Judson Family Vision Care
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ADULT VISION QUESTIONAIRE

For Patients aged 19 years and over

Date of Visit: _____

_____ _____
Patient Name (Last, First, MI) **Preferred Name / Nick Name**

_____ _____ _____ _____
Street Address **City** **State** **Zip Code**

_____ _____ _____
Home Phone **Cell Phone** **Email**

_____ _____ _____
Date of Birth **Age** **Social Security Number**

Gender : ☐ **Male** ☐ **Female** **Marital Status:** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Other** _____

Do you have Major Medical Insurance? ☐ **Yes** ☐ **No** **Name of Insurance Company:** _____

Name of Policy Holder: _____ **Relationship of Patient to Policy Holder:** _____

Policy Holder Date of Birth : _____

Policy Holder Address: _____

Employer: _____ **Policy Holder SSN:** _____

Please bring cards with you to appointment so they may be scanned into patient file. If you have more than one policy, please alert office when checking in. All co-pays and charges that are the responsibility of the patient are required to be paid on date of service.

Primary Care Physician: _____

Phone Number: _____

HIPPA

I acknowledge that I have had the opportunity to review Dr. Amanda Judson's Notice of Privacy Practices and have been given a copy of the Notice if I requested it.

Patient Signature or Legal Guardian _____ Date _____

_____Patient Name _____ Reviewed

JFVC *Revised 4/19/2018

Who may we thank for referring you to our office? _____

What is the purpose of your exam today? (eg. Diabetes exam, blurred sight, dry eye, . . .)

_____

VISUAL HISTORY

Date of last Eye Exam: _____ By Whom? _____ Were eyes Dilated? ☐ **Yes** ☐ **No**

Does patient currently wear glasses? ☐ **Yes** ☐ **No** Contact Lenses? ☐ **Yes** ☐ **No**

Does patient use a computer? ☐ **Yes** ☐ **No** If yes, How much? _____

Please answer yes or no to the following Ocular conditions as they apply to the patient

Distance vision blurred and not clear -- even with lenses_____ ☐ Yes ☐ No
Poor night vision / can't see well to drive at night_____ ☐ Yes ☐ No
Near vision blurred and not clear -- even with lenses_____ ☐ Yes ☐ No
Clarity of vision changes or fluctuates during the day_____ ☐ Yes ☐ No
Scratchy feeling of sand or grit in eye_____ ☐ **Yes** ☐ **No**
Redness of the eyes_____ ☐ **Yes** ☐ **No**
Burning of the eyes_____ ☐ **Yes** ☐ **No**
Itching of the eyes_____ ☐ **Yes** ☐ **No**
Dryness of the eyes_____ ☐ **Yes** ☐ **No**
Excess tearing/ watering eyes_____ ☐ **Yes** ☐ **No**
Foreign Body Sensation_____ ☐ **Yes** ☐ **No**
Tired Eyes, eye fatigue_____ ☐ **Yes** ☐ **No**
Cataracts_____ ☐ **Yes** ☐ **No**
Glaucoma_____ ☐ **Yes** ☐ **No**
Macular Degeneration_____ ☐ **Yes** ☐ **No**
Chronic Eye Infections_____ ☐ **Yes** ☐ **No**
Retinal Detachment_____ ☐ **Yes** ☐ **No**
Ocular Surgery_____ ☐ **Yes** ☐ **No**
Ocular Injury_____ ☐ **Yes** ☐ **No**

Please explain any Ocular Surgeries: _____

_____

Is there a family history of ocular diseases? Such as glaucoma, retinal detachment, macular degeneration. Please explain.

_____

_____

HEAD TRAUMA

Has the patient experienced any significant Head Trauma ((Stroke, Head injury, Concussion, Whiplash, Motor Vehicle Accident, Bike Accident, Brain Surgery, etc...)? ☐ **Yes** ☐ **No** Date of Most Recent Event: _____
Describe the injury: _____

_____

_____

_____Patient Name _____ Reviewed

MEDICAL HISTORY

Does the patient currently or ever have problems with any of these systems?

Gastrointestinal ☐ **Yes** ☐ **No**
(Ulcer, Liver Disease, Gallbladder)
Ear/Nose Throat ☐ **Yes** ☐ **No**
(Hearing problems, Sinus Disease, Tubes)
Endocrine ☐ **Yes** ☐ **No**
(Thyroid Disease, Pituitary Disease)
Diabetes ☐ **Yes** ☐ **No**
(Type 1, Type 2)
Cardiovascular ☐ **Yes** ☐ **No**
(Blood pressure, Heart Disease)
Blood / Lymph ☐ **Yes** ☐ **No**
(Anemia, Bleeding Disorder)
Skin Disorder ☐ **Yes** ☐ **No**
(Rashes, Eczema, Psoriasis)

Nervous System ☐ **Yes** ☐ **No**
(Seizures, Headaches, Multiple Sclerosis)
Genitourinary ☐ **Yes** ☐ **No**
(Kidney Disease, Bladder Disease)
Mental Health ☐ **Yes** ☐ **No**
(Depression, Anxiety, Alzheimer's)
Musculoskeletal ☐ **Yes** ☐ **No**
(Arthritis, Osteoporosis)
Respiratory ☐ **Yes** ☐ **No**
(Asthma, Emphysema, COPD)
Allergic/Immune ☐ **Yes** ☐ **No**
(Autoimmune Disease, HIV, Allergic Status)
Cancer ☐ **Yes** ☐ **No**

Please explain any Health Conditions marked yes: _____
_____
_____

Do any of the patient's family members (i.e. mother, father, siblings, grandparents) have problems with the above conditions? (Please list) _____
_____
_____

Please list any major illnesses, surgeries, or long-term hospitalizations: _____
_____

Is patient currently taking any medications (prescription or non-prescription)? ☐ **Yes** ☐ **No** If yes, Please list: _____
_____

Any allergies to medications? ☐ **Yes** ☐ **No** If yes, please list: _____
Any environmental allergies? ☐ **Yes** ☐ **No** If yes, please list: _____
Women only: Are you currently Pregnant? ☐ **Yes** ☐ **No** If yes, how many weeks? _____
Are you currently nursing an infant? ☐ **Yes** ☐ **No**

SOCIAL HISTORY

Occupation: _____ Employer: _____

What are patient's hobbies? _____

Does patient smoke cigarettes / tobacco? ☐ **Yes** ☐ **No** If yes, how often? _____

Does patient drink Alcohol? ☐ **Yes** ☐ **No** If yes, how often? _____

Any other substances? ☐ **Yes** ☐ **No** If yes, explain. _____

**We are required by some insurance plans to ask for this information with the Health History regardless of a patient's age.*

_____Patient Name _____ Reviewed

DILATION WAIVER

Dilation means the doctor uses eye drops to temporarily enlarge your pupils . Dilation is very important to rule out certain eye diseases in patients of all ages. Without dilation, the doctor can only see about 45% of the inside of your eye. With dilation, the doctor can see much more of the inside of your eye to be able to ensure that your eyes are free from ocular disease. With dilation, the doctor can detect eye diseases that can possibly steal your vision from you that you may not have symptoms of until your vision is impaired.

Dilation is recommended at your first exam and on a doctor prescribed basis after that. The drops used to dilate your eyes take from 10 to 20 minutes to effectively enlarge the pupils. After dilation, you may have blurred sight up close and may be more sensitive to light for a few hours. Sunglasses will aid in providing comfort outdoors. If you do not have any with you, we will be happy to provide you with a pair of disposable sunglasses. You should be able to drive after the dilated exam, but there are some people who are not able to. If you do choose to drive, please proceed with caution.

Please check: **I DO** ☐ or **I DO NOT** ☐ wish to have a dilated exam at this time.

_____ _____

Patient Name Patient Signature Date

ATTENTION MEDICARE PATIENTS

REFRACTION SERVICE AND FEE

A refraction is the part of the exam by which it is determined whether you can be helped in any way by new glasses prescription. It is also how your doctor determines your best possible visual acuity. ***Medicare does not cover a refraction.*** The fee for a refraction will be an out of pocket expense and is not billable to Medicare thus not paid by Medicare.

A refraction will be performed during your exam to assess if spectacle lenses may assist in remediating visual difficulties. **The refraction fee is $45.00 and is payable at the time of service.**

I have read the above information and understand that the refraction is not paid by Medicare and that I will pay for this service at the time of my exam. I accept full financial responsibility for the cost of this service and understand it is due at the time the service is rendered.

_____ _____

Patient Name Patient Signature Date

_____Patient Name _____ Reviewed

FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service. We regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

Please read and initial each item below that you have read and agree to the following payment terms regarding all services and materials provided by Judson Family Vision Care (JFVC).

_____ 1. I agree to provide a copy of all of my insurance cards and any necessary information to enable JFVC to be able to submit insurance claims for my care at JFVC.

_____ 2. I understand that I am responsible for payment of my account regardless of insurance coverage or eligibility.

_____ 3. I authorize the release of any medical information necessary to process all claims.

_____ 4. I understand that after my insurance company has been billed, I am responsible for payment on my account for any non-covered items or services.

_____ 5. I understand that I am responsible for all co-pays for my care and that those co-pays are due at the time that services are rendered.

_____ 6. I understand that payment is due at the time of service. I understand the methods of payment accepted by JFVC are Cash, Check, VISA, Master Card, Discover, or Debit Card.

_____ 7. I understand that I am responsible for payment of my account regardless of insurance coverage or eligibility.

_____ 8. I understand that any check returned to JFVC for non-sufficient funds will be subject to a $50.00 fee. I agree to pay this fee in addition to any collection and/or attorney fees incurred in collecting the dishonored check.

_____ 9. I understand that any outstanding amount will be due and payable within 30 days after JFVC has received written notice from my insurance company that a claim has been denied or partially paid. If insurance company pays for these charges after appealing any claim decision, JFVC will reimburse patient for covered charges.

_____ 10. I understand that any account balance over 120 days will be turned over to a collection agency or attorney for collection. I will be responsible for all fees incurred in collecting this debt.

_____ 11. I understand that I will be charged a $50.00 non-refundable fee if I fail to notify the office 24 hours in advance when a scheduled appointment must be cancelled or rescheduled.

_____ 12. I understand that if I am insured by Medicaid and have any spend down that has not been met that I will be responsible for that portion. This is not determined until after JFVC has filed a claim and received notice from Medicaid. I understand that I will be responsible for any amount shown on the Explanation of Benefits and agree to pay this within 30 days of JFVC receiving this notice.

_____ 13. I hereby authorize payment of insurance benefits to be made directly to Judson Family Vision Care for any services or materials provided to me or designated patient as furnished by this supplier. This assignment will remain in effect until revoked by me in writing.

_____ 14. I agree that I will give JFVC copies of all insurance cards and that if I have multiple insurances, that if I am sent the EOB from the first insurance that I will give JFVC a copy of that EOB so that a claim can be submitted to my secondary insurance. If I refuse to give a copy of all insurance cards and /or copy of EOBs which results in JFVC not being able to submit for coverage to its fullest, I understand that I will be financially responsible for the remaining charges.

I have read, understood and agreed to the financial policy of Judson Family Vision Care.

_____ _____

Patient Name Signature of Responsible Party Date

JFVC *Revised 4/19/2018

HIPPA INFORMATION RELEASE FORM

At Judson Family Vision Care, we take the privacy of your health information seriously. We will not release a patient's health information outside of the allowed exceptions spelled out in our Notice of Privacy Practices without your verbal or written permission.

This form gives you the opportunity to tell us whom we can speak to regarding your health information. You are not required to list anyone, and you can change whom we are permitted to speak to at any time by completing a new form.

I authorize Judson Family Vision Care physicians and/or staff to speak to the individuals listed below regarding my health and billing information. I understand that I can revoke this authorization at any time by completing a new form.

_____ _____

Patient Printed Name Date of Birth

Name	Relationship
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

_____ _____

Signature Date

JFVC *Revised 4/19/2018