at each visit.

Self-pay Services: Self pay patients will receive our self-pay discounts tailored to each service. All charges must be paid in full at time of services rendered. If you have any questions or concerns regarding specific charges or discounts, please ask our staff members prior to receiving services to assure both parties are aware of what will need to be collected on the date of service.

Non-Covered Charges: Please be aware that even if we do take your insurance, we still offer services that are **not covered by any insurance company**. If you decide to receive a non-covered service, it must be paid the same day, in full. We will not bill any of the non- covered services to your insurance company.

These will be the patient's responsibility entirely. If you have any questions or concerns regarding which services will not be covered by your insurance, please ask a staff member or your doctor prior to receiving care. We will be happy to provide clarification needed.

Referral and Pre-Authorization: It is your responsibility to ensure that any referrals, or pre-authorizations required by your insurance company be provided to our office prior to services being rendered. Failure to obtain required referrals or authorizations will result in you being responsible for the full balance.

Proof of Insurance: All patients must complete our patient information form prior to seeing the doctor. A current and valid insurance card must be presented at time of service. If you fail to provide us with the correct insurance information in a timely manner, **you may be responsible for the balance of the claim**.

Insurance Information: Payment is required when services are rendered, or when materials are ordered. Quotes of insurance coverage are based on information from the insurance company and are **not guaranteed**. Although we will gladly bill insurance for you, patients remain responsible for their charges even after insurance has been billed. If payment has not been received from insurance after 60 days, the patient will be expected to pay Pine Creek Vision Clinic. Pine Creek Vision Clinic does **not** bill secondary insurance. If the claim does not cross over, it is the patient's responsibility to bill insurance.

Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim or not. Your insurance benefit is a contract between you and your insurance company. We are not a part of that contract.

Optical Policy: Eyeglasses are custom order prescription medical devices, therefore, are **non-refundable**. The patient must pay at least half of the cost prior to the optician ordering the glasses. **No cancellations are recognized once the process has been started.** A re-stocking fee will be applied to the patient's account if it is cancelled for any reason. In addition, patients have 90 days to pick them up, unless an alternative agreement has been made.

Patients have 90 days after the prescription is filled to come in for a complimentary refraction if the prescription is not working. If the prescription needs to be adjusted due to our mistake, one lens remake in the same frame that was purchased from the original order will be covered. If the patient calls after the 90 days, stating that the prescription needs to be changed, it will be the patient's responsibility to pay for the new lenses and refraction. It is the patient's financial responsibility to replace glasses if they are lost or stolen, regardless of the 90-day period.

On occasion, a patient may need to change frames after an order has been placed. If this should occur, a re-stocking fee will apply. There are limitations and possible charges that are up to the optician's discretion.

If a patient leaves without taking their own lenses or declines to take them after picking up their new glasses, Pine Creek Vision Clinic is not responsible to hold or replace them.

For Neuro Optometric Rehabilitation, Dr. Saxerud and Dr. Wilson may use therapeutic techniques and lenses which may result in multiple pairs of lenses. This is the responsibility of the patient.

Although we always exercise the greatest of care, we are not responsible for the patient's own frame should it break while we are adjusting, repairing or reusing it for a new prescription. This includes frames that are purchased elsewhere and brought to us and non-prescription sunglasses.

<u>Contact Lens Fit:</u> A contact lens evaluation is a necessary and state regulated service in order to ensure the proper fit of a contact lens. **The evaluation is an additional service to the comprehensive eye exam and has a separate fee** that will cover the initial evaluation and all contact lens related follow-up visits for a period of **90 days** from the original appointment. This can range anywhere from $90-$1,000 depending on the complexity and type of evaluation. When contacts are purchased in office, we can offer exchanges for different contacts if needed. <u>Please let it be known that in order to exchange contact lenses, the original boxes must be unmarked, unopened, and undamaged. No exceptions. We do not offer refunds.</u>

The higher fees for a contact lens fitting are for specialty contact lenses. If your provider thinks you may be a candidate for a specialty lens, please inquire at the front desk for additional information on fees that may apply.

We thank you for your cooperation and for trusting Pine Creek Vision Clinic with your vision needs. We look forward to providing you with the best quality of care!

I, _____ have read the policy and agree to abide by the terms listed above. I understand that if any of the fees listed above may apply, I will be responsible for them in their entirety.

_____ _____

(Patient/parent/guardian signature) (Date)

Effective 2/1/2020