forster
EYECARE

Our Vision...Your Sight

COVID-19 Pandemic Essential Eye Exam and Treatment Consent Form

Patient Name: _____ DOB: ___/___/___ Date: ___/___/___

Please read the following statements and initial next to the following statements to indicate your agreement. If you cannot positively affirm to all of these questions, you will be asked to postpone or reschedule your visit to a later date.

_____ I do not currently, nor have I had in the last two weeks, a fever, cough, sore throat, loss of smell/taste or other cold symptoms.

_____ To the best of my knowledge, I do not have, nor have I been in direct contact with someone who has confirmed diagnosis of COVID-19 or a presumptive positive COVID-19 test result in the last 30(thirty) days.

_____ Neither I, nor anyone living in my immediate household, have traveled outside of the state in the last 30 days.

On March 16th, 2020, The Centers for Disease Control and Prevention (CDC) issued the following Public Health Reminder:

Healthcare facilities and clinicians should prioritize urgent and emergency visits and procedures now and for the coming several weeks. The following actions can preserve staff, personal protective equipment, and patient care supplies: ensure staff and patient safety; and expand available hospital capacity during the COVID-19 pandemic:

- Delay all elective ambulatory provider visits
- Reschedule elective and non-urgent admissions
- Delay inpatient and outpatient elective surgical and procedural cases
- **Postpone routine dental and eye care visits**

I have read the above Public Health Reminder and have answered the health questions above honestly and to the best of my knowledge. I understand that Forster Eye Care, its doctors and staff are taking precautions to limit any potential exposure I may have to the COVID-19 virus. I also understand that there is no definitive way to eliminate potential exposure by one hundred percent.

By signing this form below, I agree that I will not hold Forster Eye Care or any of its doctors or staff personally responsible should I, or someone I come in contact with, become positive or presumptively positive diagnosed with the COVID-19 virus. There are certain inherent risks associated with an eye exam during a pandemic and I assume full responsibility for personal illness that may result and further release and discharge Forster Eye Care and its doctors and staff for injury, loss or damage arising out of my visit. I understand that COVID-19 infection can lead to illness, disability, or even death and knowingly take the risk of exposure as I deem my eye exam to be essential to the maintenance of my vision.

_____ _____ ___/___/___

PRINT LEGAL NAME SIGNATURE DATE

OUR FINANCIAL POLICY

- **Our policy requires payment at the time of service.** To assist you in filing your own insurance claims, we will provide you with an itemized statement. You can simply send in the itemized statement along with your completed insurance form to your insurance carrier to expedite your reimbursement.
- **HMO & PPO MEMBERS:**
  If you are a member of an HMO or PPO in which our office participates, **payment of your co-payment or deductible is required at the time of service.** If payment of your co-payment is not made at the time of service, you will be billed an additional $10.00 for administrative fees.

You are responsible to make sure that we have a current referral on hand if your insurance carrier requires one for you to see a specialist. If you do not have a referral at the time of your specialist visit, your insurance company may hold YOU responsible for ALL charges.

PAYMENT FOR SERVICES

- **OUR AGREEMENT IS WITH YOU.** You have chosen your insurance company. ***We will assist you in submitting your bill for services for those insurance plans that we participate with, but you are ultimately responsible for payment for the services you receive.***

We accept cash, local checks, VISA, MASTERCARD, DISCOVER, or AMERICAN EXPRESS for payment of your charges. If you are ordering glasses or contacts, 50% of the charges (or in the case of insurance coverage, 50% of the non-covered options) will be required to order the glasses or contacts. **Returned checks will receive an overdraft charge of $35.00 per check.** Interest will accrue on accounts over 30 days past due from the date of service (including glasses or contacts that have not been picked up from our office).

A collection agency may take over a delinquent account. If your account is placed with a collection agency, you will be responsible for all collection costs, as well as the cost of services rendered at this office. Timely payment will prevent consequences to your credit rating.

If you have any questions about our financial policy or your insurance reimbursement, please feel free to discuss them with our business manager.

Our office REQUIRES a 24 hour notice from patients who wish to cancel or reschedule an appointment. This notice gives us the opportunity to offer the appointment time to another patient. Failure to provide 24 hour notice will result in a $25 charge to the responsible party. Thank you for your understanding.

*** Forster Eye Care, P.C. ***
rev. 06/2016

I have read and understand my financial responsibilities under this policy.

_____ Date: _____
Patient/Responsible party Signature

Receipt of Notice of Privacy Policies & Consent Form

Forster Eye Care, P.C.
725 Walther Rd., Bldg. 100
(770) 513-3300 Phone
(678) 990-8252 Fax **www.forstereyecare.com**

Patient Name: _____

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 health care operations involving our office.

The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy here at the office or from our **website.**

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices.***

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Forster Eye Care, P.C.

_____ _____
Signature Date

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

_____ _____
Relationship to Patient Print Name

Source of Authority: _____

PATIENT SOCIAL FAMILY HISTORY

YOUR PERSONAL EYE HISTORY

- ☐ DRY EYES
- ☐ NYSTAGMUS
- ☐ KERATOCONUS
- ☐ INJURY_____
- ☐ RETINAL DETACHMENT
- ☐ GLAUCOMA
- ☐ GLAUCOMA SUSPECT
- ☐ CATARACTS
- ☐ AGE RELATED MACULA DEGENERATION
- ☐ SURGERY_____
- ☐ PATCHING
- ☐ INFLAMMATORY DISORDER
- ☐ STRABISMUS (
- ☐ AMBLYOPIA
- ☐ RETINAL DEGENERATION
- ☐ RETINAL HOLE
- ☐ CONTACT LENS WEARER/ GLASSES WEARER
- ☐ OTHER_____
- ☐ NONE

YOUR FAMILY HEALTH HISTORY

MEDICAL

- ☐ DIABETES
- ☐ CANCER
- ☐ HYPERTENSION
- ☐ THYROID
- ☐ OTHER
- ☐ NONE

OCULAR

- ☐ CATARACTS
- ☐ GLAUCOMA
- ☐ AMBLYOPIA
- ☐ SEVERE MYOPIA
- ☐ GLAUCOMA SUSPECT
- ☐ MACULAR DEGENERATION
- ☐ RETINAL DETACHEMENT
- ☐ DRY EYE
- ☐ SEVERE HYPEROPIA
- ☐ STRABISMUS (CROSSED EYED)
- ☐ NYSTAGMUS
- ☐ OTHER

SOCIAL HISTORY

DRINKING YES / NO / UNKNOWN

IF YES, AMOUNT

TOBACCO USE

YES / NO / UNKNOWN

IF YES, SELECT PREFERENCE ANDSTATUS

PREFERENCE

- ☐ SMOKES CIGARETTES
- ☐ SMOKE CIGARS
- ☐ SMOKE PIPE
- ☐ SMOKE OTHER
- ☐ USES SMOKELESS TOBACCO

SMOKING STATUS

- ☐ UNKNOWN IF EVER SMOKE
- ☐ SMOKER, CURRENT STATUS UNKOWN
- ☐ NEVER SMOKER
- ☐ FORMER SMOKER
- ☐ CURRENT SOME DAY SMOKER
- ☐ CURRENT EVERY DAY SMOKER

LIST ANY OTHER MEDICAL CONDITIONS THAT YOU HAVE:

_____

_____

_____

LIST ANY MEDICATIONS (INCLUDING OVER THE COUNTER VITAMINS, SUPPLEMENTS AND EYE DROPS).

_____

_____

_____

LIST ANY MEDICATION ALLERGIES:

_____

_____

_____

Signature :_____

Date:_____

NAME: _____

DOB: _____

PRIMARY PHONE #: _____

ADDRESS: _____

_____

E-MAIL: _____

CHECK ALL THAT APPLY TO YOU
Do not leave any sections blank

CONSTITUTION

- ☐ FATIGUE SYNDROME
- ☐ DEVELOPMENT DISABILITIES
- ☐ CANCER
- ☐ NONE
- ☐ OTHER_____

EAR, NOSE, MOUTH&THROAT

- ☐ SINUSITIS
- ☐ HEARING LOSS
- ☐ LARYNGITIS
- ☐ DRY MOUTH
- ☐ NONE
- ☐ OTHER_____

NEUROLOGICAL

- ☐ MULTIPLE SCLEROSIS
- ☐ EPILEPSY
- ☐ CEREBRAL PALSY
- ☐ TUMOR
- ☐ STROKE/CVA
- ☐ MIGRAINE
- ☐ NONE
- ☐ OTHER_____

PSYCHIATRIC

- ☐ BIPOLAR DISORDER
- ☐ ANXIETY DISORDER
- ☐ ATTENTION DEFICIT
- ☐ DEPRESSION
- ☐ NONE
- ☐ OTHER_____

CARDIOVASCULAR

- ☐ HYPERTENSION
- ☐ STROKE/CVA
- ☐ CONGESTIVE HEART FAILURE
- ☐ VASCULAR DISEASE
- ☐ HEART DISEASE
- ☐ NONE
- ☐ OTHER_____

RESPIRATORY

- ☐ CIGARETTE SMOKER
- ☐ EMPHYSEMA
- ☐ CHRONIC OBSTRUCTION
- ☐ ASTHMA
- ☐ BRONCHITIS
- ☐ SLEEP APNEA
- ☐ NONE
- ☐ OTHER_____

GASTROINTESTINAL

- ☐ CROHN'S
- ☐ CELIAC DISEASE
- ☐ ACID REFLUX
- ☐ ULCER
- ☐ COLITIS
- ☐ NONE
- ☐ OTHER_____

GENITOURINARY

- ☐ STD- HERPECTIC / CHLAMYDIA
- ☐ PROSTATE DISEASE/ CANCER
- ☐ KIDNEY DISEASE
- ☐ HERPES
- ☐ NURSING
- ☐ PREGNANT
- ☐ BENIGN PROSTATE/ HYPERTROPHY
- ☐ NONE
- ☐ OTHER _____

MUSCULOSKELETAL

- ☐ GOUT
- ☐ ARTHRITIS
- ☐ OSTEOARTHRITIS
- ☐ ANKLOSING SYNDROME
- ☐ OSTEOPOROSIS
- ☐ FIBROMYALGIA
- ☐ MUSCULAR DYSTROPHY
- ☐ NONE
- ☐ OTHER_____

INTEGUMENTARY

- ☐ ECZEMA
- ☐ ROSACEA
- ☐ HERPES ZOSTER/ SHINGLES
- ☐ HERPES SIMPLEX/ COLD SORES
- ☐ PSORASIS
- ☐ NONE
- ☐ OTHER_____

ENDOCRINE

- ☐ TYPE 2 DIABETES MELLITUS
- ☐ TYPE 1 DIABETES MELLITUS
- ☐ THYROID DYSFUNCTION
- ☐ NONE
- ☐ OTHER_____

HEMOTOLOGIC/ LYMPHATIC

- ☐ ANEMIA
- ☐ HYPERCHOLESTEREMIA
- ☐ ULCER
- ☐ LARGE-VOLUME BLOOD LOSS
- ☐ NONE
- ☐ OTHER_____

ALLERGIC/IMMUNE

- ☐ DRUG ALLERGIES
- ☐ RHEUMATOID ARTHRITIS
- ☐ ENVIROMENTAL ALLERGIES
- ☐ SJOGREN'S SYNDROME
- ☐ LUPUS
- ☐ NONE
- ☐ OTHER_____