Kevin T. Corcoran, O.D. – Brian K. Kuhlman, O.D. – William R. Davis, O.D., M.S.
9711 Montgomery Rd. Cincinnati, OH 45242
Phone: 513-793-8486 Fax: 513-793-2023

Welcome to Innovative Vision! We are honored that you have chosen us for your eye care needs. This letter will introduce you to our practice and allow you to complete your patient registration forms prior to your appointment.

Before Your Appointment

1. Please complete the patient registration and medical history form prior to your appointment.
2. Bring your insurance card(s).
3. Bring current and/or preferred glasses.
4. Bring or wear current contact lenses along with your most recent prescription or the contact lens box.
5. Bring with you any records from previous doctors that may be helpful.

Your Appointment

1. Please arrive 15 minutes in advance for your new patient appointment.
2. A complete eye examination includes preliminary testing performed by an ophthalmic technician followed by a complete ophthalmic examination. A slit lamp is used to examine the eyes for conditions including glaucoma, cataracts, and retinal abnormalities. Eye drops are used to dilate the pupils, allowing the doctor to more thoroughly examine the lens, optic nerve, and retina. The doctor will discuss relevant findings and appropriate treatment as indicated. Your questions are always welcome. Visits are approximately one and a half hours.
3. If you currently wear or are interested in wearing contact lenses, a separate assessment will be performed to ensure proper fitting of the contact lens as well as maximizing potential vision improvement.
4. We required 24 hours notice if you are unable to make your scheduled appointment.

Insurance Policy

1. We accept Medicare and most commercial insurances, PPO's and some HMO's. In addition, we participate with Vision Service Plan (VSP) and EyeMed.
2. If you intend to use your insurance, please provide our staff with your current insurance information and card at the time of your visit. If your insurance changes, please promptly notify our staff to ensure accurate billing.
3. Contact lens fittings and assessments are typically not covered by insurance. You may be responsible for a separate contact lens evaluation charge.
4. Co-payments and self-pay payments are due at the time of service. Payments may be made by cash, check, Visa, Mastercard, Amex, and Discover.

If you have any questions regarding your upcoming appointment, please contact our office.

INNOVATIVE VISION

PATIENT REGISTRATION AND VERIFICATION

PATIENT INFORMATION

First Name: _____ MI: ____ Last Name: _____

Gender: ☐M ☐F Date of Birth: _____ SSN: _____ Martial Status: ☐S ☐M ☐D ☐W

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Preferred Phone: _____ Texting: ☐Y ☐N

Email: _____ Employer: _____ Occupation: _____

Whom May We Thank for Referring You? _____

Emergency Contact: _____ Phone: _____

INSURANCE SUBSCRIBER INFORMATION

Relationship to Insurance Holder: ☐Self ☐Spouse ☐Child ☐Other

First Name: _____ MI: ___ Last Name: _____ Date of Birth: _____

SSN: _____ Address (if different from patient): _____

City: _____ State: ____ Zip: _____ Phone: _____ Employer: _____

NOTICES AND CONSENTS

Financial Policy

Thank you for choosing Innovative Vision for your eye care needs. We are committed to providing the best care possible. Please understand that payment of your bill is considered a part of your treatment. The following statement explains our Financial Policy.

With the growing complexities and constant changes of insurance policies, it can be difficult to stay up-to-date. While we try our best to stay aware of patients' insurance policies, **the ultimate responsibility of knowing the specifics of your coverage lies with you.** It is your responsibility to understand and comply with any pre-determination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services and may not be considered medically necessary under Medicare, Medicaid, or other medical insurance companies.

All applicable co-pays and outstanding balances are due at the time of service. For checks returned to us unpaid by your bank, we will charge a $15.00 fee. Past due balances over 90-days outstanding are subject to collections.

Consent for Treatment, Release of Information and Claim Payment Authorization

I give permission to Innovative Vision to examine/treat myself and/or my dependent as they deem necessary.

I hereby give consent to the attending physician to release my information acquired in the course of examination or treatment and allow a photocopy of my signature to be used for insurance purposes only. I give permission to release medical records or information to other medical doctors. The patient hereby gives consent to his/her insurance company(s) at its option to issue indemnity checks to the rendering provider.

☐ I have read, understand, and agree to these notices and consents.

Patient/Guardian Signature: _____ Date: _____

INNOVATIVE VISION

PATIENT MEDICAL HISTORY

Do You Wear Glasses? ☐ Y ☐ N / Year Made: _____ Contacts? ☐ Y ☐ N / Brand: _____

Primary Care Physician: _____ Phone: _____

Height: _____ Weight: _____ Smoker: ☐ Y ☐ N / Diabetic: ☐ Y ☐ N / Blood Sugar Level: _____

Current Medications: _____

Allergies to Medications: _____

Ocular History

Please check if you have a history of any of the following eye conditions

☐ Amblyopia
☐ Cataracts
☐ Dry Eyes
☐ Inflammation
☐ Injury
☐ Glaucoma
☐ Keratoconus
☐ Lazy Eye
☐ Macular or Retinal Degeneration
☐ Retinal Detachment
☐ Other: _____

Family History

Please check if any family members have a history of any of the following conditions. ***Specify relation to family member*** *– father, mother, brother, sister, son, daughter*

☐ Cancer _____
☐ Cataracts _____
☐ Diabetes (Type 1 or Type 2) _____
☐ Glaucoma _____
☐ Heart Disease _____
☐ Hypertension _____
☐ Macular Degeneration _____
☐ Hyperthyroidism _____
☐ Hypothyroidism _____
☐ Other: _____

REVIEW OF SYSTEMS

Please check if you have any of the following medical conditions

Eyes:
☐ Sudden loss/change in vision
☐ Burning/itch; excess tearing
☐ Redness
☐ Discharge
☐ Swelling of lid or growth

Constitutional:
☐ Fever
☐ Weight loss or gain
☐ Night sweats

Ear, Nose, Mouth, and Throat:
☐ Sinus infection
☐ Hearing loss/deafness
☐ Dry mouth

Allergic/Immunologic:
☐ Seasonal allergies
☐ Allergies to foods/clothing

Endocrine:
☐ Thyroid
☐ Diabetes

Cardiovascular:
☐ Heart attack
☐ Chest pain/angina
☐ Congestive heart failure
☐ Irregular heart beat
☐ High blood pressure
☐ Low blood pressure
☐ Pacemaker/defibrillator
☐ High cholesterol

Respiratory:
☐ Asthma
☐ Emphysema
☐ Bronchitis
☐ Tuberculosis
☐ COPD

Gastrointestinal:
☐ Hepatitis/jaundice
☐ Ulcers/bleeding
☐ Abdominal pain

Genitourinary:
☐ Bladder problems
☐ Kidney disease

Integumentary:
☐ Eczema
☐ Herpes zoster/shingles
☐ Rosacea
☐ Dermatitis

Neurological:
☐ Headaches/migraines
☐ Tumor
☐ Epilepsy
☐ Stroke/TIA
☐ Multiple Sclerosis

Musculoskeletal:
☐ Arthritis
☐ Osteoarthritis
☐ Muscular dystrophy
☐ Fibromyalgia

Psychiatric:
☐ Depression
☐ Anxiety
☐ Bipolar Disorder
☐ ADD/ADHD

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HIPAA ACKNOWLEDGEMENT AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began April 14, 2003. Many of the policies have been in our practice for years. This form is a friendly version; a more complete text is posted in the office.

Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. We balance your privacy with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services at www.hhs.gov.

You acknowledge the following policies that have been adopted by Innovative Vision:

1. You understand that all patient information will be kept confidential except as is necessary to provide service or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is policy of this office to remind patients of their appointments. We may do this by telephone, email, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to the office policy, products, and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA via a Business Associates Agreement.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purpose of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You may have the right to request changes in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, *(print name)* _____, do hereby consent and acknowledge my agreement to the terms set forth in the **HIPAA INFORMATION AND CONSENT FORM** and any subsequent changes in the office's policy. I understand that this consent shall remain in force from this time forward.

Patient/Guardian Signature: _____ Date: _____

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LATE ARRIVAL / APPOINTMENT CANCELLATION / NO SHOW POLICY

Thank you for trusting your eye care to Innovative Vision. When you schedule an appointment with our doctors, we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Please see our Late Arrival/Appointment Cancellation/No Show Policy below:

- Effective February 1, 2018, any patient who is **more than 15 minutes late** for an appointment may need to be rescheduled.
- Any established patient who fails to show for his/her appointment or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours notice** will be considered a No Show and charged a **$25.00 fee**.
- Any established patient who fails to show for his/her appointment or cancels/reschedules an appointment with no 24 hour notice a **second** time will be charged a **$50.00 fee**.
- If a **third** No Show or cancellation/reschedule with no 24 hour notice should occur, the patient may be **dismissed** from Innovative Vision.
- Any new patient who fails to show for his/her initial visit may not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our Office Manager, who may be able to waive the No Show fee. You may contact Innovative Vision 24 hours a day, 7 days a week at the number above. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

I have read and understand the Late Arrival/Appointment Cancellation/No Show Policy and agree to its terms.

Print Name: _____

Patient/Guardian Signature: _____ Date: _____

INNOVATIVE VISION

RETINAL HEALTH SCREENING TESTS

We offer the most advanced technology to help our patients safeguard their eye health. As part of your exam, our doctors recommend a macular pigment optical density (MPOD) measurement and digital retinal photography. Though insurance does not yet pay for these tests, we strongly encourage you to take this opportunity to identify key risk factors for age-related macular degeneration and other serious eye diseases.

MACULAR PIGMENT OPTICAL DENSITY (MPOD) TEST

- Measures the thickness of protective macular pigment in the retina
  The denser the pigment, the more protection you have to preserve your vision

- Identifies key risk factor for age-related macular degeneration (AMD)
  AMD is the leading cause of vision loss in the U.S.

- Identifies risk of harmful blue light damage
  Macular pigment is the eye's natural defense against harmful blue light from sources such as sunlight, energy efficient light bulbs, and digital screens (TVs, computers, tablets, smartphones, etc.)

Recommended for:

Patients ≥ 30-years-old

Patients with one or more AMD risk factors:

- *Family history of AMD*
- *Low vegetable intake*
- *Light-colored eyes and/or skin*
- *Current/former smoker*
- *Female*

DIGITAL RETINAL PHOTOGRAPHY

- Takes a detailed photo of the retina and optic nerve for instant viewing
  Allows you to see what the doctor is seeing in your eye and better understand the findings

- Photo is stored electronically and can be forwarded to you or another doctor whenever needed
  Electronic storage of photo allows for comparison of changes in the eye over time

- Facilitates detection of retinal diseases such as AMD, diabetic retinopathy, macular edema, etc.
  Helps avoid permanent vision loss that can be caused by these types of diseases

- May eliminate the need for dilation
  Can take the place of dilation, unless the doctor feels the need for dilation

Recommended for:

Patients with a personal and/or family history of diabetes, high blood pressure, macular degeneration, glaucoma, and high prescriptions

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Yes, I want to take advantage of the: ☐ MPOD Test $**20** ☐ Digital Retinal Photography **$29**

☐ No, I decline these retinal health screening tests

Patient/Guardian Signature: _____ Date: _____

INNOVATIVE VISION

CONTACT LENS EVALUATIONS

Innovative Vision takes pride in providing the highest quality of contact lens care. We make every effort to ensure that our recommendations are individually tailored to each patient. Our doctors take into consideration many factors including your glasses prescription, visual needs, and eye health.

WHAT IS A CONTACT LENS EVALUATION?

Determination of the proper contact lens prescription based on each individual's eyeglass prescription, vision needs and corneal health and curvature.

- Requires additional testing and is considered separate from the comprehensive exam.
  Includes evaluation of the cornea, conjunctiva and eyelids, and how contact lens wear affects the health of the eye.

- A contact lens prescription is different from a glasses prescription.

HOW OFTEN DO I NEED A CONTACT LENS EVALUATION?

Contact lenses prescriptions **expire after one year**.

- Contact lens wear can cause irritation and infections.
  The eye is a sensitive organ and requires monitoring at least every year. Problems that are undetectable by you can develop into more serious conditions.

- Annual examinations allow your doctor to evaluate the condition of your lenses and recommend any changes that are needed before renewing the prescription for another year.

WHAT ARE THE EVALUATION FEES?

Contact lens evaluations and fittings have different levels of difficulty and time and thus, cost. This depends on the types of contact lenses needed, the visual requirements of the patient and the health of the patient's eyes.

▪ New Patient CL Evaluation (Soft Sphere Only)	**$69**
▪ Established Patient CL Evaluation (Update CL Rx – No changes)	**$49**
▪ Soft Toric CL Evaluation	**$79**
▪ Rigid Gas Permeable CL Evaluation	**$89**
▪ Monovision CL Evaluation	**$89**
▪ Soft Bifocal CL Evaluation	**$109**
▪ Keratoconus & Post Surgical CL Evaluation	**$129**
▪ Training session/visit *Required for new contact lens wearers to ensure proper insertion/removal and cleaning care*	**$29**

Please ask our staff and doctors to discuss with you additional information if you have any questions regarding this information.

☐ I have read and understand the contact lens evaluation fees.

Patient/Guardian Signature: _____ Date: _____