DOS, LLC DBA
Hauser-Ross
OPTICAL

Patient Information

Name (Last, First, Middle)		Social Security Number	Date of Birth	Sex
Local Address		**Permanent Address** *(If Applicable)*		
City, State, Zip Code		**City, State, Zip Code**		
Primary Phone	**Secondary Phone**	**Emergency Contact Name**	**Emergency Contact Phone**	
E-Mail Address	**Race** □ American Indian or Alaskan Native □ Asian □ African American □ Native Hawaiian or Pacific Islander □ Caucasian □ Other			

Who may we thank for helping you choose Hauser-Ross Optical?
□ Friend/Family □ Newspaper □Medical Doctor □ Location □ Reputation □ Insurance □ Other
Name:

Responsible Party Information (If Applicable)

Name (Last, First, Middle)		Social Security Number	Date of Birth	Sex
Address		**City, State, Zip Code**		
Primary Phone	**Secondary Phone**	**Relationship to Patient**		

Vision Insurance Information

Name of Insurance Company		Name of Policy Holder	
Address *(If different from above)*		**Social Security Number**	**Date of Birth**

Health Insurance Information

Name of Insurance Company		Name of Policy Holder	
Address *(If different from above)*		**Social Security Number**	**Date of Birth**

Secondary Health Insurance Information

Name of Insurance Company		Name of Policy Holder	
Address *(If different from above)*		**Social Security Number**	**Date of Birth**

Alternative Contact/Preferred Method of Communication Form

Patient Name_____Date of Birth_____
We at Hauser-Ross Optical take your medical confidentiality very seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff to speak only with an individual(s) you designate in the event you are not available to receive phone calls or you have an adult member that helps coordinate your medical care. You should not designate your doctor.

As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below:

_____I do NOT authorize anyone to receive information regarding my medical care.

_____I authorize my physician and the employee of this clinic to speak with:

1. Person:_____ Relationship:_____
   Phone number(s): _____
   ☐ Appointments ☐ Account/Bill ☐ Lab Results ☐ Test Results ☐ Medical Care ☐ Treatment
2. Person:_____Relationship:_____
   Phone number(s): _____
   ☐ Appointments ☐ Account/Bill ☐ Lab Results ☐ Test Results ☐ Medical Care ☐ Treatment
3. Person:_____Relationship:_____
   Phone number(s): _____
   ☐ Appointments ☐ Account/Bill ☐ Lab Results ☐ Test Results ☐ Medical Care ☐ Treatment

Please check your primary and secondary preferred methods of communication:

_____Home Phone/Answering Machine _____Mail _____Work Phone

_____Cell Phone (voice mail) _____Cell Phone (text message)

_____Email and email address _____

Electronic Communication is my preferred method ☐ yes ☐ no
(In order to electronically communicate to you or anyone you designate, we are required to have your written permission).

This authorization will remain in effect unless changed by me while I am a patient at this office. It is my responsibility to notify this office of changes and to complete a new form. Any problems and/or questions concerning this form are to be referred to the Privacy Officer.

I agree that should I desire to revoke this authorization, I will give written notice.

PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: _____

PATIENT/GUARDIAN SIGNATURE: _____

WITNESS SIGNATURE: _____

DATE: _____ TIME: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

Notice of Privacy Practices

Our "Notice of Privacy Practices" policy, available at the reception desk and also online at our website, provides detailed information about how we may use and disclose protected health information about you. The details of this policy are in full compliance with all provisions, including those most recently updated, of the Health Insurance Portability and Accountability Act passed in 1996 (HIPPA). Our "Notice of Privacy Practices" states that we reserve the right to change terms within our policy. Should this happen, we will display, and make available, the new policy and its perspective date of implementation. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment or health care operations. We are not required to agree with your restrictions; however, if we do, we are bound by our agreement with you.

By signing below, I acknowledge receipt of "Notice of Privacy Practices" and consent to your use and disclosure of protected health information about me for treatment, payment, and health care operations. I have the right to revoke this consent, in writing, except where the practice has already made disclosures in trust on my prior consent.

PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: _____

PATIENT/GUARDIAN SIGNATURE: _____

WITNESS SIGNATURE: _____

DATE: _____ TIME: _____

CONSENT FOR CARE AND TREATMENT:

I understand that Patient, which may be defined as me, my child or a child for whom I have legal responsibility, needs medical care and treatment and I consent to such treatment at Hauser-Ross Optical. Treatment provided by medical providers, nurses, and medical assistants at Hauser-Ross Optical may include evaluation and management, laboratory and other testing; routine medical, nursing and medical assistant care and procedures. I understand that photos or video of Patient may be taken in connection with such treatment and for operational, and quality improvement.

No Guarantee: I acknowledge that no guarantees or warranties have been made with respect to treatment or services to be provided by Hauser-Ross Optical. I understand that all supplies, medical devices and other goods provided to Patient are provided by Hauser-Ross Optical AS IS and Hauser-Ross Optical disclaims any expressed or implied warranties.

Patient Rights: I have been provided information regarding Patient Rights and Responsibilities. This information tells me how to register a complaint or grievance that I might have relating to Patient's care at Hauser-Ross Optical.

Communicable Disease Testing: I agree that if a Hauser-Ross Optical employee or provider is exposed to Patient's blood or other bodily fluid, pursuant to law, Hauser-Ross Optical may test Patient to determine the presence of communicable diseases including Human Immunodeficiency Virus (HIV) and hepatitis. I understand that these test results will be kept confidential.

Specimen Disposal: I acknowledge that Hauser-Ross Optical may, in its sole discretion, remove, retain, or dispose of any tissue or body parts removed from Patient.

Text Messaging: I understand that Hauser-Ross Optical can provide notifications to my cell phone. These texts are Do Not Reply texts for informational purposes only and are not intended as a form of two-way communication. I acknowledge that standard text messaging rates and fees will apply, text messaging utilizes a public telephone network and full security is not guaranteed, and any person with access to my phone will be able to see these messages unless I take steps to protect my phone with a password or PIN.

PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: _____

PATIENT/GUARDIAN SIGNATURE: _____

WITNESS SIGNATURE: _____

DATE: _____ TIME: _____

NOTICE OF BILLING PRACTICES:

THIS NOTICE DESCRIBES OUR BILLING PRACTICES, PLEASE REVIEW IT CAREFULLY.

At Hauser-Ross Optical, you can expect to receive medical services in a professional and caring manner. We are committed to providing you with the highest level of service and quality care. In return, it is your responsibility to provide your insurance information. Please have your photo identification and current insurance information available at your visit to ensure that your claim can be processed promptly.

1. APPOINTMENTS: We request that you keep scheduled appointments and arrive that the appointed time. If you are unable to keep your appointment, please give at least 48 hours notice. Cancellations of less than 24 hours prior to your appointment, or a No-Show for your appointment, will result in a $25 fee per patient.

2. CO-PAYS: According to your insurance contract, you are obligated to pay any co-pay due at the time of service. IF you are unable to pay the co-pay at the time of service, we retain the right to cancel or reschedule your appointment to a time when you are prepared to pay your co-pay. Furthermore, if your appointment is kept without payment of the co-pay at the time of service, we retain the right to levy an administrative charge of $10 to your account in order to defray the cost of securing the co-pay.

3. PRESCRIPTION REFILLS/FORMS: Please request any prescription refills and present any forms that need to be completed at the start of your examination. At that time, we have full access to your complete record and can fulfill your request. When we have to provide these services at another time, there is a $25 fee to cover the time and effort required to retrieve and review your medical record.

4. REFERRALS: If your insurance plan requires a referral, the referral must be presented before seeing a physician. If you do not have the required referral, we reserve the right to reschedule your appointment or you will have to be willing to be responsible for the entire cost of the examination.

5. RETURNED CHECKS: Any payment made by check that does not clear our bank account will result in a fee for insufficient funds. Our fee for insufficient funds is $25 and will be added to your account for each bounced check.

6. OTHER INSURANCE: I understand that Hauser-Ross Optical participates with multiple insurance plans and that not all Doctors in the Practice participate with all plans or products within the plans. I understand that it is my responsibility to verify with my insurance carrier that my physician currently participates with my plan. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Hauser-Ross Optical if I belong to a plan with which Hauser-Ross Optical does not participate.

7. NON-COVERED SERVICES: I understand that Hauser-Ross Optical contracts with health care service plans related only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care plan service plan furnishes to the patient (i.e. refraction) and treatment or tests not authorized by the

health care service plan. The undersigned agrees to cooperate with Hauser-Ross Optical to obtain necessary health care service plan authorizations.

8. FINANCIAL AGREEMENT: I agree that in return for the services provided to me by Hauser-Ross Optical, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Hauser-Ross Optical for payment. I understand and agree that if my account is delinquent, I may be charged interest of 1.5% (one and one-half percent) per month, 18% (eighteen percent) per year. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees of 33.3% (thirty-three and one-third percent) of the balance due, whether or not suit is filed. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Hauser-Ross Optical. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Hauser-Ross Optical. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

The physicians and staff at Hauser-Ross Optical appreciate your confidence in allowing us to participate in your eye care.

Your signature indicates that you have read, understand and agree to the financial responsibilities policies and procedures of our office.

PATIENT'S NAME: _____

PATIENT'S DATE OF BIRTH: _____

PATIENT/GUARDIAN SIGNATURE: _____

WITNESS SIGNATURE: _____

DATE: _____ TIME: _____

DOS, LLC DBA
Hauser-Ross
OPTICAL

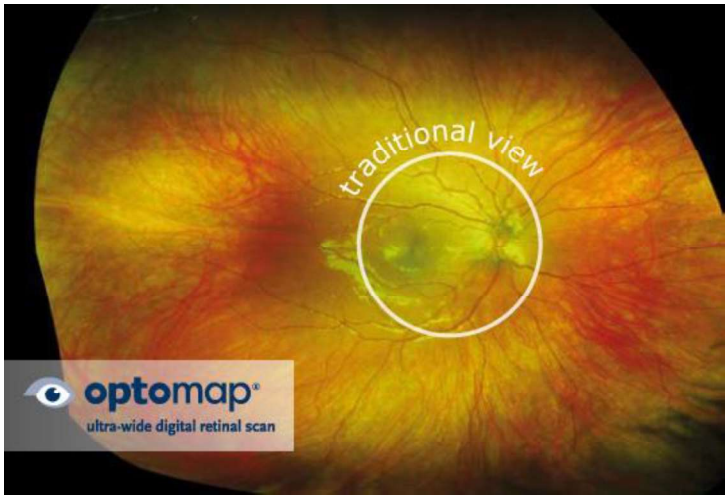
optomap®
ultra-wide digital retinal imaging

OPTOMAP RETINAL EXAMINATION INFORMED CONSENT

An optomap retinal exam provides your doctor with a view of up to 200 degrees of the retina (back of eye) in one single photo capture, compared to 45 degrees achieved with conventional methods (see picture below). And because we do not have to dilate your pupil for the optomap test there are no side effects that you would otherwise have from pupil dilation!

Optos' patented ultra-widefield digital laser scanning technology acquires images that support the detection, diagnosis, analysis, documentation, and management of ocular pathology and systemic disease that may first present in the periphery of the retina. These conditions, such as: macular degeneration, diabetes, hypertension, glaucoma, retinal holes, tears or detachments- among many others- may otherwise go undetected using traditional examination techniques.

The doctors of Hauser-Ross Optical recommend a yearly optomap retinal exam as an integral part of your comprehensive eye examination. The out-of-pocket cost of the optomap test is $39 and is not covered under your medical or vision insurance.



I understand the importance of having an optomap retinal examination and:

_____ YES I would like to have a comprehensive optomap retinal exam

_____ NO I decline the optomap retinal exam and understand that I am releasing Hauser-Ross Optical from any liability.

_____	_____	_____
Print Patient Name	Patient Signature	Date

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Medical History

What is the reason for today's visit?

Are you having trouble with any of the following? (wearing your current glasses or contacts)

□ Driving at night □ Parking □ Difficulty reading medication bottles or small print
□ Glare from headlights □ Seeing road signs □ Recent falls □ Recent accident
□ Judging distances □ Faces blurred □ Film over your eye □ Droopy lids or bumps eye

Do you currently wear glasses? □ Yes □ No **For how long?** _____ **How long ago did you see your eye doctor?** _____
Do you currently wear contact lenses? □ Yes □ No **If yes what type?** □ Disposable □ Rigid Gas Permeable □ Hybrid
Do you use eye drops? □ Yes □ No What type? _____
Are you interested in speaking with a staff member about cosmetic or skin care products and services? □ Yes □ No

Please list your food and drug allergies:

_____
_____
_____

Please list your current medications and how often you take them or provide us with a list that we can copy. Include daily use of aspirin, NSAID, Coumadin, ginko biloba, vitamin E, Plavix, other anti-coagulants, vitamins, minerals, over the counter medications.

_____
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Have you ever had or do you still have?

□ Amblyopia / Lazy Eye
□ Cataract
□ Glaucoma
□ Dry Eye
□ Keratoconus
□ Corneal Abrasion
□ Recurrent Erosion
□ Herpes Eye Infections
□ Cornea Infection / Ulcer/ Scar
□ Allergic Conjunctivitis
□ Trauma

Have you ever had or still have:

□ Asthma
□ Emphysema
□ COPD
□ Other Lung Problems
□ High Blood Pressure
*Diagnosed When?*_____
□ High Cholesterol
□ Stroke
□ Heart Attack
□ Atrial Fibrillation
□ Congestive Heart Failure
□ Rheumatic Fever
□ Circulation Problems
□ Kidney Infections
□ Kidney Failure
□ Other Kidney, Bladder or Prostate Problems
□ Hepatitis
□ Cirrhosis
□ Other Liver Diseases
□ Ulcers
□ Hiatal Hernia
□ Diverticulitis
□ Autoimmune Disorder
□ Lupus
□ HIV Positive
□ Tobacco Use

□ Cancer
*Type*_____
□ MRSA (Staph Infection)
□ Arthritis
□ Muscular Dystrophy
□ Epilepsy
□ Polio
□ Paralysis
□ Multiple Sclerosis
□ Parkinson's Disease
□ Alzheimer's / Dementia
□ Anemia / Bleeding
□ Type I Diabetes (Juvenile)
□ Type II Diabetes
*Diagnosed When?*_____
□ Thyroid Disease
□ Steroid Use (prednisone)
□ Abnormal Scarring / Healing
□ Problems with Anesthesia
□ Pregnant or trying to get pregnant?
□ Taking Fertility Meds
□ Gone through menopause
□ Other _____
□ Alcohol Use

Family History – Have any of your <u>blood</u> relatives had:

□ Cancer
□ Heart Problems
□ Glaucoma
□ Blindness
□ Diabetes
□ Macular Degeneration
□ Crossed / Lazy Eye