EMERALD COAST
EYE CARE

1714 West 23rd Street, Suite K, Panama City, FL 32405
Tel/Text: (850) 215-9101 • Fax: (850) 215-9102
emeraldcoasteyecare@gmail.com

In an attempt to keep our patients and staff safe and healthy, we have instituted some new office procedures, which are listed below. As always, if you have questions or need assistance, please do not hesitate to call our office. A few things that COVID has not changed are our appreciation for our patients and our commitment to service and care.

- If you or anyone in your home has been sick within the past 14 days, we will have to reschedule your appointment.

- We are limiting the number of people in the office at one time. No one will be able to accompany you into the office for you appointment. Exceptions include patients who are under the age of 13, and patients needing assistance.

- For the safety of our patients and employees, we will need you to wear a mask during your exam. Please bring a mask with you to your appointment.

If you have any questions, Please call our office and we will be happy to assist you.

We look forward to seeing you soon.
Thank you,
Emerald Coast Eye Care Staff

By signing this document, I agree to Emerald Coast Eye Care's COVID procedure, Billing policy (separate document), and HIPAA privacy policy (separate document).

_____ _____

Patient Signature Date

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Patient Information

Dr./Mr./Mrs./Ms. Last Name _____First Name_____ MI_____ Date_____

Date of Birth _____SSN _____ Sex M or F

Mailing Address:
Street _____City _____ST_____ ZIP_____

Home #_____Work #_____Cell #_____Other_____

Email _____

Please rank (1-4) the best method of contacting you:
( ) Text sent to cell phone ( ) Call Cell Phone ( ) Call Home Phone ( ) E-Mail

How did you hear about our office?_____

Employer _____Occupation _____

Insurance Information (MUST BE COMPLETED BEFORE BEING SEEN BY DOCTOR)

Vision Insurance _____ID:_____ Group# _____
Subscriber Name_____ SSN#_____D.O.B._____( ) self
Medical Insurance _____ID:_____ Group# _____
Subscriber Name_____ SSN#_____D.O.B._____( ) self
Secondary Insurance _____ID:_____ Group# _____
Subscriber Name_____ SSN#_____D.O.B._____( ) self

How are you planning on settling you account today( ) Cash ( ) Credit Card ( ) Check

***** Please note that Contact lens evaluation/ Fitting fees may not be covered by your insurance*****
If we are filing medical insurance for your exam, there is a $30 refraction fee in addition to your medical co-pay.

Medical Release information

I _____, give authorization for Emerald Coast Eye Care to discuss my medical and billing information with the following people.

Name _____Relationship_____
Name _____Relationship_____

********Important please review and sign********

Please be advised,vision insurance covers a ROUTINE vision exam only. If there is a medical condition or complaint that requires any additional treatment, testing and/or follow up, we may be required to bill to your medical insurance. Also, if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not Emerald Coast Eye Care. If your insurance company has not reimbursed our office in full by 90 days, you are responsible for providing payment in full to Emerald Coast Eye Care.

I have read, and agree to comply with Emerald Coast Eye Care's billing policy. I also certify that the information given is true and I accept responsibility for payment unless otherwise noted. I acknowledge that Emerald Coast Eye Care has informed me they are compliant with HIPAA and has offered me a copy of their Notice of Privacy Practice.

Signature _____Date _____

Vision and Medical History

Information in this confidential case history form is critical to the evaluation of you vision and health.

Primary Care Doctor _____ Address_____

Last eye exam? Date _____By Whom _____

Current Medications: (Please include Rx, Eye Drops, Over the Counter , Vitamins, &Birth Control)_____

_____

_____

_____

Drug Allergies:_____

If we were to Rx a medication for you today, where would you like it sent?

Pharmacy _____ Location _____

Eye Health : *Please check if you currently have or have had any of the following*

Are you interested in ( ) Glasses ( ) Contacts ( ) Vision Corrective surgery

( ) Are you having problems with current glasses or contacts? Explain._____

_____

How old is your current pair of glasses? _____

( ) Do you currently wear Contacts? Brand _____ Type of solution? _____

Contact lens Rx (if known)? Right eye _____ Left Eye _____

How often are you getting a new pair of contact Lens? _____Do you Sleep in contacts ( ) Yes ( ) No

( ) Do you work on a computer? Hrs _____a day ( ) do you spend time outdoors? Hrs _____a day

( ) Have you had eye surgery? Type _____when _____ Dr._____

What is one thing you would change about your current glasses or contact lenses?

_____

_____

Name:_____DOB:_____Date:_____

Are you currently experiencing or being treated for any of the symptoms / conditions below:

( ) Blurred Vision
( ) Burning
( ) Cataract
( ) Dry eyes
( ) Discharge from eyes
( ) Double vision
( ) Eyestrain
( ) Flashes of light
( ) Floaters
( ) Glare
( ) Headaches with phone or computer use
( ) Itching
( ) Light sensitivity
( ) Redness
( ) Watering

( ) Fever
( ) Weight Loss
( ) Fatigue
( ) Environmental Allergies
( ) Cough
( ) Runny Nose
( ) High Blood Pressure
Last BP reading?
_____
( ) Vascular Disease
( ) Stroke
( ) Asthma
( ) Chronic Bronchitis
( ) COPD
( ) Kidney Stones
( ) Frequent Urination
( ) Kidney Disease
( ) Osteoarthritis
( ) Fibromyalgia
( ) Ankylosing Spondylitis

( ) Currently pregnant
( ) Eczema
( ) Rosacea
( ) Psoriasis
( ) Chronic Headaches
( ) Migraines
( ) Seizures
( ) Parkinson's disease
( ) Multiple Sclerosis
( ) Alzheimer's disease
( ) Depression
( ) Anxiety
( ) Thyroid disease
( ) Non-Insulin dep. Diabetes
( ) Insulin dep. Diabetes
Diabetic for how long? _____
Last A1C? _____
Last BS reading? _____
( ) Anemia
( ) High Cholesterol
( ) Rheumatoid Arthritis
( ) HIV or AIDS
( ) Lupus
( ) Gastric Ulcer
( ) HSV
Height: _____
Weight: _____
( ) Current Smoker
#_____ per day
( ) Consume Alcohol
#_____ per week
Race: _____
Ethnicity: _____
Primary Care Doctor: _____
_____

If any blood relatives have had the following conditions, please mark below.

(Ex. B = Brother, S = Sister, F = Father, M = Mother, GP = Grandparent)

Glaucoma:
_____

Macular Degeneration:
_____

Cataracts:
_____

Retinal Detachment:
_____

Color Blindness:
_____

Diabetes:
_____

High Blood Pressure:
_____

High Cholesterol:
_____

Cancer:
_____

Autoimmune Disease:
_____

Thyroid Disease:
_____

Q & A with Dr. Patterson

Q: What is an Optomap?

A: The Optomap is a panoramic digital image of the retina. It helps me to detect certain conditions more quickly and easily, and it can be saved in your records for future comparisons to monitor eye health.

Q: Does the Optomap replace dilation?

A: If you are an established patient with no history of retinal pathology, you can get an Optomap and not be dilated (unless I see something during the exam that deems dilation necessary). If you are a new patient, I will still need to perform a dilated exam to establish a baseline of what I see in the back of your eyes.

Q: Do I have to pay for the Optomap?

A: Yes, there is a fee to have an Optomap. **$35** is charged for a routine screening photo. If retinal pathology (macular degeneration, etc.) or systemic conditions (diabetes, etc.) are being tracked, then the photos are accompanied by an interpretation and report that is billed to medical insurance. The fee is then determined by your insurance usual and customary allowable.

Q: What is dilation and why is it so important?

A: Dilation is essential for detecting and treating retinal conditions. It is a vital part of a thorough eye exam. Yes, I know it seems like a hassle, but it gives me a much better look inside your eye. It is especially important if you are having eye pain or vision problems, or if you have, or are predisposed to, certain eye diseases.

Normally, your pupil gets smaller when light shines into it. When I use special dilating eye drops in your eyes, it forces your pupil to stay open so I can see much more of the back of your eye. Dilating helps me to see your entire retina, the part of the retina called the macula, and your optic nerve. During a dilated exam, I can also spot problems like a torn or detached retina or an eye tumor. I use a dilated exam to help me diagnose and monitor common eye diseases that can take away your sight such as diabetic retinopathy, glaucoma and age-related macular degeneration.

OPTOMAP Retinal Screening

I _____, understand the benefits of the annual **Optomap**
(Patient's Name Printed)

Retinal Screening as:

- Fast, easy, and comfortable
- A permanent record to compare and track potential eye diseases
- An in-depth view of nearly the entire retina
- Educational tool for your Doctor to discuss your health and wellness

___ I choose the **Optomap** Retinal Screening and understand that the $35.00 screening is not covered by my insurance

___ I decline the **Optomap** Retinal Screening. I understand that a wide field view of the retina is an important part of a comprehensive eye exam and I am declining the Doctor's recommendation to obtain a comprehensive view of my retina.

Patient's Signature _____

Date_____

Doctor's Signature_____ Date_____

Contact Lens Informed Consent & Compliance Agreement

Risks of Contact Lens Wear: The use of contact lenses is not without risk. A small, but significant, percentage of individuals wearing contact lenses develop potentially serious complications which can lead to permanent eye damage and vision loss. Specifically, extended wear contact lenses pose the risk of complication 5 to 15 times greater than that of daily wear. Presbyopic contact lens corrections (monovision or bifocal contact lenses) can create vision compromises that may reduce visual acuity and depth perception for distance and near tasks. For extended wear patients, extra care is necessary to help prevent eye-health complications and for presbyopic patients, supplemental or alternative vision correction during hazardous activities is advised.

Remove your lenses IMMEDIATELY, if you:

- ♦ Develop unusual pain
- ♦ Experience stinging or redness
- ♦ Have unusually foggy or blurred vision that does not clear
- ♦ Have any discharge or unusual light sensitivity

When in doubt, take them out and call our office, or go to your local emergency hospital.

Contact Lens Exam Fees-This is required in order to receive a prescription for contacts

Level 1 Fitting Fee: $75 New and Established patients. Spherical Lens only when corneal health is stable.

Level 2 Fitting Fee: $95-115 New and Established patients (based on prescription and complexity of fitting) New contact lens wearers, Astigmatism correction contacts, Mono Vision contacts, Multi Focal contacts, RGP, and patients whose eye health is not stable

Level 3 Evaluation Fee: $55 Established patients only when there is little or no change with current prescription prescribed by this office within a reasonable time from your last exam AND corneal health is stable.

The Fitting fee includes all follow-up visits pertaining to contacts during the first 45 days. All follow up appointments must take place within 45 days of original fitting to receive a contact lens prescription. Failure to complete your fit during the allotted time will result in additional fitting fees and/or another exam.

____ **YES**…I would like to be evaluated for contacts today. I understand the fitting fee is required and is a separate service from the comprehensive eye exam.

____ **NO**….I would NOT like to be evaluated for contacts today. I understand that I will not be able to purchase contacts or receive a contact lens prescription. I understand I will only have 90 days after my exam to return to the office for a contact lens fitting. After 90 days, I will require and be billed for a new comprehensive exam.

Compliance Agreement

Emerald Coast Eye Care reserves the right to terminate the agreement upon non-compliance of prescribed wearing times or follow-up visits. This Contact Lens Compliance Agreement expires 45 days after the date of your appointment. A written copy of your contact lens prescription will be provided to you upon completion of the contact lens medical management services.

By signing below, I acknowledge that I have read, understand, and have received a copy of this agreement. I am aware of the potential risks, side effects and adverse reactions due to contact lens wear. I agree to wear my contacts no longer than prescribed by the doctor, agree to properly care for my contact lenses as instructed and agree to return for recommended follow-up visits. I understand that I will be given the opportunity to ask the Doctor questions during my appointment. I agree to the current fees and policies of this Contact Len Compliance Agreement and my responsibilities as a contact lens wearer.

Patient Name: _____ **Patient Signature**: _____ **Date**: _____