Welcome to Cascade Family Eye Care

Patient Name: ______________________________ Date of Birth: ____________________
Preferred Name: ______________________________ Sex: __________
Occupation: ______________________________ Employer: ______________________________
Home Address ____
City ____________________ State ____________________ Zip Code ______________
If patient is a minor, Name of Parents/Guardians ______________________________
Home Phone ______________________________ Okay to leave detailed message: Yes______ No______
Cell Phone ______________________________ Okay to leave detailed message: Yes______ No______
E-mail address ______________________________ (will not be released to vendors/advertisers)

Primary Vision Plan: ____________________ Subscriber Name: ______________________________
Secondary Vision Plan: ____________________ Subscriber Name: ______________________________
Primary Medical Plan: ____________________ Subscriber Name: ______________________________
Secondary Medical Plan: ____________________ Subscriber Name: ______________________________

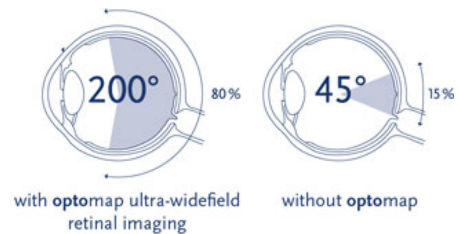
Cascade Family Eye Care offers advanced ultra-wide field retinal imaging that allows us to view the inside of your eye without the use of dilation drops *in many cases*. The Optos Optomap allows us to evaluate your retina for problems such as retinal tears, retinal detachments, retinal tumors, macular degeneration, glaucoma, hypertension, and diabetic retinopathy. This scanning system is completely safe for kids and adults and does not emit radiation like an X-ray.

Optomap Benefits:
- Quick, safe and efficient screening for children and adults, with no side effects
- In many cases, dilation may not be required
- Provides you and your family the best standard of care
- Up to 82% of your retina captured in one scan compared to 15% with traditional imaging

We recommend that ALL patients have a thorough examination of their retina during every routine eye exam with Optomap imaging. The additional fee of $39 for Optomap imaging is not generally covered by vision or health plan benefits.* The cost is the responsibility of the patient, due at time of service, and can be paid for with a flexible spending account (FSA) or health savings account (HSA).
*** If it is a covered benefit, we will submit our usual and customary fee of $75 for reimbursement. ***

Please initial selection:

_____ Yes, I elect to have Optomap imaging performed.
_____ I would like more information about Optomap imaging.
_____ No, I decline to have Optomap imaging performed, and understand I will likely be dilated.



We require 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 require at least 50% as a down payment before placing an order. We accept cash, checks and most credit cards for payment. There is a $25 charge for NSF checks.

For those wearing contact lenses, it is our office policy to provide a 3-month window from the time of your comprehensive eye exam to schedule and be seen for a contact lens evaluation. After that 3-month period, we require a full eye exam as your vision can change. It is the patient's responsibility to comply with clinic policies and provider instructions to finalize contact lens prescription within 3 months of the contact lens evaluation.

Please be advised that missed or rescheduled appointments in which the office was given less than 24 hours advanced notice, will be subject to a $40 charge.

Patient Name: ______________________________

Signed: ______________________________ Date: ____________________

Please circle one: I'm the patient/ I'm the parent/guardian

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**_______________

Do you drink alcohol? ☐Yes☐No **If yes, type/amount/how long**_________________

Have you been exposed or infected with: ☐***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 _____**

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 ____________

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

*****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 ST SE STE D-121
Lake Stevens, WA 98258
Phone: 425-377-9747
Fax: 425-377-8757

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. 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 website 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 upon request. If I have any questions or concerns about our privacy practices, I may notify CFEC 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?

____

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Patient's Name: ____

Authorization for Use/Disclosure of Information: I voluntarily consent to and authorize CFEC to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Recipient's Name: ____

Address: ____

Phone Number: ____

Fax Number: ____

Purpose: I authorize the release of my health information for the following specific purpose: ____.
(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ❑ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]

- ❑ Only verbal communication regarding my account.

- ❑ Only the following records or types of health information: ____.

Term: I understand that this Authorization will remain in effect:
- ❑ From the date of this Authorization until the _____ day of __________, 20____. (If no date is selected, this authorization is effective for three years.)
- ❑ Until the Provider fulfills this request.
- ❑ Until the following event occurs:____

[1] **NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.**

Redisclosure: I understand that my eye care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at CFEC. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to CFEC at the address listed below. The revocation will be effective immediately upon my eye care provider's receipt of my written notice, except that the revocation will not have any effect on any prior action taken by my eye care provider in reliance on this Authorization before it received my written notice of revocation.

Questions: I may contact CFEC for answers to my questions about the privacy of my health information at 9623 32nd ST SE Suite D121 Lake Stevens, WA 98258, or by telephone at (425) 377-9747.

_____________________________ ___________________
Signature Date

If Individual is unable to sign this Authorization, please complete the information below:

________________________ _________________ _________
Name of Guardian/ Representative Legal Relationship Date

I DECLINE Authorization for Use/Disclosure of Information:

_________________________________ ___________________
Signature **Date**