Issaquah Vision COMP CLEX MED EST NEW DOS:

Dr. Stephan Cassidy **Dr. Erinn Tolomei** **Dr. Catherine Tsang**

Dilation Opto Declined

Reason for today's visit: _____

Date of last eye exam: _____

Primary Care Physician: _____

Please check box if address listed on label is correct ☐

Please circle **current visual symptoms**:

Blurry vision: near/ far	Burning	Light Sensitivity	Excessive Tearing
Dryness or Itching	Redness	Double Vision	Floaters or Flashes

Have you worn contacts previously? No Yes Are you interested in contacts? No Yes

If you are a current contact lens wearer, are you happy with your current lenses? No Yes

Ocular History: Please circle if you have had any of the following:

Eye surgery/ eye injury	Glaucoma	Cataracts
Lazy eye	Macular degeneration	Eye disease (please explain below)

Please circle any **medical conditions** that you currently have.

Heart disease	High blood pressure	Allergies	High cholesterol
Diabetes	Lung disease	Cancers	Thyroid disease
Skin conditions	Gastrointestinal	Depression/Anxiety	Multiple sclerosis/Neuro

Additional medical conditions not listed above: _____

List any **medications** you are currently taking, including over the counter medications and eye drops:

_____

Do you have any **allergies** to medications? No Yes List: _____

Do you smoke? No Yes No. of alcoholic drinks/week _____ Females: Are you pregnant or nursing? No Yes

What is your height? ____ ft. ____ in. What is your weight? _____ lbs.

Family Medical History: (please note relationship in box)

High blood pressure	Heart disease	Cataracts	Diabetes
Cancer	Thyroid	Blindness	Stroke
Glaucoma	Macular degeneration	Retinal Detachment	Lazy eye

Employer/Occupation: _____ Hobbies:_____

Email address: _____ May we use email to contact you? Yes No

May we leave a voicemail for you regarding your medical information? Yes No Cell #_____

Please list individuals with whom you authorize us to share your medical information.

Name: _____Relationship: _____ Phone # _____Leave Msg OK? Y N

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I acknowledge receipt of Issaquah Vision's *Notice of Privacy Practices.* Initials_____

Signed: _____ Date: _____

Who may we thank for your referral? _____

2/25/2021

Issaquah Vision Explanation of Insurance and Financial Policy

Issaquah Vision treats patients for a wide variety of eye care concerns. Your visit with us may be a vision exam or a medical eye exam.

Vision insurance is used when you are here for *routine care* and may include a glasses prescription or contact lens prescription at the end of your exam. This type of visit is billed to your vision insurance.

Medical insurance is used when you are here for a medical eye concern. Some examples of medical visits include care for diabetes, glaucoma, cataracts, dry eyes, or red eyes. This type of visit is billed to your medical insurance.
Note: Medical insurance does not cover a refraction (the testing used to determine your glasses prescription).

If medical concerns are discovered during a routine vision exam, the doctor may wish to order additional testing necessary for proper diagnosis and management of your condition. These tests are billed to your **medical insurance** and are subject to your medical co-pay and/or deductible, as well as co-insurance. Examples of advanced tests that are billed to medical insurance include OCT, Visual Field, and Photos. Your insurance may consider a particular test to be a non-covered service.

Please ask us if you have questions regarding billing for vision or medical visits.

Payment is expected at the time services are rendered, including portions not covered by insurance. Most insurance policies pay only a portion of your total charges. We do not guarantee the accuracy of benefit information given to us by insurance companies. *Please understand that financial responsibility for your account is yours, not your insurance company's.* We offer a reduction in fees for exams and medical visits for non-insured patients if payment is made on the day of service.

Any invoice not paid within thirty (30) days of such billing is subject to a $2.50 monthly charge.

I authorize release of any medical or other information necessary to process insurance claims. I authorize payments of medical benefits to Issaquah Vision for services and supplies rendered.

Patient Name(s) _____

Signature _____ Date _____

Updated: 9/24/2020

ISSAQUAH VISION

Optomap/Dilated Exam Consent Form

As part of a comprehensive eye examination, it is recommended that **ALL** patients have the internal health of their eyes thoroughly evaluated every year. This is performed as either a **dilated** retinal examination or the **Optomap** retinal imaging.

A thorough retinal exam can detect eye diseases including glaucoma, macular degeneration, retinal detachment, and diabetic retinopathy, as well as risk for conditions such as hypertension, diabetes, and stroke. These health conditions are difficult to detect without the **Optomap** or **dilation** of the pupils with eye drops due to the limited view of the internal structures of the eye.

Optomap	**Dilation**
No blurred vision	Blurred near vision for approx. 4 hours
No light sensitivity	Light sensitivity for approx. 4 hours
Takes 2 minutes to capture photos	Takes 20-30 minutes for drops to take effect
Approx 80% of retina viewed	Nearly 100% of retina viewed
You will review image with the doctor	Only doctor can view the retina

The **Optomap** provides an annual, permanent record for your medical file. The ability for our doctors to view last year's image and this year's image side by side for comparison is an invaluable tool in providing comprehensive eye care.

Many patients who choose to have the **Optomap** will not require pupil dilation, however your doctor will determine if dilation is necessary based on your specific conditions or concerns.

THERE IS AN ADDITIONAL $39 FEE FOR THE OPTOMAP RETINAL EXAM WHICH IS NOT COVERED BY INSURANCE

PLEASE CHOOSE ONE OF THE BELOW:

☐ I have read and understand the above, and **agree** to the **Optomap Retinal Exam** ($39)

☐ I have read and understand the above, and **agree** to **pupil dilation** (no additional charge)

_____ _____

Patient Name (Print) Date

_____

Patient Signature