Welcome to Cascade Family Eye Care

Patient Name _____ Date of Birth_____
Home Address _____
If patient is a minor, Name of Parent/Guardian_____
Home Phone_____ Cell Phone_____
E-mail address _____(we won't release this to vendors/advertisers)

Do you have **Eye/Vision Care Insurance**? Yes_____ No_____
If "Yes," name of Primary Plan _____ Subscriber Name _____

Secondary Eye/Vision Insurance_____ Subscriber Name _____

Name of **Major Medical/Health Insurance Plan**_____
Subscriber Name (if other than patient) _____

Keeping an accurate record of a person's retina (the lining of the inside of the eye) is very helpful in monitoring your eye health. In our office we have the technology to take a high resolution digital photo of a patient's central retina which is much more accurate than the conventional drawing/verbal description most doctors make.

As many insurance companies do not cover the extra charge unless there is a specific medical diagnosis, we offer this service for a discounted fee of $34 paid at the time of service. These baseline photos are not necessary at every visit, but we may recommend having them updated at some point if indicated. For patients with diabetes, however, the standard of practice is to take retinal photos at least once per year.

Please initial
_____ **Yes**, I would like to have retinal photos taken.
_____ **No**, I do not wish to have retinal photos taken.

We request payment in full for services at the time they are provided, except for amounts billed to your insurance carrier(s). We are happy to bill your insurance company for you, but insurance quotes are not a guarantee of payment and you will be responsible for any allowable charges your insurance does not cover. For material such as frames and lenses, we request at least 50% as a down payment before placing an order. We accept cash/checks and credit cards (Visa, MasterCard, Discover, and American Express) for payment. There is a $25 charge for NSF checks.

For those wearing contact lenses, it is our office policy to provide a 6 month window from the time of your comprehensive eye exam to schedule and be seen for a contact lens evaluation. After that 6 month period, we require a full eye exam as your vision can change. It is your responsibility as the patient to call and finalize your contact lens prescription or come back in for any contact lens follow ups that have been scheduled. Insurance plans typically will cover up to 3 follow up visits within a 90 day global period from the date of your contact lens examination.

Please note that anyone missing/rescheduling an appointment for a complete eye exam without providing our office with at least 24 hours advanced notice will be subject to a $40 charge.

Signed _____ Date _____
Please circle one: I'm the patient/ I'm parent/guardian
For subsequent visits:
Reviewed by_____ ___ No Changes Date _____
Reviewed by _____ ___ No Changes Date _____
Reviewed by _____ ___ No Changes Date _____
Reviewed by _____ ___ No Changes Date _____
Reviewed by _____ ___ No Changes Date _____

INFORMED CONSENT OR REFUSAL FOR A DILATED FUNDUS EXAM

In order to provide the most comprehensive exam possible we request that all of our patients have a dilated eye exam. At least 60% of the retina cannot be viewed without dilation. The purpose is to enlarge the pupils to enhance the detection of any ocular diseases such as cataracts, glaucoma, retinal disease, malignant growth, and retinal detachment; all of which can lead to vision loss. In addition, some systemic conditions such as diabetes and hypertension can cause changes in the health of the eye and can be detected by dilation.

Possible side effects (**these side effects typically do not last longer than 4-6 hours**):

- Inability to focus at near
- Sensitivity to light
- Blurry distance vision for some patients
- Mild burning upon instillation
- Induced ocular hypertension: RARE cases have been reported in which redness and sharp pain is experienced because of increased eye pressure. If this happens, contact the doctor immediately.

Please Check One Box:

☐I understand the above and consent to have dilation done.

☐ I understand the above and decline dilation at this time. I understand that potential for partial or total loss of vision may exist and, without dilation, may go undetected.

Signature:_____ **Date**:_____

Medical History/ Social History

Are you Pregnant or Nursing? ☐Yes☐No **Are you Diabetic?** ☐Yes☐No **Have you had refractive surgery?** ☐Yes☐No

Are you Allergic to any medications ☐Yes ☐No, **if yes, explain**_____

List Current Medications:_____

List major injuries/surgeries/hospitalzations:_____

List any Eye Surgeries:_____

Last Eye Exam:_____ **Last Medical Exam**:_____

Do you wear glasses ☐Yes ☐No **Do you wear contact lenses** ☐Yes ☐No **If yes, what type:** ☐Soft ☐Rigid

Your contact lens brand/RX_____**Would you like to be fitted for contacts today** ☐Yes ☐No

Do you use tobacco products? ☐Yes☐No **If yes, type/amount/how long**_____ **Have you been exposed or infected with:**

Do you drink alcohol? ☐Yes☐No **If yes, type/amount/how long**_____ ☐***Gonorrhea*☐***Hepatitis***☐***HIV***☐***Syphilis***

Family History:

Ocular/Systemic Conditions	Family Member Affected (Maternal/Paternal)
☐Blindness due to Disease	
☐Blindness due to Injury	
☐Glaucoma	
☐Macular Degeneration	
☐Retinal Detachment	
☐Retinal Degeneration	
☐Arthritis	
☐Cancer ▫Type:	
☐Diabetes	
☐Heart Disease	
☐Hypertension	
☐Kidney Disorder	
☐Thyroid Disease	
☐Other:	

***If none of the above apply please initial here _____**

Ocular History/Review of Systems

***If none apply please initial here_____**

☐Blurry Vision ☐Double Vision ☐Dryness ☐Redness
☐Itching ☐Burning ☐Eye Pain ☐Light Sensitivity
☐Watery Eyes ☐Eye Fatigue ☐Flashes ☐Floaters

Patient History/Review of Systems

Cardiovascular ☐Heart Disease ☐Elevated Cholesterol ☐High Blood Pressure	**Lymphatic/ Hematologic** ☐Anemia ☐Coagulation Disorder ☐Leukemia	**Musculoskeletal** ☐Arthritis ☐Muscle Pain ☐Joint Pain ☐Rheumatoid arthritis	**Integumentary (Skin)** ☐Lupus ☐Psoriasis ☐Eczema
Gastrointestinal ☐Diarrhea ☐Constipation	**Respiratory** ☐Asthma ☐Bronchitis ☐Emphysema	**Endocrine** ☐Diabetes Insipidus ☐Diabetes Mellitus ☐Thyroid Dysfunction	**Psychiatric** ☐ADD/ADHA ☐Anxiety ☐Depression
Constitutional ☐Fever ☐Weight Gain ☐Weight Loss	**Genitourinary** ☐Kidney Problems ☐Bladder Problems **Neurologic** ☐Seizures ☐Multiple Sclerosis ☐Headaches ☐Migraines	**Ears/Nose/ Throat** ☐Chronic Cough ☐Dry Mouth ☐General Allergies ☐Head Colds	**Eyes** ☐Crossed Eyes ☐Lazy Eye ☐Glaucoma ☐Retinal Disease ☐Retinal Detachment ☐Cataract ☐Other _____

***If none of the above apply please initial here ____**

Please note any other medical or ocular conditions not listed _____

Cascade Family Eye Care (CFEC).
9623 32nd Street S.E., Bldg D, Ste 121
Lake Stevens, WA 98258
Voice: 425-377-9747
Fax: 425-377-8757
receptionist@cascadefamilyeyecare.com

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

It is completely my decision whether or not to agree to this authorization to release my information as described in the "Notice of Privacy Practices" which was provided for my inspection. While I cannot be refused treatment if I choose not agree to this authorization, I will be required to pay in full at the time of service for any care I receive and/or any goods ordered/delivered because CFEC won't be able to submit claims for any insurance coverage I may have. I understand that any emergency or routine care I might need may be hindered if CFEC is not authorized to consult about my care with other health care personnel.

If I agree to this authorization, I can revoke it later. The only exception to my right to revoke is if my eye doctor and/or staff have already acted in reliance upon the authorization. If I want to revoke my authorization, I will notify CFEC with a written note telling them that my authorization is revoked. I will send this note to the office to the attention of the contact person listed at the top of this form. If CFEC has not received payment from my insurer(s) by the date of my revocation, I may be required to pay in full for any care or goods previously delivered to me by CFEC.

When health information is disclosed as provided in the "Notice of Privacy Practices", the recipient/business associate may use and/or re-disclose the information only as permitted or required by the business associate contract or as required by law.

If I received the aforementioned document or this one on CFEC's web-site or by electronic mail (e-mail), I am entitled to a written copy as well. I understand that printed copies of the "Notice of Privacy Practices" are available on the reception counter. If I have any questions or concerns about our privacy practices, I may notify the contact person at the address/phone listed at the top of this page.

I HAVE READ AND UNDERSTAND THE "NOTICE OF PRIVACY PRACTICES" AND I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THAT DOCUMENT.

Patient Name (Print) _____

Dated _____ Signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient.

Relationship to Patient _____ Print Your Name _____

If you are not the patient or parent of the patient, what is the source of your legal authority to sign this form?

_____

(Note: If you have any questions about privacy issues, please feel free to discuss them with the contact person above.)