PRESTIGE LASER & CATARACT
INSTITUTE

CONSENT FOR TREATMENT, PAYMENT, AND/OR HEALTHCARE OPERATIONS

The undersigned acknowledges and permits Prestige Laser & Cataract Institute to use and disclose personal health information to carry out treatment, payment, and/or health care operations. Further, the undersigned acknowledges receipt of Prestige Laser and Cataract Institute's Notice of Privacy Practices which details permitted uses and disclosures of information.

The undersigned understands that the Notice of Privacy Practices may, from time to time, be amended or changed. Patients (individuals) will be notified of any changes that might affect them prior to application of those changes to use of their personal health information. Notice will be provided to them, in person, at our offices or delivered to them by mail if requested by the patient.

Patients (individuals) have the right to request that PLCI restrict how his or her personal health information is used or disclosed to carry out treatment, payment, and/or healthcare operations. PLCI is not required to agree with such a request, but if PLCI agrees to the request, PLCI will be bound by that request.

Patients (individuals) have the right to revoke consent by writing to the Privacy Officer at PLCI. If PLCI has already used or disclosed information in reliance on the consent, such as revocation will have effect only on future use or disclosure–after it has been received by the Privacy Officer at PLCI.

_____ _____

Patient Signature Date

_____ _____

Signature of Authorized Representative Relationship

Patient Information

PRESTIGE LASER & CATARACT
INSTITUTE

Who is your Optometrist? _____

Who is your Primary Care Provider? _____

PATIENT INFORMATION

Name _____ Social Security # _____
Last First M.I.

Address _____
Street Apt # City State Zip

DOB _____ Age _____ Sex _____ Email _____ Marital Status _____

Phone (____) _____ (____) _____ (____) _____
Home Work Cell

Employer _____
Name Occupation

Address _____
Street Suite # City State Zip

SPOUSE OR PARENT OR EMERGENCY CONTACT INFORMATION

Name _____ Social Security # _____
Last First M.I.

Address _____
Street Apt # City State Zip

DOB _____ Relationship to Patient _____

Phone (____) _____ (____) _____ (____) _____
Home Work Cell

Employer _____
Name Occupation

Address _____
Street Suite # City State Zip

PRIMARY INSURANCE INFORMATION

Primary Insurance Company _____ Policy # _____ Group # _____
Name

Name of Insured _____ Relationship to Patient _____
Last First M.I.

DOB of Insured _____ Phone # of Insured (____) _____ Social Security # of Insured _____

Employer _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company _____ Policy # _____ Group # _____
Name

Name of Insured _____ Relationship to Patient _____
Last First M.I.

DOB of Insured _____ Phone # of Insured (____) _____ Social Security # of Insured _____

Employer _____

PRESTIGE LASER & CATARACT
INSTITUTE

Please help us to get to know you better

Patient Name _____ DOB _____ Date _____

What brings you to our office today? _____

_____

_____

PLEASE CHECK THE CONDITIONS THAT YOU EXPERIENCE

EYE PROBLEMS	*LEFT EYE*	*RIGHT EYE*	*HOW LONG?*	*OTHER PROBLEMS*	
REDNESS	☐	☐	_____	SINUS CONGESTION	☐
DRY EYE FEELING	☐	☐	_____	NASAL CONGESTION	☐
MUCOUS DISCHARGE	☐	☐	_____	POST-NASAL DRIP	☐
SANDY OR GRITTY FEELING	☐	☐	_____	CHRONIC COUGH	☐
ITCHING	☐	☐	_____	BRONCHITIS	☐
BURNING	☐	☐	_____	ASTHMA SYMPTOMS	☐
FOREIGN BODY SENSATION	☐	☐	_____	ALLERGY SYMPTOMS	☐
CONSTANT TEARING	☐	☐	_____	SEASONAL ALLERGY	☐
OCCASIONAL TEARING	☐	☐	_____	HAY FEVER	☐
WATERY EYES	☐	☐	_____	COLD SYMPTOMS	☐
LIGHT SENSITIVITY	☐	☐	_____	EAR CONGESTION	☐
EYE PAIN OR SORENESS	☐	☐	_____	SNEEZING	☐
CHRONIC EYE INFECTIONS	☐	☐	_____	DRY THROAT/MOUTH	☐
STIES OR CHALAZION	☐	☐	_____	HEADACHES	☐
FLUCTUATING VISION	☐	☐	_____	ARTHRITIS	☐
"TIRED EYES"	☐	☐	_____	JOINT PAIN	☐

PAST EYE/MEDICAL HISTORY	*YES*	*NO*	*IF YES, PLEASE GIVE DETAILS BELOW*
DO YOU USE LUBRICATING EYE DROPS?	☐	☐	WHAT BRAND? _____
DO YOU WEAR GLASSES?	☐	☐	FOR NEAR? _____ FOR FAR? _____
HAVE YOU EVER HAD AN EYE INJURY?	☐	☐	DESCRIBE: _____
HAVE YOU EVER HAD AN EYE SURGERY?	☐	☐	DESCRIBE: _____
DO YOU USE CONTACT LENSES?	☐	☐	ARE THEY COMFORTABLE _____
ARE YOU ALLERGIC TO ANYTHING?	☐	☐	PLEASE LIST: _____

ARE YOU SENSITIVE TO? (PLEASE CIRCLE ALL THAT APPLY):

HEATERS, BLOWERS, AIR CONDITIONING, CIGARETTE SMOKE, SMOG, DUST, POLLEN, WIND,
VIDEO DISPLAY TERMINALS, SUNSHINE, CONTACT LENSES, OR SOLUTIONS, EYE DROPS

PRESTIGE LASER & CATARACT
INSTITUTE

HIPAA GENERAL PURPOSE AUTHORIZATION
NOTICE OF PRIVACY PRACTICES

The undersigned acknowledges receipt of Prestige Laser and Cataract Institute's Notice of Privacy Practices and authorizes the use and disclosure of the following personal health information: Medical, Billing, and Personal Identifying Information (UNLESS CROSSED OUT) to the following: Health Care Providers and Health Benefits–Insurance–Payment Entities (UNLESS CROSSED OUT) by PLCI. This authorization is valid indefinitely (UNLESS AN EXPIRATION DATE IS FILLED IN HERE) _____.

The undersigned has a right to revoke this authorization by writing to the Privacy Officer at PLCI. Information used or disclosed prior to a revocation of this authorization is not subject to the revocation. Such a revocation will be honored by PLCI, unless precluded by law, only after a written request has been received by the Privacy Officer at PLCI.

A potential patient has the right to refuse to sign this authorization and no treatment, payment, and/or healthcare operations will be conditioned upon obtaining this authorization or the use of personal identifying information. However, under HIPAA, PLCI is not required to establish a patient-physician relationship or provide care to an individual who refuses to sign this authorization. (If you desire not to sign this form, speak to the front desk receptionist now to determine whether one of our doctors will agree to see you without your authorization to use your personal identifying information.)

_____ _____

Patient Signature Date

_____ _____

Signature of Authorized Representative Authority to Act for Patient

PRESTIGE LASER & CATARACT
INSTITUTE

REFRACTION POLICY

What is a refraction? Refraction is the process of determining the eye's refractive error, or need for corrective glasses and/or contact lenses. A refraction is sometimes necessary depending on the patient's diagnosis and/or complaints presented that day. For example, if a patient is experiencing blurred vision and/or a decrease in visual acuity on the eye chart a refraction would be necessary to see if this is due to a need for glasses or due to a medical problem. A refraction is also necessary to prove to insurance the need for cataract surgery. We must prove that your vision cannot be simply improved with a glasses prescription. As you can see a refraction is an essential part of an eye exam, however, Medicare and most insurances DO NOT cover it.

You will be notified in advance by the technician or doctor if this procedure is necessary. They will let you know if this procedure is necessary BEFORE it's done. You will be given the option to accept or decline this service.

Our office policy is to charge $50 for a refraction in addition to the office visit co-pay and/or deductible. This is due at the time services are rendered. If you decide to be billed for this fee an addtional $25 charge will be added.

Note: This fee is due and payable even if you do not receive a written glasses prescription. Sometimes the change is not significant enough to warrant the cost of purchasing new glasses and a new prescription will not be given. However, the fee covers the technician's time and effort in completing this process. You always have the option to use your vision benefits with your optometrist.

By signing below I acknowledge that I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The co-pay and deductible are seperate from, and not included in, the refraction fee

_____ _____

Patient Signature Date

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VISUAL FUNCTION QUESTIONNAIRE

Do you have difficulty with any of the following activities? *(circle one)*

SEEING STREET SIGNS OR DRIVING (curbs, freeway exits, traffic lights, halos/glare around lights)	YES	NO
SEEING TV OR MOVIES (faces)	YES	NO
READING SMALL PRINT WITH GOOD LIGHT AND PROPER GLASSES (books, newspapers, telephone book, medicine labels, instructions	YES	NO
PERFORMING HANDIWORK (sewing, knitting, crocheting, embroidering)	YES	NO
COMPLETING PERSONAL CORRESPONDENCE (writing checks, reading bills, filling out forms)	YES	NO
PARTICIPATING IN LEISURE ACTIVITIES (playing cards, bingo, dominos, sports activities such as bowling, hunting, golf)	YES	NO
NAVIGATING AROUND THE HOUSE (cooking, ironing, climbing steps, dialing telephone, telling time)	YES	NO
SEEING/RECOGNIZING FACES OF PEOPLE (in church, grocery store)	YES	NO
CARING FOR YOURSELF WITH YOUR PRESENT VISION	YES	NO

Do you have any of the following visual symptoms?

DOUBLE OR DISTORTED VISION	YES	NO
GLARE, HALOS, OR RINGS AROUND LIGHTS	YES	NO
DIFFICULTY WITH COLOR PERCEPTION	YES	NO
DIFFICULTY WITH DEPTH PERCEPTION	YES	NO
WORSENING OF VISION OR BLURRED VISION	YES	NO

Patient Signature _____ Date _____