Medical History Questionnaire   Rebuck Associates Eye Care

Patient Name: ______________________________ Today's Date: ______________
Address: ______________________________ Home Phone: ______________
City: ______________ State: ________ Zip: ________ Cell Phone: ______________
Email: ______________________________ Work Phone: ______________
Birth Date: ______________ Social Security #: ______________ Preferred Contact: H ___ C ___ W ___
Guardian (If Applicable): ______________________________ Patient's Occupation: ______________
Name of Medical Doctor: ______________________________ Dr.'s Phone: ______________
Last Medical Exam: ______________________________ Last Eye Exam: ______________
With whom may we discuss your medical history (spouse, parent, sibling, etc)? ______________
How did you hear about us? ______________________________

Medical History

Do you have any allergies (medications, food, latex, etc)? ☐ no ☐ yes If yes, please list: ______________
____

List all medications you take (including oral contraceptives, aspirin, over the counter and home remedies):
____
____

List all major injuries, surgeries, hospitalizations: ______________________________
____

Have you had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, LASIK, cataracts, eye infections, or eye injury: ______________________________

Are you pregnant or nursing? ☐ no ☐ yes

Do you wear glasses? ☐ no ☐ yes If yes, how old is your present prescription? ______________

Do you wear contacts? ☐ no ☐ yes If yes, how old is your present pair of lenses? ______________

Type of contacts: ☐ Hard ☐ Soft ☐ Extended Wear ☐Other Are they comfortable? ☐ yes ☐ no
Brand, if known: ______________ Do you sleep in your contacts? ☐ yes ☐ no

Family Medical History

Please note any **family history** parents, grandparents, siblings, children; living or deceased for the following:

Disease/Condition	NO	YES	?	Relationship to you
Blindness	☐	☐	☐	______________
Cataract	☐	☐	☐	______________
Crossed Eyes	☐	☐	☐	______________
Glaucoma	☐	☐	☐	______________
Macular Degeneration	☐	☐	☐	______________
Retinal Detachment/Disease	☐	☐	☐	______________
Arthritis	☐	☐	☐	______________
Cancer	☐	☐	☐	______________
Diabetes	☐	☐	☐	______________
Heart Disease	☐	☐	☐	______________
High Blood Pressure	☐	☐	☐	______________
Kidney Disease	☐	☐	☐	______________
Lupus	☐	☐	☐	______________
Thyroid Disease	☐	☐	☐	______________
Other______________	☐	☐	☐	______________

* PLEASE TURN OVER AND COMPLETE OTHER SIDE. THANK YOU *

Social History *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

□ Yes, I would prefer to discuss my social history information directly with my doctor. (Check box)

Do you have any visual difficulty while driving? □ no □ yes If yes, please describe: ________________________________

____

Do you use tobacco products? □ no □ yes If yes, type / amount / how long: ______________________________

Do you drink alcohol? □ no □ yes If yes, type / amount / how long: ______________________________

Do you use illegal drugs? □ no □ yes If yes, type / amount / how long: ______________________________

Have you ever been exposed to or infected with: □ Gonorrhea □ Hepatitis □ HIV □ Syphilis □ None

Personal Medical History

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?		NO	YES	?
Constitutional				**Ears, Nose, Mouth, Throat**			
Fever, weight gain/loss	□	□	□	Allergies/hay fever	□	□	□
Skin	□	□	□	Chronic cough	□	□	□
Neurological				Dry throat/mouth	□	□	□
Headaches	□	□	□	Post-nasal drip	□	□	□
Migraines	□	□	□	Runny nose	□	□	□
Seizures	□	□	□	Sinus congestion	□	□	□
Eyes				**Respiratory**			
Blurred vision	□	□	□	Asthma	□	□	□
Burning	□	□	□	Chronic bronchitis	□	□	□
Distorted vision/halos	□	□	□	Emphysema	□	□	□
Double vision	□	□	□	**Vascular, Cardiovascular**			
Dryness	□	□	□	Diabetes	□	□	□
Excess tearing, watering	□	□	□	Heart pain	□	□	□
Eye pain or soreness	□	□	□	High blood pressure	□	□	□
Flashes/floaters	□	□	□	Vascular disease	□	□	□
Foreign body sensation	□	□	□	**Gastrointestinal**			
Glare/light sensitivity	□	□	□	Constipation	□	□	□
Infection of eye or lid	□	□	□	Diarrhea	□	□	□
Itching	□	□	□	**Genitourinary**			
Loss of side vision	□	□	□	Genitals/kidney/bladder	□	□	□
Loss of vision	□	□	□	**Bones, Joints, Muscles**			
Mucous discharge	□	□	□	Joint pain	□	□	□
Redness	□	□	□	Muscle pain	□	□	□
Sandy or gritty feeling	□	□	□	Rheumatoid arthritis	□	□	□
Sties or chalazion	□	□	□	**Lymphatic, Hematologic**			
Tired eyes	□	□	□	Anemia	□	□	□
Endocrine				Bleeding problems	□	□	□
Thyroid/other glands	□	□	□	**Allergic, Immunologic**	□	□	□
				Psychiatric	□	□	□

If you have answered YES to any of the above or have a condition not listed, please give details:

____

____

____

Dr. Richard C. Rebuck OD
R&A Eye Care, PLLC

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Suite #3 **Fax: (304) 725-2027**
Ranson, WV 25438 **www.RandAEye.com**

Like us on Facebook!

At Rebuck & Associates Eye Care, we have advanced equipment to ensure the best possible care for our patients and detect any problems as soon as possible, so it is important to get the Optomap Retinal Scan and Ocular Coherence Tomograph screenings.

We take an extremely high quality digital photo (of most patients) to see a wide view of the retina to evaluate the health of your eyes. It has already enabled us to detect problems we would have otherwise missed. The pictures will be kept in your file for future comparisons at future eye exams and we recommend them every year. This is a great addition to dilation, but not a substitution. The regular price for this imaging is $85.00, but we offer it at a significant savings for only $39.00.

These are additional screenings that are NOT COVERED BY ANY VISION OR MEDICAL PLAN.

___ Yes, I choose to have the Optomap Retinal Scan today.

___ I decline this test.

Our second recommended screening is the Ocular Coherence Tomograph or OCT. This takes a three dimensional thickness scan of your retina and optic nerve to compare you to a normal data base . The charge for the OCT screening is $39.00, which is a savings off the regular price of $110.00.

___ Yes, I choose to have the OCT screening.

___ I decline this test.

If you are having this done, please arrive a bit early to your appointment.

___ Yes, I choose to have both tests and agree to pay an additional $50.00 today.
(By Getting both screenings done today you will be saving over $140.00)

Signature ____ Date _____________
Parent or guardian, please sign if patient is less than 18 years old.

Rev 5/2018

SUMMARY of Notice of Privacy Practices (One page + your signature)

Rebuck and Associates, Medical Director, 304-725-2020

The following is a brief summary of your rights and our responsibilities as detailed in the attached Notice of Privacy Practices (the "Notice"). *This Summary is for your convenience and is not a substitute for reading the entire Notice (available upon request) and does not modify the terms of the Notice.*

1. **Uses and Disclosures of Your Health Information.** We may use the information we develop and collect for treatment by our practice or disclose the information to others to whom we refer you for treatment, for payment for these services and for certain health care "operations" such as improving the competence and quality of our staff and business planning and management. We may disclose your information to our business associates such as medical transcriptionists, billing services and others who assist in the operations of our practice. We may call you to remind you of appointments and may leave a message on your answering machine if you have one. We may also disclose information to your family about your location and general condition. If you are available and able, we will ask your consent first. We may also use your information to recommend products or services related to your care. Your medical information may be disclosed without your authorization as required by law, for public health purposes, healthcare oversight, including audits and investigations, medical research, judicial and administrative proceedings, subject to the limits imposed by state and federal law, and certain other purposes as specified by law.

2. **Other Uses and Disclosures**. Except as described in the Notice, we will not use or disclose your medical information without your written authorization. You can revoke an authorization at any time, except to the extent that we have already taken action in reliance on the authorization.

3. **You're Health Information Rights**. You have a number of rights under state and/or federal law which are subject to the terms and conditions specified in the Notice:
   a) You may request restrictions on certain uses and disclosures of your information
   b) You may request that you receive your information from us in a certain way
   c) You may inspect and copy your medical records
   d) You may request an amendment to any record you believe is inaccurate
   e) You may request an accounting of disclosures made of your records

4. **Changes to the Notice**. We reserve the right to change the Notice. If we do so, we will post it in our office, [and on our website] and provide a copy upon request.

5. **Complaints**. You may file a complaint to our Privacy Official whose name is above or with the federal government as detailed in the Notice. You will not be penalized for filing any complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

Rebuck and Associates, Medical Director, 304-725-2020

Name of Patient: ______________________________

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed:______________________________ Date:______________________

Print Name: ______________________________ Telephone: ______________________

If not signed by the patient, please indicate your relationship to the patient: ______________________

For Office Use Only:

- ☐ Signed form received by: ______________________
- ☐ Acknowledgment refused: ______________________
  - Efforts to obtain: ______________________
  - Reasons for refusal: ______________________

Rebuck & Associates Eye Care - Office Policies

We want you to enjoy your visit with us and you should know that by being examined at our office, you agree to the following policies:

1. If you want your examination to be billed to any type of coverage, then you must present your medical insurance and vision plan cards before we will treat you. If you do not, then we won't bill your insurance and you will have to pay in full on the date of service. We will not bill you later. If you are unable to pay on the date of service, then you must reschedule, unless it is a true ocular emergency. We do offer financing through Care Credit.
2. Vision plans (Davis, Spectera, VSP, Eyemed, etc.) only cover healthy eye exams for nearsightedness, farsightedness, astigmatism, and the need for reading glasses. If you have other eye conditions like cataracts, glaucoma, diabetes, red/pink eye, etc., then your vision plan will not be billed and it must be paid out of pocket or billed through your medical insurance. Your vision insurance will not be billed if your medical insurance denies your claim, except for the refraction/glasses testing charge.
3. Glasses testing/refraction (if your examination is medical in nature) and contact lens evaluations are separate procedures, so both have additional and separate fees, which are not covered by some vision plans or medical insurance. If you desire to get a prescription for contact lenses, then you must have a contact lens evaluation. You have the right to decline the refraction or contact lens evaluation, but you will be unable to order glasses or contact lenses without a current prescription. You can't legally order contact lenses from a glasses prescription. <u>If you are being fit with contact lenses, then you must return in a timely manner so that your follow up visits are completed within 60 days after you receive your first contact lenses. After this period, you must pay for another fitting at full price.</u>
4. Co-pays must be paid on the date of your examination. If you can't pay your co-pay today, then you will have to reschedule. If we can verify that your medical coverage has an unmet deductible, then you will have to pay towards your deductible today and we will submit a claim to your insurance. After receiving the response from your insurance, we will notify you whether you owe any additional fees or are due a refund.
5. All charges incurred are the financial responsibility of the patient, parent, or guardian regardless if the insurance covers any of the fees. Our staff may attempt to explain your benefits, but we are not insurance experts. You are responsible for knowing what your benefits cover, whether you need a referral and for obtaining a referral prior to your examination.
6. Any balances remaining unpaid after 30 days will accrue 1.5% interest per month. Balances over 60 days may be taken to collections or court. You are responsible for all court costs. If you still don't pay, then this can be reported to credit agencies and this may constitute breach of contract, thus enabling cancellation of your insurance coverage.
7. There may be a charge when requesting copies of your medical records and all balances must be paid before this information will be released.
8. You have a right to your eyeglass prescription and as a patient you will be provided with a copy. Local opticians generally do a good job of filling our prescriptions, but we have some concern with the use of eyeglass vendors over the internet. Fitting eyewear properly involves precise measurements such as PD/pupillary distance and segment height that an internet vendor cannot provide. We provide these measurements at no charge for patients purchasing eyewear from us. If you want these measurements to buy your glasses elsewhere, there will be a $40.00 charge. Payment of this fee entitles you to free adjustments and prescription verification for the glasses.

<u>Assignment and release</u>

I hereby authorize and request that my insurance company pay directly to Rebuck & Associates the amount due in my pending claim for vision or medical treatment or services by reason of such treatment or services. I further assign to Rebuck & Associates all rights afforded to me under ERISA with respect to the services rendered, including the right to bring an action to enforce ERISA and my ERISA rights. I understand that insurance is a private arrangement between me and the insurance company, and that I am fully responsible for all monies due as a result of the services, products, or treatments provided to me by this office. Also, by my signature below, I acknowledge that I received and reviewed a copy of Rebuck & Associates Eye Care, PLLC's Notice of Privacy Practices.

<u>By signing below, I understand that I am financially responsible for all charges whether or not paid by my vision or medical coverage and have been provided the HIPAA privacy policy of this office.</u>

Print patient name____________________________ Signature (parent/guardian)________________________Date ________________

If the patient is covered under another person's policy please provide their name, date of birth and social security number.

Insured's name________________________ Date of Birth _____________________

Social security number _____-___-______ Relationship to patient ____________

Rebuck & Associates Eye Care - Glasses and Prescription Policies

Thank you for considering purchasing your eyewear from us. We truly appreciate your business and we do our best to make sure that your glasses will fulfill your needs. The following are our policies on eyewear:

1. If your vision plan makes your glasses for our office, then you are subject to the vision plan's policies on cancellations, prescription changes, remakes, refunds, etc. and you will typically not be able to get glasses made elsewhere under your vision plan until you are eligible again for that benefit in 1 or 2 years.

2. You have a right to your eyeglass prescription and you will be provided with a copy. Local opticians generally do a good job of filling our prescriptions, but we have some concern with the use of eyeglass vendors over the internet. Fitting eyewear properly involves precise measurements such as PD/pupillary distance and segment height that an internet vendor cannot provide. We provide these measurements at no charge for patients purchasing eyewear from us. If you want these measurements to buy your glasses elsewhere, there will be a $40.00 charge. Payment of this fee entitles you to free adjustments and prescription verification for the glasses.

3. Please realize that it may take time to adapt to your new prescription, so you must try to wear your new glasses as much as possible for **at least two weeks**. If the vision seems strange when you pick them up, then take them home and put them on when you awaken tomorrow. If our practice makes your glasses, then we will remake the lenses once within 60 days of when you received them if you can't adapt to the prescription.

4. All prescription glasses are custom made. Once the lenses are started at our lab, we will not cancel your order or refund your money. Occasionally some patients have chosen a frame, but later decide that they don't like the frame after they receive their glasses. If we can cancel the order for the lenses before they're started, then we will refund 90% of the total frame and lens purchase (We charge a 10% restocking fee). If you want to cancel the order after the lenses are started, then we do not provide refunds. Please make sure that you are satisfied with your choice when your order is placed. We do not provide refunds for buyer's remorse (deciding after you selected your glasses that you no longer want to purchase them).

5. If you decide that you don't like the frame that you chose and the lenses have been started at our lab, we offer you the one time option of having your lenses put into another color of the same size and brand of frame when available. The lenses can't otherwise be used. We will offer you a credit of 60% of the cost of your lenses if you wish to switch to another style of frame after the glasses are made by our lab. If the frame is in brand new condition, then we will provide a full credit toward the cost of another frame from us. The frame you are returning must be the same frame that you purchased from us and be in brand new condition or no credit will be given.

6. Our staff does their best to calculate exactly how much you will owe for your glasses under your vision plan, but occasionally they will not be able to determine that exact amount until the claim has been processed by the vision plan or insurance. Please realize that you are responsible for any amounts indicated by your vision plan and you are financially liable for the entire cost of your glasses if your insurance declines payment for any reason.

7. We will notify you at least twice when your glasses are ready for pickup. The full balance must be paid before you may take them home. If you do not pick them up within 45 days of the first notification, then the lenses will be removed and the frame will be resold and there is no refund. If your vision plan notifies us that you still owe a balance on the glasses even though you already have received the glasses, you will be notified of this bill and you agree to pay the balance within 30 days of notification.

8. It takes significant time and expertise for our staff to make lens and frame recommendations to our customers, so if you need or choose to change to a less expensive lens for any reason, we will remake your lenses once within 30 days, but you will not be refunded the difference in price and you must pay any frame cost above the 90% credited from the initial price of the frame, if you wish to change to another frame.

These policies have been provided to me and I agree to abide by them.

Patient Name ________________________________ Signature (parent/guardian) _________________________ Date __________________

Rev 2/2019