Patient Demographics

Please review, make necessary changes, and supply any missing information.

First Name: Middle Name: Last Name:
Nickname: Salutation: Date of Birth:
Street Address:
City: State: Zip: Country:
Home Phone: Cell Phone:
Email:

Marital Status:	
Primary Language:	
Race:	
Ethnicity:	
Occupation:	
Employer:	
Mothers Maiden Name:	
Your Birth State:	
Your Maiden Name:	

Account Responsible (If other than Patient)	
Name:	
Street:	
City:	
State:	
Zip:	
Home:	
Cell:	
Relationship:	

Authorization

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers, please indicate that below, so we may best serve you. If you do not want any of your medical information provided to a family member, please check the box next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later, please confirm this in writing or call our office.)

_______________ _______________ ☐ Yes ☐ No Phone: _______________
Name Relation

_______________ _______________ ☐ Yes ☐ No Phone: _______________
Name Relation

_______________ _______________ ☐ Yes ☐ No Phone: _______________
Name Relation

_______________ _______________
Patient/POA Signature Date

Release of Information, Privacy Standards, Financial Agreement, Assignment of Benefits,

RELEASE OF INFORMATION and PRIVACY NOTICE: The Chu Vision Institute may disclose all or any part of my medical records and/or financial ledger, to any person or corporation (1) which is or may be liable or under contract to the Chu Vision Institute for reimbursement for services rendered, and (2) any health care provider for continued patient care. The Chu Vision Institute may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute, or regulation. A copy of this authorization may be used in place of the original. By signing this form, I am acknowledging that I understand the HIPAA compliance privacy regulations and that a copy of the Notice of Privacy Standards are available in paper form upon request.
I also acknowledge that Chu Vision Institute will not release confidential medical information regarding my treatment to family members or friends, except for (i)parent/legal guardian, (ii) other persons authorized by me, the patient, (iii) as Chu Vision may reasonably infer from the circumstances (for example, if I bring a family member or friend into the exam room, Chu Vision Institute may assume, that that person is entitled to receive information regarding my treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The of the Notice of Privacy Practices is available to me on Chu Vision's website at https://www.chuvision.com/privacy-policy and within the office.

FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by the Chu Vision Institute, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to the Chu Vision Institute for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, are hereby assigned to the Chu Vision Institute. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to the Chu Vision Institute. 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, refractions, and specialized testing used to determine candidacy for refractive surgery. **However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.**

MEDICARE (if applicable): I request that payment of authorized Medicare benefits be made on my behalf to the Chu Vision Institute for services furnished me by the Chu Vision Institute. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. The Chu Vision Institute accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

__________________________________ ____________
Signature of Patient/Authorized Party Date

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INSTITUTE

REFRACTIVE & HEALTH HISTORY QUESTIONAIRE

Patient's Ocular History Check All That Apply:

☐Dry Eye Disease/Ocular Surface Disease ☐ Glaucoma ☐ Strabismus
☐ Macular Degeneration ☐ Retinal Disease ☐ Cataract ☐ Other: ____________________

Currently Wear Glasses or Contacts for: ☐ Near ☐ Far ☐ Both

Do you wear Contact Lenses? ☐ Yes ☐ No

If yes, what type? ☐ Soft ☐ Toric ☐ Bifocal ☐ Rigid ☐ Gas Perm

How many hours a day do you wear your contacts: ___________

Date last worn: _______________________

Have you tried monovision? ☐ Yes ☐ No

Any previous eye injuries? ☐ No ☐ Yes, please describe:

Check all past eye surgeries and list the dates:

☐ NONE ☐ CATARACT Date: ______________
☐ LASIK/SMILE/PRK Date: ______________ ☐ STRABISMIS Date: ______________
☐ RK / AK Date: ______________ ☐ OTHER: ___________________Date: ____________

Have you had previous *evaluations* for refractive surgery? ☐ Yes ☐ No

If yes, where? ____________________________________ When? _______________________________

Result of exam: ☐ Good Candidate ☐ Poor Candidate

Have you turned down refractive surgery in the past? ☐ Yes ☐ No

If yes, please indicate reason: ____

Patient's Current and Past Medical History Check All That Apply:

Heart Problems: ☐ Chest Pain ☐ Heart Failure ☐ Pacemaker/ICD ☐ Heart Attack ☐ Irregular Heart Beats
☐ Hypertension (High Blood Pressure) ☐ Hyperlipidemia (High Cholesterol)

Central Nervous System: ☐ Stroke ☐ Seizure

Lung Disorders: ☐ Emphysema ☐ Asthma ☐ COPD ☐ Tuberculosis ☐ Sleep Apnea

Diabetes: ☐ Type 1 ☐ Type 2 **Controlled with:** ☐ Insulin ☐ Oral ☐ Diet

Digestive Disorder: ☐ GERD (Reflux) ☐ Other:____

Infectious Disease: ☐ Hepatitis ☐ HIV/AIDS ☐ Other:____

Hematologic: ☐ Anemia ☐ Bleeding Problems: ____

Cancer: ☐ No ☐ Yes List Type(s):

Mental Health Disorders: ☐ No ☐ Yes List Type:

Please check if you have been diagnosed with any of the following:

☐ Arthritis ☐ Dry eye syndrome ☐ Acne Rosacea ☐ Blepharitis ☐ Keloid ☐ Diabetes
☐ Immune System Disorders ☐ Skin Disorders ☐ Seasonal Allergies ☐ Ocular Herpes Simplex Virus ☐ None

Possibility of Pregnancy? ☐ No ☐ Yes **Are you currently nursing?** ☐ No ☐ Yes

Social History:

Alcohol use? ☐ None ☐ Former ☐ Social ☐ Yes, Frequency: ___________
Tobacco use? ☐ Never ☐ Former ☐ Yes: Frequency: ____________________

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List your hobbies: ____

How many hours per day do you spend: ____ Driving ____ On your phone ____ On the computer ____ Reading

Medications & Allergies: You may provide medication & allergy list on the day of your appointment.

Do you or have you used any of the following medications: Check All That Apply

☐ Accutane ☐ Alternative Medications (i.e., herbal) ☐ Antihistamine ☐ Imitrex ☐ Prednisone

☐ Prozac ☐ Valium ☐ Hormone Replacement Therapy ☐ Xanax

List Current Medications/Vitamins and Dosages: ☐ I do not take any medications or vitamins

Allergies and Reactions: ☐ No Known Allergies to Medications

Family Ocular History: This includes your mother, father, sibling/s, and grandparents. Check all that apply.

☐ Cataract ☐ Glaucoma ☐ Macular Degeneration ☐ Retinal Disease ☐ Strabismus ☐ Blindness

☐ Dry Eye Disease ☐ Keratoconus ☐ Other: ______________________

Patient Primary Care and Pharmacy:

Primary Care Provider Name & Location: ______________________________________

Primary Eye Doctor Name & Location: ______________________________________

Preferred Pharmacy Name & Location: ______________________________________

What are your expectations from refractive surgery (i.e., LASIK)?

____

________________________ ________________

Patient Signature Date

INFORMATION REGARDING DILATING EYE DROPS

Dilating eye drops are used to dilate or enlarge the pupils of the eye to allow the doctor to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time, which varies from person to person and may make bright lights bothersome. The doctor can't predict how much your vision will be affected. If you are uncomfortable driving yourself, we recommend making driving arrangements.

Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating eye drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize the medical staff at Chu Vision Institute to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

______________________________ ____________________

Patient Signature Date

VIRTUAL VISITS ACKNOWLEDGMENT

1) Nature of Virtual Eye Health Visit

During the virtual visit: a) We will use a HIPAA compliant platform for our visit. b) Details of your medical history, prior tests and examinations will be discussed, as well as a current history and plan using interactive audio and video technology. c) Physical examination will be visual, where feasible. d) Digital photos may be taken to enter into your chart during the virtual visit, but we will not record video or audio with our HIPPA compliant system.

2) Medical Information and Records

All existing laws regarding your access to medical information and copies of your medical records apply to this virtual visit.

3) Confidentiality

Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the virtual visit. All existing confidentiality protections under federal and Minnesota State law apply to information disclosed during this telemedicine consultation.

4) Risks and Consequences

The virtual visit will be similar to a medical office visit, except interactive video technology will allow you to communicate with a doctor at a distance. At first you may find it difficult or uncomfortable to communicate using video. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to physician contact. Following the virtual visit, your physician may recommend a private consultation visit be scheduled in our office for further evaluation or follow up.

5) Rights

You may withhold or withdraw consent to the virtual visit (i.e., end the appointment) at any time without affecting your right of future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

Signed Acknowledgement:

I have been advised of all the potential risks, consequences, and benefits of virtual visits. I have asked the clinic representative any questions that I have about the written information provided above. I understand the written information provided above.

_______________________________   ____________________

Patient Signature   Date