

During a comprehensive eye exam our doctors monitor you for retinal complications including macular degeneration, glaucoma, and retinal holes or detachments. Arizona's Vision offers the latest optomap technology with OCT to detect these conditions.

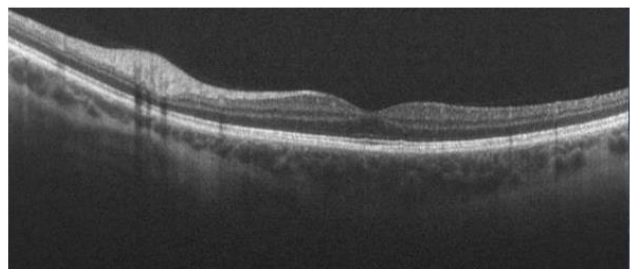
This screening procedure can also detect problems unrelated to the eye that may show early signs in the retina such as hypertension, cancer/tumors, auto-immune disorders, and others.

The new OCT technology allows us to scan all the layers of the retina to detect diseases such as macular degeneration or diabetic retinopathy earlier than possible with traditional methods.

The **Optomap**[®] Retinal Exam with OCT:

- ✓ Is the doctors preferred method of monitoring your eye and overall health
- ✓ DOES NOT REQUIRE DILATION DROPS
- ✓ allows your doctor to detect the presence of disease **early** in its progression
- ✓ will be saved in your medical file enabling your doctor to make important comparisons during your annual exams

The cost for these scans is \$39, It is not covered by your insurance.



____ I understand that the **optomap** retinal exam will be performed today and do not have any questions.

____ I want to speak to the doctor for more information and understand that declining this procedure may limit the doctor's ability to optimally assess my ocular health.

Signature: _____

Admin use only: ☐ OCT ☐ Optomap ☐ MED ☐ AMA _____

Qualitative Understanding and Nutritional Treatment Intervention for the EYE

To Our Patients,

Join the thousands of others who have used Quantifeye® to give an early detection of Macular Degeneration. Recently, we acquired a device that allows us to assess your risk of developing an eye disease called Macular Degeneration. This disease is a leading cause of blindness in adults and there is no adequate treatment; however, it may be managed if caught early, with the use of dietary supplements and ultraviolet protection. We can now take measures to reduce your risk of developing this disease. The light response test only takes a few minutes. **We now offer the screening to all patients 19 years and older** to develop a baseline measurement that allows us to track any changes that might occur in the future.

Risk Factors *(please check all that apply)*

Family History of:

- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Cataract
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Heart Disease

If You have:

- ☐ Glaucoma
- ☐ Cataract
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Heart Disease

Smoker:

- ☐ Current
- ☐ Prior
When did you quit? _____

Do You experience:

- ☐ Night Driving Difficulty
- ☐ Discomfort from Glare
- ☐ Sensitivity to bright light
- ☐ Difficulty seeing objects against their background
- ☐ Difficulty seeing close or near objects

Additional Factors:

- ☐ Age (Are you over 50?)
- ☐ Light colored eyes
- ☐ Caucasian
- ☐ Female
- ☐ 6 servings of fruits & vegetables per day
- ☐ 1 serving of cold-water fish per week

If you have two or more risk factors we strongly recommend that you take this test so we can assess your risk for Macular Degeneration, and develop a base-line measurement that allows us to track any changes that might occur in the future. Since this is a new test, never before available, it is not covered by your insurance. The cost to you will be \$14.00. We feel it is well worth the cost as it may offer you additional protection against a very devastating disease. For a 6 month Quantifeye re-evaluation there is a \$29.00 fee. **Should you have any questions, please do not hesitate to ask.**

★ In honor of Dr. Pages's mother, a portion of each QuantifEYE® examine is donated annually to a scholarship fund helping local Ahwatukee High School seniors attend college.

I understand my risk factors for Macular Degeneration and choose to:

- ☐ ACCEPT TEST
- ☐ DECLINE TEST

Patient Signature

Date

For Office Use

Doctor's Risk Assessment:

(circle one) | High | Medium | Low

MPOD Score _____ R / L

< .25

LOWER RANGE

.25 - .45

MID-RANGE

> .45

HIGHER RANGE



Understanding your contact lens care & fees

What are contact lens professional fees for? As a contact lens wearer additional tests are done for you that are necessary to make sure your eyes are healthy, that your lenses fit properly, and to ensure that you are seeing as well as possible. Contact lens professional fees are for the extra testing and time taken by the staff and doctor each year to properly evaluate your contact lenses and overall health of your eyes as it pertains to wearing contact lenses.

How much does it cost? Depending on the type of lenses you wear the cost for the professional services can vary. Costs for the contact lens evaluation **starts as low as \$79.00 and can increase up to \$250 for non-medically necessary fittings depending on the type of contacts prescribed and the complexity of your prescription.** The office staff will be able to give you the exact cost for the lenses that you wear and the professional services after you are finished with the doctor

Doesn't my insurance cover contact lens professional fees? It depends on your plan's coverage. Most insurance plans cover a routine eye exam which determines your glasses prescription and evaluates your eye health. Contact lens services are separate procedures that often are not covered by insurance but may be discounted pursuant to your insurance guidelines.

What type of additional tests are needed? Corneal topography is one example of a test done for contact lens wearers. With this computerized data we can detect any undesirable changes of the cornea caused by wearing contact lenses. A second test uses the microscope to examine the fit of the contact lens and the health of the cornea. Thirdly, prescription measurements are done which are different than those for glasses.

Isn't this part of my annual eye exam? These contact lens-related tests are done in addition to the eye examination. These procedures, that only need to be done for contact lens wearers, are not done for patients who don't wear contact lenses.

I have read and understand the purpose of the contact lens examination and accept the fees associated with wearing contact lenses.

PATIENT NAME: _____ **DATE:** _____

PATIENT SIGNATURE (Parent/Guardian if under 18): _____

PATIENT INFORMATION:

Patient's Name _____ Birth date _____
Mailing Address _____
City _____ State _____ Zip _____
Parent / Guardian _____ (If patient is a minor)
Primary Phone # (____) _____ Secondary/Work Phone # (____) _____
E-mail address _____ Occupation _____
Employer or School (if patient is a student) _____ Grade _____
How did you find out about our office? _____
Insurance _____ Policy Holder Name _____
Member ID # or SS # _____ Policy Holder Birth Date _____
I, _____, am responsible for payment if my insurance
(signature of patient/guardian) company does not cover the services provided.

EYE HISTORY:

Date of last eye examination: _____ Doctor: _____
Do you currently wear glasses? Yes No Do you currently wear contacts? Yes No
Have you had any of the following? Have you had eye surgery for any of the following?
Strabismus (eye turn) Yes No Cataract Yes No
Amblyopia (lazy eye) Yes No Trauma Yes No
Keratoconus Yes No Laser Vision Correction Yes No
Macular Degeneration Yes No Foreign Body Removal Yes No
Glaucoma Yes No Retinal Detachment Yes No
Diabetic Retinopathy Yes No Other (please list) _____
Retinal Detachment Yes No Has anyone in your family had any of the following?
Retinal Disease Yes No Macular Degeneration Yes No
Optic Nerve Disease Yes No Glaucoma Yes No
Other (please list) _____ Retinal Detachment Yes No

MEDICAL HISTORY:

Are you pregnant and/or nursing at this time? Yes No
Please list any medications you are taking (including eye drops & over-the counter)

Are you allergic to any medications? Yes No | If yes, please list:

Social History:

Do you drive? Yes No | If yes, do you have visual difficulty when driving? 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: _____
How did you hear about our office? _____
If Someone referred you, please indicate name: _____
May we use your name in thanking this person? Yes No

PLEASE COMPLETE: Do you currently, or have you ever had problems in the following areas?

Eyes (Ocular symptoms)	YES	NO
Eye pain or soreness	☐	☐
Fatigue/tired eyes	☐	☐
Dry/gritty feeling	☐	☐
Redness	☐	☐
Burning	☐	☐
Itching	☐	☐
Excess watering	☐	☐
Mucous discharge	☐	☐
Chronic infections	☐	☐
Squinting	☐	☐
Glare/light sensitivity	☐	☐
Halos around lights	☐	☐
Double vision	☐	☐
Loss of vision	☐	☐
Blurred vision	☐	☐
Flashes	☐	☐
Floaters	☐	☐
Constitutional	YES	NO
Fever	☐	☐
Weight loss or gain	☐	☐
Skin	☐	☐
Rosacea	☐	☐
Metal allergies	☐	☐
Ear, Nose, Throat, Mouth	YES	NO
Allergies/hay fever	☐	☐
Sinus infections	☐	☐
Hearing Loss	☐	☐
Respiratory	YES	NO
Asthma	☐	☐
Chronic bronchitis	☐	☐
Emphysema	☐	☐
Vascular/Cardiovascular	YES	NO
Heart disease	☐	☐
High blood pressure	☐	☐
High cholesterol	☐	☐
Stroke	☐	☐
Gastrointestinal	YES	NO
Acid reflux	☐	☐
Intestinal problems	☐	☐
Liver/spleen problems	☐	☐
Endocrine	YES	NO
Thyroid/other glands	☐	☐
Diabetes	☐	☐
Genitourinary	YES	NO
Genitals/kidney/bladder	☐	☐
Lymphatic/hematologic	YES	NO
Anemia	☐	☐
Bleeding	☐	☐
Bones/joints/muscles	YES	NO
Rheumatoid arthritis	☐	☐
Muscle/joint pain	☐	☐
Neurological	YES	NO
Headaches	☐	☐
Seizures	☐	☐
Alzheimer's	☐	☐
Parkinson's	☐	☐
Multiple Sclerosis	☐	☐
Psychiatric	☐	☐
Immune system	☐	☐
Cancer (Type) _____		

DATE ____/____/____



Acknowledgment of Receipt of Notice of Privacy Practices

Signing this document signifies that you have received a copy of our Notice of Privacy Practices.

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the Notice of Privacy Practices from Arizona's Vision.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to this form:

Relationship to Patient: _____ Source of Authority: _____

Our patient's allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this portion. Signing this form will only give information to family members indicated below.

I authorize Arizona's Vision to release my medical and/or billing information to the following individual(s):

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____