

Screening Retinal Photography



We are pleased to offer our patients a powerful tool to enhance the comprehensive eye exam at Avalon Park Eye Care. Through the use of our Nidek AFC camera, we are able to photograph the inside of your eye, and in most cases without any dilation. This allows the doctor a clear, magnified view of the most critical structures inside your eye. This screening image is highly recommended by the doctor for everyone, especially those with systemic conditions such as diabetes and high blood pressure.

Does it hurt? This camera is designed for your comfort. It is no different than someone taking a picture of you and using a flash.

Does it replace a dilated exam? While this provides a view of the optic nerve, macula, and blood vessels, it does not provide a view of the peripheral retina. It is important that your eyes be dilated so the doctor can have a complete view of your eye.

If my eyes are healthy, why would I need this? If your eyes are healthy, this will serve as a baseline image. Should something appear to change a few years down the road, we will be able to reference back and see what your eye originally looked like.

How long does it take? In most cases, less than a minute.

Name (First Name, Middle Initial, Last)		Address	
Nickname		City, State	
Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male	Zip Code	
Date of Birth		Preferred Contact Phone Number	<input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Cell Phone
Employment Status	<input type="checkbox"/> Employed Full-time <input type="checkbox"/> Employed Part-time <input type="checkbox"/> Not Employed <input type="checkbox"/> Full-time Student <input type="checkbox"/> Part-time Student <input type="checkbox"/> Retired		
Occupation		Hobbies	
Parent/Guardian (if under 18)		How did you hear about us?	

Are you the primary for your VISION insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No (Please put primary's information to the right) Pt's relationship to primary? _____	Name: _____ Date of birth: _____
Are you the primary for you MEDICAL insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No, but same primary as for VISION <input type="checkbox"/> No (Please put primary's information to the right) Pt's relationship to primary? _____	Name: _____ Date of birth: _____

FINANCIAL RESPONSIBILITY

We will be happy to file the insurance claim forms for the medical/vision plan(s) which you state you are a member. If your plan determines that you are not eligible for coverage, have not met your deductible, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement, you hereby agree to be **financially responsible for any and all charges incurred by you and not paid by the plan**. If an overpayment has been determined by your plan, you will be refunded (amounts less than \$10 will be credited to your account unless a refund is requested).

SIGNATURE:	DATE:
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, the patient, have received a copy of this office's Notice of Privacy Practices for review.

SIGNATURE:	DATE:
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COMMUNICATION CONSENT

If you would like to authorize us to discuss your medical information with anyone (spouse, family members, etc...) please list their full names to the right

Name: _____

Name: _____

SIGNATURE:	DATE:
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DILATION AND ACKNOWLEDGEMENT

To effectively provide you with a complete and thorough eye examination, **we feel it is extremely important to dilate the pupils of your eyes**. It allows the doctor to detect many eye diseases. This will require placing drops in your eyes, followed by a waiting period of 10-20 minutes. Side effects of pupil dilation include sensitivity to light and blurred reading vision (in most cases distance vision is unaffected). Driving may be difficult and should be done with caution. The side effects last 4-6 hours and in some cases may last as long as 24 hours (the doctor will indicate when this may take place). Please let the doctor know if you are pregnant or nursing prior to being dilated.

- I wish to be dilated today
- I do not wish to be dilated at this time, but will return within 3 months for my dilated exam (there is no additional charge when you return for routine dilation).*
- I do not wish to be dilated

SIGNATURE:	DATE:
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SCREENING RETINAL PHOTOGRAPHY (OPTIONAL)

I have received information regarding the importance and advantages of retinal photography. I understand that this is recommended by the doctor for the long term care of my eyes. Furthermore, I understand that because this is above and beyond the standard of care, **there will be a charge of \$20.00, which my insurance company will not cover & this expense will be out of pocket.**

- I agree
- I decline

SIGNATURE:	DATE:
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Current Allergies	Check severity of allergy			Ocular History	<input type="checkbox"/> Pregnant/Nursing <input type="checkbox"/> Wears glasses <input type="checkbox"/> Wears contacts <input type="checkbox"/> Soft <input type="checkbox"/> Hard <input type="checkbox"/> They are Comfortable
	Mild	Moderate	Severe		
<input type="checkbox"/> No known allergies					

Current Medications (please include dosage) <input type="checkbox"/> None	Injuries/Surgeries <input type="checkbox"/> None
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Primary Care Provider	Last Eye Care Provider	Referring Physician
Name		
Phone		

If you do not wear contact lenses, are you interested in trying them? Yes No

If you wear contact lenses,

<ul style="list-style-type: none"> How often do you dispose of your contact lenses? How often do you sleep in your contact lenses? What type of solution do you use? 	<ul style="list-style-type: none"> Current contact lenses <ul style="list-style-type: none"> Brand: Base curve: Power right eye: Power left eye:
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FAMILY HISTORY

Check the condition that apply, and list the relation to yourself (i.e., father, sister, maternal grandmother, etc.)

<input type="checkbox"/> Blindness	
<input type="checkbox"/> Cataracts	
<input type="checkbox"/> Macular Degeneration	
<input type="checkbox"/> Glaucoma	
<input type="checkbox"/> Retinal Detachment	
<input type="checkbox"/> Crossed Eyes	
<input type="checkbox"/> Lupus	
<input type="checkbox"/> Cancer	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart Disease	
<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Thyroid Disease	
Other	

PATIENT HISTORY

Eyes <input type="checkbox"/> (Complete/ Permanent) Vision Loss <input type="checkbox"/> Blurry Vision <input type="checkbox"/> Distorted Vision <input type="checkbox"/> Double Vision <input type="checkbox"/> Dryness <input type="checkbox"/> Redness <input type="checkbox"/> Mucous Discharge <input type="checkbox"/> Gritty Feeling <input type="checkbox"/> Itching <input type="checkbox"/> Burning <input type="checkbox"/> Excess Watering <input type="checkbox"/> Light sensitivity <input type="checkbox"/> Eye Pain/ Soreness <input type="checkbox"/> Chronic Infection <input type="checkbox"/> Sties <input type="checkbox"/> Flashes <input type="checkbox"/> Floating Spots <input type="checkbox"/> Tired Eyes <input type="checkbox"/> Cataracts <input type="checkbox"/> Diabetic Retinopathy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Retinal Detachment	Gastrointestinal <input type="checkbox"/> Colitis <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Ulcers <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea Constitutional <input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss/Gain <input type="checkbox"/> Fatigue <input type="checkbox"/> Trauma Integumentary (Skin) <input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea <input type="checkbox"/> Psoriasis Neurologic <input type="checkbox"/> Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Seizures <input type="checkbox"/> Mult. Sclerosis Endocrine <input type="checkbox"/> Non Insul. Diabetes <input type="checkbox"/> Insul. Diabetes <input type="checkbox"/> Thyroid Dysfunction <input type="checkbox"/> Hormonal Dysfunction Respiratory <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema	Cardiovascular <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hypercholesterolemia <input type="checkbox"/> Hypertension Ear/Nose/Throat <input type="checkbox"/> Allergies <input type="checkbox"/> Sinus Congestion <input type="checkbox"/> Runny Nose <input type="checkbox"/> Post Nasal Drip <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Dry Throat/ Mouth Allergic/Immune <input type="checkbox"/> Drug Allergies <input type="checkbox"/> Seasonal Allergies <input type="checkbox"/> Lupus <input type="checkbox"/> Arthritis Lymphatic/ Hematologic <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding Problems <input type="checkbox"/> Leukemia Musculoskeletal <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Musc Dystro <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Ankylosing Spond. Genitourinary <input type="checkbox"/> Kidney Problems <input type="checkbox"/> Bladder Problems <input type="checkbox"/> STDs
Other		

PATIENT SOCIAL HISTORY

<input type="checkbox"/> Doesn't Drive	<input type="checkbox"/> Drives
Explain driving difficulties:	
<input type="checkbox"/> Doesn't Use Tobacco	<input type="checkbox"/> Uses Tobacco
Type/AMT/How Long:	
<input type="checkbox"/> Doesn't Drink Alcohol	<input type="checkbox"/> Drinks Alcohol
Type/AMT/How Long:	
<input type="checkbox"/> No Use of Illegal Drugs	<input type="checkbox"/> Uses Illegal Drugs
Type/AMT/How Long:	
Have you ever been exposed to or infected with:	
<input type="checkbox"/> Gonorrhea <input type="checkbox"/> Hepatitis <input type="checkbox"/> Syphilis <input type="checkbox"/> HIV	

Avalon Park Eye Care
12001 Avalon Lake Dr. Ste. J
Orlando, FL. 32828
Notice of Privacy Practices
Contact Person: Kenneth Tesinsky

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please read it carefully. The privacy of your health information is important to us.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We will use and communicate your health information only for the purpose of providing your treatment, obtaining payments and conducting health care operations.

USES AND DISCLOSURES OF HEALTHCARE INFORMATION

To Provide Treatment: We will use and disclose your health information within our office to provide you with the best health care possible. This may include business office staff, assistants, opticians, physician assistants, nurses, and physicians. In addition, we may share your health information with referring physicians, laboratories, pharmacies, and other health care personnel providing you treatment, including contact lens and frame companies.

To Obtain Payment: We may use and disclose your health information to obtain payment for services, materials, and treatment you received in our office. We may do this with insurance forms filed for you by mail or send electronically.

Health care Operations: Your health information may be used during performance evaluation of our staff, training programs for students, interns, associates, and business and/or clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing or credentialing activities.

Appointment Reminders: Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time to contact us for an appointment. Additionally, we may contact you for follow up on your care and inform you of treatment options or services that may interest you or a family member. These may include postcards, folding cards, letters, telephone, voice mail, or email.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we believe a patient is a victim of abuse, neglect or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Public Health and National Security: We may disclose to Federal Officials or military authorities your health information required for lawful intelligence, counterintelligence, and other national security activities.

Law Enforcement: As permitted or required by State or Federal Law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends, and Caregivers: We may disclose your health information to a family member, friends, care giver, or other person who you tell us will be helping you with your home hygiene, treatment, medications, or payment. In case of an emergency, where you are unable to tell us what you want we will use our very professional judgment when sharing your health information. We will also use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, materials, or other similar forms of health information.

To Coroners, Funeral Directors, and Medical Examiners: We may be required by law to provide information about your health to coroners, funeral directors, and medical examiners for the purpose of determining a cause of death and preparing for a funeral. **Required by Law:** We may use or disclose your health information when we are required to do so by law.

Your Authorization: Other than stated above or where Federal, State or Local Law requires us, we will not disclose your health information without your written authorization. You may revoke your authorization in writing at any time. Your revocation will not effect any use of disclosures permitted by your authorization while it was in effect.

PATIENT RIGHTS:

Access: You have the right to look or get copies of your health information, with limited exceptions (you must make a request in writing to obtain access to your health information). If you request copies, we will charge you a fee for each page, and per hour for staff time to locate, duplicate and assemble your copy, and postage if you request the copies to be mailed to you.

Documentation of Health Information: You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health care operations and certain other activities. Our documentation procedures will enable us to provide information from April 14, 2002 and forward. Please let us know in writing the time period for which you are interested. Your request must be limited to no more than six years at a time. We may charge you a reasonable fee for your request.

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative location. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location. We will make every effort to honor your reasonable request for confidential communications.

Amendments: You have the right to ask us to amend your health information. In order to standardize our process, please submit your request in writing and describe the reason for the change. Your request may be denied under certain circumstances.

Request a Paper Copy of this Notice: You have the right to obtain a copy of this Notice of Privacy Practices from our office at any time.

Complaints: If you think that we have not properly respected the Privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office of Civil Rights. We support your right to the privacy of your health information. If you want more information please contact our office.