PERFORMANCE VISION

Today's Date: _____

How did you hear about our office? (Please check box and list name)

□ Friend/Relative: _____ □ Another Healthcare Provider: _____

□ Internet: _____ □ Event/Other: _____

GENERAL INFORMATION

Name (Last, First, MI, Preferred): _____ Date of Birth: _____

Address: _____ Gender: □ Male □ Female

City, State, Zip: _____

Social Security #_____

Please list your Phone #, then check which # you prefer to be contacted:

□ Home: _____ □ Work: _____ □ Cell: _____

E-mail: _____

Race (please circle): Caucasian African American Hispanic/Latino Asian Indian
Multiracial American Indian Hawaiian African Arab Unknown

Ethnicity (please circle): Hispanic/Latino Not Hispanic/Latino

Language: _____

Employer (or School): _____ Occupation (or Grade):_____

Emergency Contact and Phone #:_____

If married, name of spouse_____ If child, name of parents_____

HEALTH HISTORY:

Last eye exam: _____ Doctor/Location:_____

Do you currently wear contact lenses? □ Yes □ No. If yes, what kind?_____

Do you wear glasses? □ Yes □ No. If yes, how old are they?_____

Have you been experiencing any of the following?

□ Blurred Vision
□ Flashes
□ Floaters
□ Light Sensitivity
□ Burning/Sandy Feeling
□ Dry Eyes
□ Redness
□ Tired/Strained Eyes
□ Itching
□ Watery Eyes

Are you interested in?

□ Contact Lenses
□ Lasik
□ Computer glasses
□ Sports glasses
□ Sunglasses

Any specific visual/eyewear needs for your work or hobbies? _____

Do you currently work at a computer for long periods? How long per day? _____

Current Medications (Include over-the-counter, eye drops/meds, vitamins, oral contraceptives)

_____

_____

Have you experienced or been diagnosed or treated for: (If yes, check box and explain below)

EYES
□ Cataracts
□ Glaucoma
□ Macular Degeneration
□ Dry Eye Syndrome
□ Retinal Tear/Detachment
□ Lazy Eye
□ Eye Injury
□ Eye Surgery/LASIK

CONSTITUTIONAL
□ Developmental Disability
□ Cancer

EAR/NOSE/THROAT
□ Hearing Loss
□ Sinusitis

NEUROLOGICAL
□ Multiple Sclerosis
□ Stroke
□ Migraines
□ Concussion

PSYCHIATRIC
□ Depression
□ Anxiety Disorder
□ Bipolar Disorder

CARDIOVASCULAR
□ High Blood Pressure
□ Heart Disease
□ Vascular Disease

RESPIRATORY
□ Asthma
□ COPD
□ Sleep Apnea

GASTROINTESTINAL
□ Crohn's, Colitis

GENITOURINARY
□ Kidney Disease
□ Sexually Transmitted Disease

MUSCULOSKELATAL
□ Osteoarthritis

SKIN
□ Rosacea
□ Eczema/Psoriasis

ENDOCRINE
□ Diabetes
□ Thyroid dysfunction

HEMOTOLOGIC/LYMPHATIC
□ Anemia
□ High Cholesterol

ALLERGY/IMMUNOLOGIC
□ Rheumatoid Arthritis
□ Lupus

OTHER: _____
Please Explain: _____

Primary Physician:_____ Clinic/Location:_____Last Exam:_____
Are you currently, or is there a possibility that you may be, pregnant or nursing? □ Yes □ No
Height:_____Weight:_____

Allergies
Are you allergic to any medications? □ Yes □ No. If yes: _____
Do you have any environmental allergies/hay fever? □ Yes □ No

Social History:
Do you use any tobacco products? □ Yes □ No. How often_____. Have you ever smoked? □ Yes □ No
Do you drink alcohol? □ Yes □ No. How often_____.

Is there a family history of any of the following? (Explain relationship)
□ Glaucoma _____
□ Macular Degeneration _____
□ Cataracts _____
□ Retinal Detachment/Tear _____
□ Lazy Eye_____
□ Other Eye Disease_____
□ Type II Diabetes _____
□ Type I Diabetes_____
□ Hypertension_____
□ Cancer_____
□ Hyperthyroid_____
□ Hypothyroid_____

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment or health care operations.
The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
The practice reserves the right to change the Notice of Privacy Practices.
The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by: _____ _____

Printed Name (Patient or Responsible Party) Printed Name (Practice Representative)

_____ _____

Patient Signature or Responsible Party Date Signature Date

_____

Relationship to Patient (if other than patient)

GUARANTEE OF ACCOUNT

Performance Vision requests payment for co-pays and deductibles at time of service. Your contract with your insurance carrier, depending on the type of insurance and the carrier, states that you are responsible for co-pays and deductibles at the time of service and Performance Vision also has an agreement with your carrier to collect such fees at time of service. If your carrier has not paid your account with Performance Vision in 60 days, we ask that you pay the balance and seek settlement direct from your carrier.

I hereby authorize and assign payment directly to Performance Vision for any medical benefits, injury benefits due because of third party liability, or proceeds of all claims resulting from the liability of the third party until such time as the account is paid in full upon the completion of treatment.

By signing this form, I accept responsibility for reasonable costs incurred if my account becomes delinquent. I have read, understand and agree with the above.

X_____ _____

Signature of Patient and/or Authorized Representative Date

PATIENT SIGNATURE AUTHORIZATION / RELEASE OF INFORMATION

I hereby consent and authorize Performance Vision to furnish any insurance company, organization, hospital, physician or pharmacist any information requested with respect to any physical or mental condition and/or treatment of me or my child. I understand the information obtained by this authorization will be used to determine eligibility for insurance and eligibility for benefits under my insurance coverage. Any information will not be released except to persons or organizations performing business or legal services in connection with the claim, or as may be otherwise lawfully required or as I may further authorize. I agree that this authorization shall be valid until rescinded in writing or replaced by one at a later date.

X_____ _____

Signature of Patient and/or Authorized Representative Date

optomap®

Retinal Exam

_____ **Yes**, I want Dr. Winton to review and evaluate my **optomap®** digital images with me today. I understand Dr. Winton recommends having an annual **optomap®** exam and it is the preferred method of reviewing the health of my retina. I understand these images are not covered by insurance and there is a $35 charge for this service.

_____ **No**, I do not want Dr. Winton to review and evaluate my **optomap®** digital images with me today. I understand the **optomap®** digital technology is Dr. Winton's preferred method of reviewing the health of my retina.

_____ **Undecided,** I would like to discuss this with the Doctor.

I understand the benefits of the annual **optomap®** Retinal Exam as:

* Fast, easy and comfortable.
* A permanent record to compare and track potential eye diseases.
* An in-depth view of nearly the entire retina.
* Educational tool for your doctor to discuss your health and wellness.

I understand that a widefield view of the retina is an important part of a comprehensive eye exam and my doctor recommends having the back of my eye documented with digital imaging.

Patient's Signature_____Date_____

Records Release

Date:_____

To: _____
Doctor/Physician

Address: _____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

I authorize the release of my records and request that they be transferred to:

Performance Vision
Dr. Kenneth R. Winton
6511 Highway 431, Suite A
Owens Cross Roads, AL 35763
E-Mail: Office@pvhsv.com
Phone #: 256-- 469-6427
Fax #: 256-888-1299

_____

Print name of patient Date of Birth

_____

Signature (patient, parent, guardian)