Patient Request for Treatment, Representations and Consent

I acknowledge and understand that there is an increased risk that COVID-19 can be transmitted in any place of public accommodation, including an optometric office, and I have been informed that my optometrist desires to protect the safety of the optometric office and the patients, staff and other individuals who come upon the premises.

Accordingly, as a precondition to rendering treatment, I have confirmed that I have no symptoms commonly associated with COVID-19 including fever, loss of smell, shortness of breath, gastrointestinal distress, dry cough, running nose or sore throat and that I have not, or had close contact with a person who has confirmed positive or suspected to be positive for COVID-19.

I consent to the performance of the policies put in place by my optometrist.

Name:____

Signature:______________________________________

Date:______________________

Retinal Health Screening Tests

Both offices have the OPTOMAP (OPTOS):

We started requiring retinal photos at the start of COVID for social distancing and the Doctors were better able to diagnose more eye conditions. The Doctors have now made the **retinal photography a requirement** to fully evaluate everyone's ocular health. The cost of the photography is $39.00, and cannot be opted out of.

Retinal Photo *Computerized imaging of the retina and optic nerve*	*$39 co-pay*	***Required***	✓

OR, we encourage you to combine the retinal photography with a Macular Pigment Density Test (normally a $25 co-pay on its own).

Retinal Photo and Macular Pigment Density Test *(age 30 and above only)* *Retinal photo and measurement of macular degeneration risk*	*$50 co-pay*	*Optional*	

Additionally, if you are 65 or older and/or diabetic, you **WILL BE DILATED** to meet insurance requirements.

By signing, I also understand that Piedmont Eyecare Associates, O.D. is required by law to protect my privacy and health information, as stated in the *Notice of Privacy Practices*. A copy of this is available at the front desk.

Patient name (Print) ______________________________

Patient/Guardian Signature ______________________________ Date: ______________

Please Read:
In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.
Your signature will allow Piedmont EyeCare to file the insurance you provided for your exam today. Payment from my insurance is to be paid directly to Piedmont EyeCare. I understand that my insurance will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quote to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

______________________________ ______________________________
Signature **Date**

Patient/Guardian Signature ______________________________ Date: ______________

Piedmont EyeCare
Associates, OD, PLLC

Patient Name or ID # ______________________

CONTACT LENS EVALUATION CONSENT

☐ Yes, I confirm I would like a contact lens evaluation to renew or get an initial contact lens prescription. I am aware my vision plan may not cover the cost nor offer any discounts.

☐ No, I decline to have a contact lens evaluation to renew my contact lens prescription. Measurements necessary for a contact lens prescription will not be performed.

____
Signature   Date

Contact lens evaluation pricing ranges from $70.00-$110.00. Specialty evaluation pricing starts at $250.00. Please note: Some of the evaluation cost may be covered by your vision plan.

SPEED™ QUESTIONNAIRE

Name: ______________________ Date: ___/___/___ Sex: M F (Circle) DOB: ___/___/___

For the Standardized Patient Evaluation of Eye Dryness (SPEED) Questionnaire, please answer the following questions by checking the box that best represents your answer. Select only one answer per question.

1. Report the type of SYMPTOMS you experience and when they occur:

Symptoms	At this visit		Within past 72 hours		Within past 3 months	
	Yes	No	Yes	No	Yes	No
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

2. Report the FREQUENCY of your symptoms using the rating list below:

Symptoms	0	1	2	3
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

0 = Never **1** = Sometimes **2** = Often **3** = Constant

3. Report the SEVERITY of your symptoms using the rating list below:

Symptoms	0	1	2	3	4
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

0 = No Problems
1 = Tolerable - not perfect, but not uncomfortable
2 = Uncomfortable - irritating, but does not interfere with my day
3 = Bothersome - Irritating and interferes with my day
4 = Intolerable - unable to perform my daily tasks

4. Do you use eye drops for lubrication? ☐ YES ☐ NO **If yes, how often?** ______________

Cornea. 2013 Sep;32(9):1204-10
© 2011 TearScience, Inc All rights reserved.
13-ADV-123 A

For office use only
Total SPEED score (Frequency + Severity) = ___/28

A MEMBER OF

Vision Source

Piedmont EyeCare Associates
Welcome To Our Office

Welcome to Piedmont EyeCare Associates. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. If you have any questions, please do not hesitate to ask.

HEALTH HISTORY

What is the main reason for today's exam? ______________________________

When was your last exam? ______________

When was your last health exam? ______________

Past Illnesses or Injuries: ______________________________

Past Surgeries: ______________________________

Current Medications: ______________________________

____

Current Eye Drops: ______________________________

____

Medicines that cause reactions or sensitivities: ______________________________

Specific Allergies: ______________________________

Patient name (Print) ______________________________

Piedmont EyeCare
Associates, OD, PLLC

MEDICAL RECORDS RELEASE FORM

LIST ANYONE YOU AUTHORIZE TO HAVE ACCESS TO YOUR MEDICAL RECORDS FROM OUR OFFICE. THIS CAN INCLUDE OTHER MEDICAL OFFICES AS WELL AS FAMILY MEMBERS.

NAME: ______________________________

PHONE: ______________________________

RELATIONSHIP: ______________________________

NAME: ______________________________

PHONE: ______________________________

RELATIONSHIP: ______________________________

PATIENTS NAME: ______________________________

PATIENTS DOB: ______________________________

PATIENT/GUARDIANS SIGNATURE: ______________________________

PIEDMONT EYECARE ASSOCIATES
8811 BLAKENEY PROFESSIONAL DRIVE, STE 100
CHARLOTTE NC 28277
PHONE # 704-926-EYES (3937)
FAX # 704-926-3938

DR. SCOTT L. PHILIPPE **DR. MICHAEL J. JOHNSON** **DR. PRIYA SHETH**

DR. REBECCA MAJOR **DR. SHALINI PATEL** **DR. AMANDA HEYWARD**

DR. SEAN PITALE

Piedmont EyeCare
Associates, OD, PLLC

DATE: ____________

MEDICAL RECORDS RELEASE FORM

MEDICAL RECORDS ARE BEING REQUESTED FROM:

____

____

____

PATIENTS NAME:______________________________

PATIENTS DOB: ______________________________

PATIENT/GUARDIANS SIGNATURE: ____________________

PLEASE RELEASE MY RECORDS TO:

PIEDMONT EYECARE ASSOCIATES
8811 BLAKENEY PROFESSIONAL DRIVE, STE 100
CHARLOTTE NC 28277
PHONE # 704-926-EYES (3937)
FAX # 704-926-3938

___ **DR. SCOTT L. PHILIPPE, OD**

___ **DR. MICHAEL J. JOHNSON, OD**

___ **DR. REBECCA MAJOR, OD**

___ **DR. AMANDA HEYWARD, OD**

___ **DR. SHALINI PATEL, OD**

___ **DR. PRIYA SHETH, OD**

___ **DR. SEAN PITALE, OD**

Blakeney Location

How did you hear about our practice?

- ☐ Friend ____________________
- ☐ Relative ____________________
- ☐ Doctor ____________________
- ☐ Next Door App.
- ☐ School Email/Newsletter
- ☐ Facebook
- ☐ Piedmont Eye Care Mailer
- ☐ Internet Search
- ☐ Insurance Website
- ☐ Our Website
- ☐ Google
- ☐ YMCA
- ☐ Drive by
- ☐ Church Bulletin
- ☐ Truck Advertisement
- ☐ Piedmont Eyecare Employee ______________________________
- ☐ Other (please explain) ____________________________________