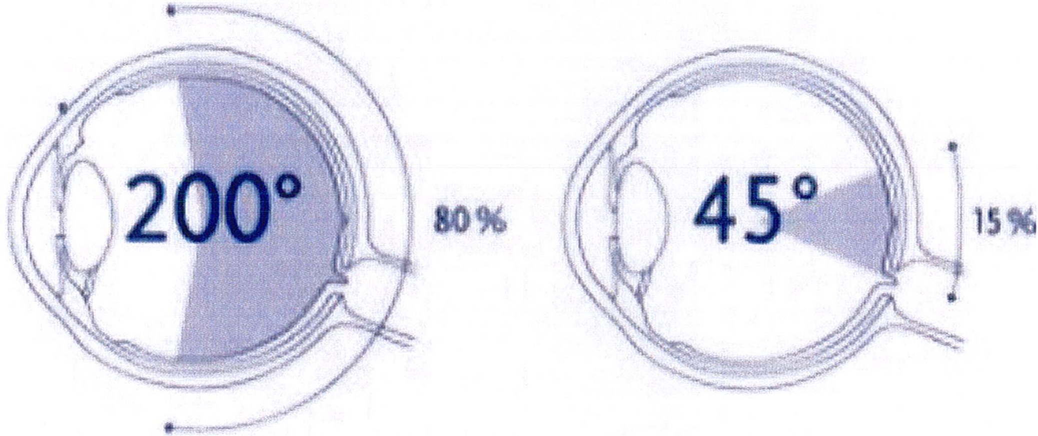
Benefits of an optomap

Account#________

The **opto**map exam is fast, painless and comfortable. Nothing touches your eye at any time. It is suitable for the whole family. To have the exam, you simply look into the device one eye at a time (like looking through a keyhole) and you will see a flash of light to let you know the image of your retina has been taken.
Under normal circumstances, dilation drops might not be necessary, but your eye care practioner will decide if your pupils need to be dilated depending on your conditions. The capture takes less than a second. Images are available immediately for review.

The view with Optomap **The view without**



Our doctors recommend that all patients have a thorough examination of their retina every year. **Manteca Optometric Eye Care Center** is excited to offer revolutionary non dilating retinal scanning technology. The retinal evaluation allows our doctors to view the inside of your eye to detect any abnormal findings such as macular degeneration, diabetic retinopathy, retinal holes and tears, ect. Doctor will review the images and share the 3D view of the optimal retinal image during your exam.

Without the Optomap or a dilated examination, the doctors cannot fully asses the health of the eye. **There is an additional fee of $25 for adults and $15 for children for the Optomap**. In most cases, the procedure is not covered by insurance but is generally a flexible spending (FSA) expense. Dilation may still be required in rare instances. When it comes to children the doctor may still have to dilate to get a more accurate reading for their eye glasses prescription and the Optomap fee will not be refunded.

_____ I elect to have the Optomap Retinal exam today and pay the fee stated above

_____ I prefer a dilated exam and have been informed of the side effects (No fee)

_____ **I understand a retinal evaluation is recommended and refuse Optomap Retinal exam and dilated exam and the health of the eye will not be checked.**

______________________________ ______________
Patients Name Date

______________________________ ______________
Parent/ Guardian Date

(Revised 3/2016)

Manteca Optometric Eye Care Center

Account#________

Patient Information

First______________________________ Last name ______________________ MI_____
Name Used/Nickname ______________________ Sex: Male Female
Race (If multiracial, list races) ______________________________
Date of Birth____________________ Age____________ Language______________
PO Box______________________ Street Address__________________________
City_____________________________ State__________ Zip Code___________
Home Phone__________________Cell Phone ______________ Work Phone__________
Email Address_________________________________ Patient's SSN______________
Employer (or School)____
Address________________________City__________,State______________Zip_______
Student__________________________________ Full Time __________ Part Time ____________

Marital Status Circle: Single Married Divorced Widow Legally Separated

Who may we thank for referring you to our office?

Name of friend/relative_________________________________
If not referred, how did you choose our office? Another Dr., If so, who?_______________
Insurance Listing___________________________________
Saw Sign/Building___________________________________
Newspaper/Radio/TV_________________________________
Friend____
Facebook____
Other____

Who will be responsible for your account please circle below:

Self Spouse Mother Father Other: _______________________________________
SSN#________________________________
Birthdate____________________ Age_______
Phone______________________Cell______________________
Street______________________________City________________State________Zip_____
Employer____________________ Business__________________Phone______________

Please note that not all Insurance covers the Contact Lens Fitting

Primary Medical Insurance____
Subscriber Name____
Subscriber SSN _____________________Subscribers ID _________________________
Subscriber Birth Date____

Vision Insurance____
Subscriber Name____
SubscriberSSN ______________________Subscribers ID _________________________
Subscriber Birth Date____
Subscriber Employer____

Emergency contact____________________Phone__________________Relationship______________
Medical Doctor_________________________________
Address____________________________________City_________State_____Zip______

Consent to use or disclose Health information for Treatment, Payment and Health Care Operations.

In the course of providing service to you, we create,receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practice that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practice, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health informational as maybe necessary or appropriate for you to receive follow-up care from another health care professional. Similarly, the use and disclosure of your health information for purposes of payment includes submission of your health information to third-party payers or insurers for claim review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practice. Our Notice of Privacy Practice will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this document, you signify that you authorize us to use and disclose your health information to treat you, to obtain payment for services, and to preform health care operations. You can revoke this consent in writing at any time, unless we have already treated you, sought payment for our services, or preformed health care operations in reliance upon our ability to use nor disclose your health information in accordance with consent. We can decline to serve you if you elect not to sign this consent form. You have the right to ask us to restrict the uses of disclosures made for purposes of treatment,payment or health care operations,but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree ,however, the restrictions are binding on us.

I have read this consent and understand it. I consent to the use and disclosure of my health information for the purposes of treatment,payment and health care operations.

Print First Name______________________ Last Name________________ MI_____

Signature__________________________ Date____________________

Parent/Legal Guardian______________________ Relationship__________________

I_________________________, herby give authorization to Manteca Optometric Eye care Center to release my medical information/records in regards to my care to the following person listed below.
Name:______________________ Relationship:________________________

__________Check here if you consent to release records by Email

Patients Name: ________________ **Account#** ________

PATIENT QUESTIONNAIRE

Do you wear glasses________________ How old is you Prescription________________
Do you wear glasses while working on a computer________________
When was your last exam______________By whom ________________
Do you wear contacts________ Have you ever tried contacts________________
Are you interested in color contacts________________
Do you participate in any Sports/Hobby that require protective eye wear?
____

Have You/Family ever been diagnosed with any of the following health problems

	Me	Family		Me	Family
Hepatitis/HIV	______	______	Macular Degerneration	______	______
Arthritis	______	______	Retinal detachment	______	______
Blood/Lymph	______	______	High Blood pressure	______	______
Cancer	______	______	Crossed/Lazy eye	______	______
Cholesterol	______	______	Ear/Nose/Throat	______	______
Diabetes	______	______	Eczema/rashes	______	______
Endocrine	______	______	Eye Surgery/Injury	______	______
Fatigue	______	______	Heart Problems	______	______
Cataracts	______	______	Kidney/Thyroid	______	______
Glaucoma	______	______	Lung/Respiratory	______	______

Other Medical conditions: ________________
Other concern you may have: ________________

Please indicate all medication's/supplements and dosage you are currently taking:

____

____

Do you have any Drug Allergies? ________________

How many hours a day do you spend on electronic devises/computers

Desk top_____ Lap Top______ Tablet ______ Phone_______Video Games _____

Have you experienced any of the following symptoms

Dry/Watery eyes	_____	Double Vision	______________
Muscle strain	_____	Sensitive to light	_________
Blurred near vision	_____	Burning/Itching/Red Eyes	_____

Over all health please circle? Excellent / Good / Fair / Poor

Do you smoke or drink alcohol? Yes / No / Both / Rarely
Do you take any illegal street drugs? Yes / No
Please List what you take: ________________

Are you pregnant?________ **Due Date?**________ **Nursing?**________

(Revised 3/2016)

Manteca Optometric Policy   Account# ______

Cancellation: In order for us to give our patients the best eye care possible and give them prompt appointments, we must adhere to a strict cancellation policy. Therefore, if you Cancel three appointments with less then a 24 hour notice to us you will no longer be able to see our doctors. If you No Show/No Call twice we will not book any future appointments for you.

Financial: It is the patients responsibility to Notify Our office of any change in insurance coverage that takes place. By withholding the correct insurance information, including the required authorizations the patient is liable for payment in full if the claim is denied. We will bill all insurance accordingly to the information provided at the time of service. It is the patients responsibility to know their insurance and provide it to our office. All Co-Pays and deductibles and purchases made are due in full at the time of the patients appointment. Also fee's for professional services are non refundable.

Glasses/Opthalmic Products: Glasses are complex,custom-made devices comprised of a set of frames and spectacal lenses. In the event that a patient is not satisfied with the visual acuity obtained with the prescription lens provided by our office the patient will be asked to return for an adjustment of the glasses and as necessary, schedule a short prescription check appointment with the doctor. Our office will make every effort to provide glasses that are accurate. This process must be initiated within 90 days of the original purchase.

Refunds on Glasses/Frames: Due to insurance policy changes we are no longer allowed returns or frame exchanges once the order has been processed. **All sales are final.**

Contact Lens Prescription change: In case of a prescription change for contact lenses, you may return or exchange with in one year of the original purchase date. All contact lenses must not be opened and has to be in the original packaging. **Merchandise must be like-new condition.**

(Please ask staff any questions you may have before signing)
I understand by signing this page, I am agreeing to this policy

Print First Name____________________________ Last __________________ MI__

Signature__________________________________ Date:_____________

Staff Initials___________

(Revised 3-2016)