Patient Questionnaire of Optic Dimension, Pllc

Last Name: _____ First Name: _____ M.I. _____

Birth Date: _____ Age: _____ Sex:_____ Marital Status: _____ Phone: _____

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

Occupation/Employer: _____ Hobbies: _____ E-mail: _____

Insurance Company: _____ Insurer Name: _____

Insurer Birth Date: _____ Insurer Last 4 SSN: _____ Insurer Employer: _____

Last Medical Exam: _____ Where/Doctor: _____ Last Eye Exam: _____ Where/Doctor: _____

Do you currently wear ◯ Glasses ◯ Contact Lenses: Soft / Toric / Rigid Brand of contact lenses: _____

Reason for today's visit: _____

Review of Systems - Please indicate any Personal or Family History below

Allergic/Immune			
Hepatitis/TB/STD/HIV/AIDS/ Shingles	◯ Yes		◯ No
Lupus/Sarcoidosis	◯ Yes		◯ No
Cancer	◯ Self	◯ Family	◯ None
Integumentary (Skin)			
Eczema	◯ Self	◯ Family	◯ None
Rosacea	◯ Self	◯ Family	◯ None
Rash, Itching, Pimples, etc.	◯ Self	◯ Family	◯ None
Neurological (Nerves)			
Numbness/Tingling	◯ Self	◯ Family	◯ None
Headaches/Migraines	◯ Self	◯ Family	◯ None
Seizures/Convulsions	◯ Self	◯ Family	◯ None
Light Headed/Dizziness	◯ Self	◯ Family	◯ None
Multiple Sclerosis	◯ Self	◯ Family	◯ None
Ocular (Eyes)			
Blurred Near/Far Vision	◯ Yes		◯ No
Recent Change in Vision	◯ Yes		◯ No
Distorted Vision/Halos	◯ Yes		◯ No
Eye Surgery: Retinal, Cataract, LASIK, Eye Turn, etc.	◯ Yes		◯ No
Eye Injury	◯ Yes		◯ No
Flashes/Floaters	◯ Yes		◯ No
Glare/Light Sensitivity	◯ Yes		◯ No
Itching/Redness	◯ Yes		◯ No
Tearing/Watery/Discharge	◯ Yes		◯ No
Dry/Burning	◯ Yes		◯ No
Double Vision/Lazy Eye	◯ Self	◯ Family	◯ None
Cataracts	◯ Self	◯ Family	◯ None
Glaucoma	◯ Self	◯ Family	◯ None
Macular Degeneration	◯ Self	◯ Family	◯ None
Retinal Disease	◯ Self	◯ Family	◯ None
Blindness	◯ Self	◯ Family	◯ None
Psychiatric			
Memory Loss/Confusion	◯ Self	◯ Family	◯ None
Anxiety/Depression	◯ Self	◯ Family	◯ None
Violent/Suicidal	◯ Self	◯ Family	◯ None
Bipolar	◯ Self	◯ Family	◯ None
Schizophrenia	◯ Self	◯ Family	◯ None

Ear/Nose/Throat/Mouth			
Swollen Glands in Neck	◯ Yes		◯ No
Allergies/Hay Fever	◯ Yes		◯ No
Dry Mouth/Throat	◯ Yes		◯ No
Sinus Congestion	◯ Yes		◯ No
Post-Nasal Drip	◯ Self	◯ Family	◯ None
Hearing Loss/Ringing	◯ Self	◯ Family	◯ None
Respiratory (Lungs)			
Asthma/Emphysema	◯ Self	◯ Family	◯ None
Bronchitis	◯ Self	◯ Family	◯ None
COPD	◯ Self	◯ Family	◯ None
Chronic Cough	◯ Self	◯ Family	◯ None
Shortness of Breath	◯ Self	◯ Family	◯ None
Cardiovascular/Vascular (Heart)			
High Cholesterol	◯ Self	◯ Family	◯ None
High Blood Pressure	◯ Self	◯ Family	◯ None
Chest Pain/Heart Attack	◯ Self	◯ Family	◯ None
Stroke/Vascular Disease	◯ Self	◯ Family	◯ None
Gastrointestinal (Stomach/Intestines)			
Diarrhea/Constipation	◯ Yes		◯ No
Nausea/Vomiting	◯ Yes		◯ No
Colitis/Crohn's	◯ Self	◯ Family	◯ None
Genitourinary (Kidney/Bladder/Genitals)			
Kidney/Bladder/Genitals	◯ Yes		◯ No
Frequent Urination	◯ Yes		◯ No
Bones, Joints, Muscles			
Fibromyalgia	◯ Self	◯ Family	◯ None
Rheumatoid Arthritis	◯ Self	◯ Family	◯ None
Muscle Pain/Weakness	◯ Self	◯ Family	◯ None
Joint Pain/Stiffness/Arthritis	◯ Self	◯ Family	◯ None
Hematologic/Lymphatic (Blood)			
Anemia	◯ Self	◯ Family	◯ None
Bruise Easily	◯ Self	◯ Family	◯ None
Slow to Heal	◯ Self	◯ Family	◯ None
Endocrine			
Diabetes	◯ Self	◯ Family	◯ None
Hormone Changes	◯ Self	◯ Family	◯ None
Thyroid/Other Gland	◯ Self	◯ Family	◯ None

Are You Pregnant? ◯ Yes ◯ No

Other Conditions not listed for you or your family: _____

Please List All Medications You Currently Take: _____

Please List All Medication Allergies: _____

Social History:

Alcohol Use: Never / Rarely / Moderate / Daily **Tobacco Use**: Never / Quit / # Per Day **Illicit Drug Use**: Never / Type / Frequency

Please List Any Major Injuries, Surgeries, Hospitalizations: _____

Patient Orientated To Person, Place

Doctor's Signature and Date

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status.

Y / N Reviewed _____ **Patient Signature** _____ **Date** _____

Y / N Reviewed _____ **Updated by** _____ **Date** _____

Y / N Reviewed _____ **Updated by** _____ **Date** _____

Patient Financial Responsibility

Thank you for choosing Optic Dimension for your eye care needs for you and your family. We are pleased to be your eye care provider and look forward to a lasting relationship**.** As part of this relationship, we have outlined our expectations for your financial responsibility. Please read this thoroughly and keep a copy for your records.

24 Hour Cancellation Policy
Optic Dimension, Pllc reserves the right to secure a credit card on file for all patient appointments, on which a $50 no-show fee could be charged in the event that the patient fails to provide a minimum of **24 hour** cancellation notice or keep your scheduled appointment. Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you.

Contact Information
Please update any changes to your contact information as we correspond with our patients via these methods and we use this information in insurance claims.

Co-payments
Copays, insurance deductibles, fee-for-service fees are collected at the time of check-out. We accept cash and most credit cards.

Self-Pay Patients and Medically Related Visits
Self-pay patients should be prepared to pay at the time of each visit. As we are **NOT** a provider for **MEDICAL** insurance plans, any medically related visit will be an out-of-pocket cost. Your MEDICAL insurance may cover the cost or apply it towards your deductible if you self submit to your insurer. If you have any questions regarding cost please be sure to call our office to speak with the staff member before the visit so we may discuss your specific options.

Failure to Pay
Patients who ignore overdue/collection notices and fail to pay their balance risk negative credit ratings and possible dismissal from the practice. Past Due accounts may hinder your ability to have appointments scheduled. Should your account balance become uncollectible you will not be entitled to our services. Service charges of 1.5% per month will be added on all balances over 60 days past due. If it becomes necessary to collect fees through litigation or a collection agency, I agree to pay all collection fees, court costs, deposition fees and attorney's fees incurred by Optic Dimension, Pllc

Returned Checks
Returned checks are subject to a $30 fee and your account will be placed on a "cash-only basis." We will accept payments only by cash or credit card until the balance is cleared.

Guarantor
Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. If another party is responsible for payment of your account, you must have all arrangements made prior to visiting our office as service fees are collected at checkout. In the event of a divorce and another party is responsible for payment of your account, please pay the balance in full and negotiate with them outside our office.

Minors and Dependents
Parent and guardians are responsible for payments for their dependents at the time services are rendered. Minors and dependents must present a valid insurance card at each visit if a

claim is to be filed.Minors and dependents will not be seen in the absence of a parent or guardian without written permission by parent or guardian.

Vision Insurance
Vision insurance plans may include benefits to purchase glasses or contacts which may be annually as well. The routine eye exam consists of determining an individual's VISION and a prescription for glasses and/or contacts (often a contact fitting fee applies depending on the plan). There is a screening for glaucoma through a pressure test, and an evaluation of the health and function of the eyes. If a medical condition is detected and a patient requires medical treatment for their eyes, medical insurance is then utilized to cover further testing and treatment NOT vision insurance.

Optic Dimension, Pllc contracts with many VISION insurance plans. Your vision insurance policy is a contract between you and your VISION Insurance company or employer. Before your appointment, please understand your plan's specific rules/regulations/policy benefits/out-of-pocket fees/coverage limits; please ensure that your doctor is in-network and the services are covered under your plan otherwise, you will be billed in full.

You have a responsibility to provide correct information to our office so a claim can be properly submitted. If your insurance company has not paid a claim on your behalf within 60 days, the balance will be transferred to your account and you will be responsible for payment. If we receive payment at a later date, you will be reimbursed.

We will bill your insurance company. If problems arise regarding coverage issues, we will attempt to work with your insurance company to help resolve them prior to making it your responsibility. Also, please be advised that you are nevertheless ultimately financially responsible for payment of professional services rendered beyond your insurance's plan coverage.

Refunds
A refund is issued when an overpayment has been identified. If you feel a refund is due, please contact our office. As with other doctors that you see, kindly understand that one fee is not for unlimited care and that fees and copays are due at the time of service and are not refundable**.**

What's covered in the exam fee
We will give individual, careful attention to you, but because of many factors we may have to adjust your prescription. The doctor will gladly see you for Rx changes at **NO CHARGE** as long as you return **WITHIN 60 DAYS** of your **ORIGINAL** exam date. As with other doctors that you see, kindly understand that one fee is not for unlimited care. Problems arising after the initial visit (except for 60 day changes) will have additional fees. All contact lens evaluations include **60 DAYS** of related follow up beginning from the day of visit when trials are dispensed. In the case when trials are ordered, the **60 DAYS** begins when trials arrive at the office and the patient is notified to schedule a dispense appointment. **AFTER THE 60 DAYS PERIOD, ANY CHANGES TO THE GLASSES OR CONTACTS RX WILL BE CHARGED AS A FULL EXAM. ANY VISITS DURING THIS 60 DAY PERIOD UNRELATED TO PRESCRIPTION ADJUSTMENTS (I.E.MEDICAL) WILL BE CHARGED AS AN OUT-OF-POCKET EXPENSE.**

Signature_____ Date_____

Print name_____ Relationship to patient_____

Optic Dimension Covid-19 Safety reopening protocol

We at Optic Dimension want to ensure that patients continue to have access to eye care during these uncertain times. The health and safety of our patients and staff remains our top priority. In line with official guidance, we're resuming routine eye exams and continuing to offer 'essential care' appointments for those with urgent needs. We look forward to welcoming you back. The following procedures will be implemented as precautions and to promote efficiency to minimize office time:

1. Scheduling patients to 30 minute slots to allow for social distancing (at least 6 feet) and time to thoroughly clean and sanitize rooms and equipment before and after patients.
2. Changes in the waiting room to promote social distancing.
3. Doctor and staff will be using protective equipment to increase safety; patents will wear masks covering mouth and nose.
4. All patients will wash their hands prior to being pre-tested and brought into the exam room.
5. Patients are encouraged to come alone for their appointment to encourage social distancing.
6. Temperature of patients will be taken prior to appointment. Any patients with risk factors or have any symptoms of COVID-19 (coughing, shortness of breath, fever, chills, muscle pain, headache, sore throat, new loss of taste/smell) or have been in contact with someone with COVID-19 will have to delay their appointment by at least 14 days.
7. To comply with CDC distancing guidelines, **Optomap retinal imaging will be performed on all patients instead of dilation**. Optomap is a **contactless** evaluation of the health of the eyes. Optomap takes an image of the back of the eye so the doctor can assess the health of the eye without dilating in most cases. Imaging is an **additional cost of $35 that vision insurance doesn't usually cover**. Medical insurance may cover the cost or apply it towards your deductible if you self submit to your insurer. **Please plan accordingly.**
8. Reserved first appointments of the day for sensitive population and frontline workers.
9. Safety shields on equipment to promote safety.

Please contact me if you have any questions regarding our new procedures.

Thank you all in advance for your cooperation and patience while we adapt to our 'new normal". Stay safe and positive and we will all persevere together!

Dr. Mok

I have read the above information and I do not have any symptoms of COVID-19 nor have I been in contact with anyone whom I know to have COVID-19. I understand if I have symptoms of have had contact with someone with COVID-19, I will have to delay my appointment by 14 days. I acknowledge that by signing, I agree to properly wear a mask during the examination process. Refusal to wear a mask during the examination process will result in the forfeiture of my appointment.

_____ _____

Signature Date

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Permission to Use and Disclose My Health Information: By signing this form, I give Optic Dimension, Pllc permission to use and/or disclose my health information to provide treatment, obtain payment, and/or conduct health care operations.

Right to Refuse: I have the right not to sign this consent. If I refuse to sign this consent, Optic Dimension, Pllc has the right to refuse to treat me. However, treatment required by law, i.e.emergency services, can be provided to me whether or not I sign this consent.

Right to Review Notice of Privacy Practices: I have been provided with a copy of the Notice of Privacy Practices for Optic Dimension, Pllc which describes how Optic Dimension, Pllc may use and disclose my health information. I have the right to review this Notice before signing this consent.

Changes to the Notice of Privacy Practices: Optic Dimension, Pllc may change the Notice of Privacy Practices as needed. I may obtain a current copy of the Notice of Privacy Practices for Optic Dimension, Pllc by contacting Optic Dimension, Pllc via email.

Right to Request Restrictions on Use/Disclosure: I have the right to request that the usage of my protected health information by Optic Dimension, Pllc be restricted in how it is used and/or disclosed for the purpose of providing treatment, obtaining payment, and/or conducting health care operations.

Right to Withdraw Consent: I have the right to withdraw this consent at any time. I must do so in writing by contacting Optic Dimension, Pllc at 14500 W Colfax Ave #309, Lakewood, CO 80401. My withdrawal of this consent will not be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then Optic Dimension, Pllc may refuse to provide to me further treatment or follow-up, other than required emergency services.

Effective Period: This consent is good unless and until I withdraw it in writing.

References to "I" or "me": References to "I" or "me" in this Consent include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, it is because I am that person's parent, legal guardian, or agent under an active Power of Attorney for Health Care; and I am legally authorized to sign this Consent on behalf of that person.

_____ _____

Signature of patient/parent/guardian Date

_____

Print name of patient or authorized representative and relationship to patient