WELCOME TO DELTAVISION OPTICAL

OFFICES OF DR. GREG POPOWITZ AND DR. ELLEN DOHR

Patient's Last Name: ______________________ First Name: __________________ MI: _____

Date of Birth: ______________ Age: ________ Sex: M F Social Security #: ________________

Street Address: ____________________________ City: ____________ State: ___ Zip Code: _____

Cell #: ____________________ Home #: ____________________ Work #: ____________________

Occupation: ______________________ Employer: ______________________________________

If a minor, who is responsible for patient? ____
Relationship to Patient ____

In accordance with government Electronic Health Record guidelines, it is necessary for us to ask for the following information. Please circle only one choice for each of the following questions:

1) *Preferred Language:* *English* *Spanish*

2) *Race:* *Caucasian* *African American* *Hispanic* *Asian* *American Indian/Alaskan*

   Native Hawaiian/Pacific Islander *Other*

3) *Ethnicity:* *Non-Hispanic/Non-Latino* *Hispanic/Latino* *Native Hawaiian/Pacific Islander*

4) *Communication Preference:* *Email* *Postal* *Telephone*

We are now making greater use of e-mail and text to communicate with our patients. To help us provide the most prompt service possible, please enter your current e-mail address below. Please note: All patient information is kept <u>strictly</u> confidential. Your address and phone number are NEVER shared.

If we have something important to tell you, or we cannot contact you any other way, would you like a text message sent to your cellular phone? No ___ Yes ___ Cell #: ______________________________________

Vision Insurance: ______________________________ ID #: ______________________________

Policy Holder's Name: ___________________________ Policy Holder's Date of Birth: ________________

Policy Holder's Social Security Number: ____

Secondary Vision Insurance: ____

Medical Insurance: ______________________________ ID #: ______________________________

Policy Holder's Name: ___________________________ Policy Holder's Date of Birth: ________________

Primary Care Physician Name/Telephone Number: ____________________________________

How did you discover DeltaVision Optical? ____

Do you currently wear: Glasses Y / N, Contacts Y / N Date of Last Eye Exam: ____________________

HIPAA ACKNOWLEGDEMENT OF RECEIPT OF PRIVACY POLICIES

I acknowledge that I have received/reviewed a copy of DeltaVision Optical's Notice of Privacy Practices. Pursuant to the information and rights presented in the Notice, you may submit your written request to restrict uses and/or disclosures of your protected health information should you choose to do so. I authorize DeltaVision Optical to share all of my protected health and prescription information, unless otherwise noted, with the following individuals for 24 months from the date of this document:

1) ______________________________ 2) ______________________________

Patient/Guardian's Signature______________________________ Date ______________

ABOUT YOUR INSURANCE

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

1. Vision care plans (such as VSP and EyeMed)
2. Medical insurance (such as BlueCross/Blue Shield and Medicare)

- Vision Care plans only cover routine vision exams along with eyeglasses and contact lenses. Vision care plans only cover a basic screening for eye disease. They do not cover the diagnosis, management or treatment of eye diseases.
- Medical insurance must be used if you have any eye health problem or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.
- If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.
- We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pays or non-covered services as determined and allowed by the insurance contract.

STATEMENT OF PROFESSIONAL FEES AND POLICIES

NEW PATIENT COMPREHENSIVE EXAMINATION	$99.00
ESTABLISHED PATIENT COMPREHENSIVE EXAMINATION	$89.00
MEDICAL OFFICE VISITS	$69.00 & UP
CONTINUING CONTACT LENS WEAR EVALUATION (WITHOUT FOLLOWUP)	$39.00
STANDARD SOFT CONTACT FITTING*	$89.00
TORIC SOFT CONTACT FITTING*	$99.00
BIFOCAL SOFT, MONOVISION SOFT or RGP FITTING*	$129.00
MULTIFOCAL and MULTIFOCAL TORIC FITTING*	$149.00
SPECIALTY, KERATOCONUS or MEDICAL CONTACT FITTING	Specialty Pricing

*CONTACT LENS FITTINGS INCLUDE UNLIMITED FOLLOW-UP CARE VISITS FOR 60 DAYS FROM THE EXAM DATE.

- All prescription rechecks for contacts and glasses must be completed within 60 days.
- $69.00 office visit charge will apply if after 60 days.
- A comprehensive examination charge will apply if after 90 days.
- All fees are non-refundable and subject to change.
- All returns are subject to a 20% restocking and shipping fee.
- Medical fees are separate and not part of the comprehensive eye exam. Whenever necessary, your medical insurance will be billed as primary for procedures and testing used to diagnose, monitor and manage ocular health and medical conditions.
- Any services not payable by medical and vision insurance including, but not limited to, deductibles, co-pays, and non-covered options, are the patient's responsibility.
- The release of monocular and binocular pupilary distance measurements, vertex distance, and other specialized measurements required for the individualized customization of prescription eyewear is subject to a fee.

I have read, understand and agree with these policies.
Patient/Guardian's Signature______________________________ Date ______________

Medical Information

Last Name: ______________________________ First Name : ______________________ MI: ______

Reason for today's visit: ____

Are you interested in any of the following: □ Contacts □ Computer Glasses □ Sunglasses
□ Second Pair Eyeglasses Special □ Sports Eyewear □ Corrective Laser Surgery □ Other: ______________

Are you Diabetic? Y / N Date of Diagnosis: ______________ HbA1c: ______________________
Type of diabetes: □ Type I □ Type II □ Due to Underlying Conditions □ Drug/Chemical

Average sugar level: ____________________ Medication Dosage: __________________________

Do you experience any of the following eye symptoms?

Blurred Vision	Y	N	Flashes of Light	Y	N
Burning Eyes	Y	N	Floaters or Spots	Y	N
Computer Eye Strain	Y	N	Halos or Glare	Y	N
Color Vision Difficulties	Y	N	Headache	Y	N
Depth Perception Difficulties	Y	N	Itchy Eyes	Y	N
Discharge from Eyes	Y	N	Light Sensitivity	Y	N
Dizziness	Y	N	Losing Place While Reading	Y	N
Double Vision	Y	N	Night Vision Problems	Y	N
Dry Eyes	Y	N	Problems Viewing 3D Movies	Y	N
Eye Strain	Y	N	Watery Eyes	Y	N

If you work at a computer daily, how many monitors do you work on? ______________________
How many hours are you on a computer or other type of screen daily? ______________________

Medications Currently Taken:
1) ______________________________ 3) ______________________________
2) ______________________________ 4)______________________________

Known Drug Allergies: ____

Have you or a family member experienced or been treated for any of the following medical conditions:

Cataracts	Y	N	Family	High Cholesterol	Y	N	Family
Crossed Eye	Y	N	Family	Lasik/ IOL/PRK	Y	N	Family
Diabetes	Y	N	Family	Lazy Eye	Y	N	Family
Glaucoma	Y	N	Family	Macular Degeneration	Y	N	Family
Heart Disease	Y	N	Family	Retinal Detachment	Y	N	Family
High Blood Pressure	Y	N	Family				

Smoking Status: Non-smoker _____ Former Smoker _____ Smoker _____

Do you have any of the following health conditions:

_____ Allergies	_____ Cancer	_____ Migraines	_____ Skin Disorders
_____ Anxiety	_____ Depression	_____ Multiple Sclerosis	_____ Thyroid Disorder
_____ Arthritis	_____ Emphysema	_____ Prostate	_____ Ulcers/Reflux
_____ Asthma	_____ Hormone Replacement	_____ Seizures	Other ______________
_____ Blood/Lymph Disorder	_____ Kidney Disease	_____ Sinus	

Are you Pregnant? Yes No How many months? ______________________________
Other information we should be aware of: ______________________________________

I understand it is my responsibility to inform DeltaVision Optical of any changes to the above information.

Signature: ____ Date: ________________

Check In Time
Appointment Time

For Office Use Only

NEW / ESTABLISHED

Medical Office Visit

Diabetic

State of MI Employee

Exam - Lens - Frame - Contacts

Name: ______________________________ Date: ______________

Chief Complaint: ______________________________

Primary Medical: ______________________________ Copay: ______________

Secondary Medical: ______________________________ Copay: ______________

Primary Vision: ______________________________ Copay: ______________

Secondary Vision: ______________________________ Copay: ______________

Presenting Spectacle RX
OD:
OS:
Add:

Presenting Contact Lens RX
OD: BC:
OS: BC:
Add:

___92004 Comp Exam New
___ 92014 Comp Exam Est
___ 92002 Interm Exam New
___ 92012 Interm Exam Est
___ 99205 OV Comp New
___ 99204 OV Comp New
___ 99203 OV Detailed New
___ 99202 OV Expand New
___ 99215 OV Comp Est
___ 99214 OV Comp Est
___ 99213 OVExpand Est
___ 99212 OV Focus Est
___ 92225 Extended Ophth/ Dilation

___ 92015 Refraction
___ S0620 Comp Exam New
___ S0621 Comp Exam Est
___ 92310 CL Fit Annual
___ 92310 CL Fit Standard Soft
___ 92310 CL Fit Toric Soft
___ 92310 CL Fit Bifocal Soft
___ 92310 CL Fit Monovision Soft
___ 92310 CL Fit RGP
___ 92310 CL Fit Multifocal
___ 92310 CL Fit Multifocal Toric
___ 92310 CL Fit Specialty
___ 66984 Cataract Comanagement

___ 92083 VF Static Threshold
___ 92082 VF Quantitative
___ 92133 GDX Posterior Seg
___ 92134 GDX Anterior Seg
___ 92135 GDX Screening
___ 92250 Photo Fundus
___ 92285 Photo External Eye
___ 92286 Photo Anterior Seg
___ 65205 Conjunctival FB
___ 67938 Eyelid FB
___ 65222 Corneal FB
___ 92020 Gonioscopy
___ 67820 Epliation/Trichiasis

Additional Testing Ordered: ______________________________

Date to be Performed: ______________ Ordering Doctor: ______________

___ Referral to Specialist ___ Diabetes ___ Hypertension ___ Diabetic Retinopathy

___ PCP Communication ___ High Cholesterol ___ Dilation Performed

_____ Finalized _____ Ordered _____ Recall ___ Billing