PRIMARY VISION CARE CENTER, O.D. P.A.
Total Professional Eyecare
DR. PHILLIP C. TART

MEDICAL HISTORY QUESTIONNAIRE

Medical History:

Do you have any allergies to medications? ☐ No ☐ Yes If yes please list below:

_____

_____

List any medications you are currently taking (including oral contraception, aspirin, over the counter medications and home remedies):

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had:

_____

_____

List any of the following you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

_____

	Yes	No	
Are you pregnant or nursing?	☐	☐	
Do you wear glasses?	☐	☐	If yes, how old is your present pair of lenses? _____
Do you wear contacts?	☐	☐	If yes, how old is your present pair of lenses? _____
Type of contact lenses:	☐ Rigid	☐ Soft	☐ Extended Wear ☐ Other
Are they comfortable?	☐	☐	

Family History:	Yes	No	?	RELATIONSHIP TO YOU
Blindness	☐	☐	☐	_____
Cataracts	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lupus	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other _____	☐	☐	☐	_____

OFFICE USE

Patient Name: _____ D.O.B. _____

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with your doctor if you prefer.

☐ Yes, I would prefer to discuss my Social History Information directly with my doctor (Check box)

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes

If yes, please describe below:

_____

Do you use tobacco products? ☐ Yes ☐ No If yes, type/ amount/ how long: _____

Do you drink alcohol? ☐ Yes ☐ No If yes, type/ amount/ how long: _____

Do you use illegal drugs? ☐ Yes ☐ No If yes, type/ amount/ how long: _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

REVIEW OF SYSTEMS:

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

System Constitutional	Yes	No	?
Fever, Weight loss/gain	☐	☐	☐
Integumentary (skin)	☐	☐	☐
Neurological			
Headache	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Eyes			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted/ Vision Halos	☐	☐	☐
Loss of side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Red Infection of Eye or Lid	☐	☐	☐
Sites or chalazion	☐	☐	☐
Flashes/ Floaters in Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
Endocrine			
Thyroid/Other Glands	☐	☐	☐
Bones/ Joints/ Muscles			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Allergic/Immunologic	☐	☐	☐

Ear, Nose, Mouth, Throat	Yes	No	?
Allergies/ Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat/Mouth	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Vascular/Cardiovascular			
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
Gastrointestinal			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Genitourinary			
Genitals/Kidney/Bladder	☐	☐	☐
Lymphatic/Hematologic			
Anemia	☐	☐	☐
Bleeding/Problems	☐	☐	☐
Psychiatric	☐	☐	☐

If you answered yes to any of the above or have a condition not listed, please explain and list medications:

_____

_____

Primary Vision Care Center, O.D., P.A.
13520 Hwy 50 Surf City, NC 28445
(910)803-0555

Patient Name: _____
(Last) (First) (Middle Initial)

Mailing Address: _____
(City) (State) (Zip + 4)

Home Phone: _____ **Cell Phone:** _____

Email Address: _____ **Drivers License #:** _____

Date of Birth: _____ **Age:** _____ **Social Security #:** _____

(Circle one below)
Sex: Male or Female **Marital Status:** Married Single Legally Separated Divorced Widowed

Race: _____ **Language:** _____ **Ethnicity:** _____

Employment: _____ **Work Phone:** _____

Emergency Contacts & People we may discuss care with: (please list name, relation, phone number):

_____

_____

How did you hear about our practice: _____

Primary Insurance: _____ **Secondary Insurance:** _____
(Photocopies of all insurance cards required)

Responsibility Party Information:

Name: _____ **DOB:** _____

Address: _____

Phone Number: _____ **Relationship to Patient:** _____ **SS#** _____

Medical Doctor: _____ **Pharmacy:** _____
(Name and Phone Number) (Name and Phone Number)

Patient Signature: _____ **Date:** _____

How do you wish to pay today? Cash Check Credit Card

Payment is expected at the time of service unless other arrangements have been made prior to visit. Signing this form gives us the right on your behalf to file your insurance. If insurance does not pay in a timely manner you may be billed for services rendered. The refraction may not be a covered service and you will be responsible for this fee at the time of service. This office requires a 24 hour cancellation for appointments, failure to do this will result in a $25 NO SHOW FEE*

Primary Vision Care Center, O.D. PA

Payment Policy

Thank you for choosing Primary Vision Care Center as your provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of you contract with your insurance company. **Failure on our part to collect co-payments and deductibles from patients can be considered fraud.** Please help us in upholding the law by paying your co-payment at each visit. There will be an additional charge of $2.00 if we have to bill your co-pay.

3. Non-covered services. Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay these in full at the time of your visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we refer your account to a collection agency and you or your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis. Please be aware that should your account be referred to a collection agency, the percentage charged by the collection agency to our practice will be added to the total amount of your bill.

8. Missed appointments. **There is a $25 no-show/late cancellation fee**. All appointments must be canceled by 3 PM the day prior to your appointment (or by 3 PM on Friday for a Monday appointment), to avoid charges for a no-show or late cancellation. Insurance will not cover charges for a no-show/late cancellation fees.

9. Copies of Medical Records and Insurance/Disability Forms. Our office will gladly make copies of medical records for you. The fee for this service is based on the number of pages copied. If you need our office to complete any disability forms or forms for your insurance company or other parties, we will be glad to do so for a fee of $15.00,

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of Patient or Responsible Party

Date

Primary Vision Care Center, O.D. PA

Consent for Purposes of Treatment, Payment and Healthcare

Operations CONSENT FOR TREATMENT:

The undersigned consents to any examination, laboratory procedure, or other medical treatment or service rendered to the patient under the general and special instructions of Dr. Phillip Tart. The undersigned is aware that the practice of medicine is not an exact science and acknowledges that no guarantee or assurance has been made or implied to the patient as to the result that may be obtained from examination or treatment. The undersigned has been informed of the patient's rights and responsibilities.

RELEASE OF INFORMATION:

The undersigned hereby authorizes this medical office to disclose all or any part of the patient's medical record or other medical information to any person or corporation which is or may be liable for all or part of this medical office's charges or having the responsibility for reviewing such charges, including but not limited to this medical office or medical service organizations, health maintenance organizations, insurance companies, workers compensation claims, welfare funds, or peer review organizations. The undersigned agrees to the copying of all medical record(s) which is/are to be sent to a receiving facility in the event that the undersigned must be transferred to another provider/facility. The undersigned acknowledges and consents that medical records, laboratory results, radiology reports, and billing information may be sent electronically or via facsimile to another medical facility or physician office involved in the care of the patient or responsible for any part of the patient's charges.

REQUEST FOR PAYMENT. ASSIGNMENT OF BENEFITS. AND RELEASE OF INFORMATION FOR MEDICARE / MEDICAID PATIENTS:

The undersigned requests payment of authorized Medicaid/Medicare benefits, if any, for any services furnished to the patient by Primary Vision Care Center, including physician services, and hereby assigns such benefits otherwise payable directly to the patient, to Primary Vision Care Center or the physician(s) furnishing such services. The undersigned authorizes Primary Vision Care Center or such physicians to submit a claim for such services to Medicare/ Medicaid. The undersigned authorizes any holder of medical or other information about the patient to release to Medicare/Medicaid, or its agent, claims processor, or utilization reviewers, any information needed to determine these benefits or benefits for related services.

ASSIGNMENT OF INDIVIDUAL BENEFITS:

In the event the undersigned is entitled to medical benefits of any type whatsoever arising out of any policy of insurance insuring patient or any other party liable to patient, the undersigned authorizes Primary Vision Care Center, or physicians to submit a claim for such services, and benefits are hereby assigned to this medical office for application on the patient's bill. It is agreed that Primary Vision Care Center, may receive any such payment and such payment shall discharge the paying insurance company of any and all obligations under the policy to the extent of such payment. The undersigned and/or patient are responsible for charges not covered by the insurance. The undersigned certifies that the patient information given by or on behalf of the patient in applying for payment from all third party payors is correct.

FINANCIAL AGREEMENT:

The undersigned understands and agrees that the patient and guarantor are financially responsible to Primary Vision Care Center, for charges for medically necessary services or services requested by or on behalf of the patient if such services are not covered by the patient's insurance plan or Medicare/Medicaid. The undersigned certifies that he/she has read the foregoing and is the patient or guarantor of this bill, or is duly authorized as the patient's general agent to execute the above and accept its terms.

I HAVE READ, OR I HAVE HAD EACH OF THE ABOVE SECTIONS READ TO ME, AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED.

Signature of Patient or Personal Representative	Name of Patient or Personal Representative	Date

REGARDING VISIONCARE &
MEDICAL INSURANCE

We often have patients that have both vision insurance (for example, VSP or EyeMed) and medical insurance (for example, Blue Cross, Aetna, Blue Shield, or Medicare). They are very different in terms of the services they cover, and it's important for our patients to understand these differences.

Vision insurance is designed mainly to cover determining a prescription for glasses, to help pay for glasses or contact lenses, and to cover a yearly routine evaluation of the health of the eyes in a healthy patient that has no particular problems or symptoms. It is not equipped to deal with and does not usually cover medical conditions, injuries, and/or treatments. **Medical insurance** is designed to cover you when you have a medical problem, including one that affects your eyes. Medical insurance does not cover routine services or examinations for glasses, or routine vision problems such as nearsightedness, farsightedness, and astigmatism. Those are only covered by your vision insurance.

When a medical diagnosis or medical condition is present that affects your eyes, such as high blood pressure, high cholesterol, or diabetes, to name just a few examples, or you have an eye disease or eye problem such as an infection (pink eye), dry eyes, allergy, or cataracts, again, just to name a few, we must file the claim with your **medical insurance**, and the co-pays and deductibles for that insurance will apply. Your vision plan does not cover these kinds of problems. Our office does not make these rules, they are made by the insurance companies themselves, and we must comply with them.

There is often no way to know prior to your examination which type of insurance will be the right one to file your claim with. We make every effort to join as many insurance panels, both medical and vision, as we can for your convenience. If we are on your insurance company's panel we will file those claims for you. In the event that we do not accept your medical or vision insurance we will provide you with an itemized receipt so that you may file a claim for reimbursement with your insurance company yourself. If you have any questions, please let us know.

I understand the information I've just read about the difference between vision and medical insurance. I authorize _____ to file my claim with the appropriate insurance based on the reason for my visit and the results of my examination.

Signed: _____

Age-Related Macular Degeneration (AMD) Risk and Symptom Assessment

AMD is the leading cause of vision loss among older Americans. It is a progressive condition that causes a part of your retina called the macula to deteriorate with age. The macula is responsible for your central vision, which allows you to do things like read, watch TV, recognize faces and drive.

Risk factors for AMD

There are several factors that may increase your risk of developing AMD, including the ones listed below. Check all that apply:

- ☐ 50 years of age or older
- ☐ Current or past smoker
- ☐ Family history of AMD
- ☐ Overweight
- ☐ Caucasian (white)
- ☐ Heart disease, high blood pressure and/or high cholesterol

Since poor night vision is a common symptom of AMD, we use the AdaptDx® to measure the number of minutes it takes you to adjust from bright light to darkness. This number is your RI, or Rod Intercept, and it can help us detect AMD at its earliest stages. The AdaptDx test is non-invasive and takes 5-10 minutes to complete

Early symptoms of AMD

Before any structural changes can be seen in the back of your eye, you may experience the following early symptoms. Check all that apply:

- ☐ Difficulty seeing at night
- ☐ Difficulty driving at night
- ☐ Difficulty reading in dim light
- ☐ Distorted / blurry vision
- ☐ Recent changes in vision

Patient Name _____ Patient Signature _____ Date _____

AdaptDx®

iWellness Exam

Your eyesight is priceless and we are here to protect it!

Vision threatening diseases such as glaucoma, macular degeneration and diabetic retinopathy often have no outward signs or symptoms in the early stages. Therefore, in an effort to provide a more thorough eye exam, our practice has recently joined with other elite practices now performing comprehensive eye exams using the iVue SD-OCT by Optovue.

The iWellness Exam™ is a **quick, non-invasive** scan that allows our doctors to see beneath the surface of your retina. Like an MRI of the eye, the iWellness Exam™ reveals ocular anatomy and signs of disease in exquisite detail. This breakthrough technology can help Dr. Tart detect potentially vision threatening, as well as systemic diseases in their very early stages, when they are most treatable.

As part of your pre-exam testing, our technician will perform the iWellness Exam™, which your doctor will review with you during your examination today. The **$45 charge** is typically not covered by your vision or medical insurance unless being used to actively follow disease. This charge will be added into the cost of your visit today. Any questions you have about iWellness Exam™ and the results of the test can be discussed with the doctor during your examination.

Regular iWellness Exams™ can help your doctor detect common eye diseases such as:

- Diabetic Retinopathy
- Glaucoma
- Macular Degeneration

The iWellness Exam™ provides:

- Detailed SD-OCT scan reports to show a healthy eye or detect early signs of disease.
- Thickness maps of the retina and ganglion cell complex giving your doctor detailed information simply not available with other methods.
- The opportunity for you to view and discuss your iWellness Exam™ scan reports with your doctor at the time of your exam.
- A permanent record for your file, which allows your doctor to compare your iWellness Exam™ scan reports each year to look for changes.

_____ **YES,** I would like to have the **iWellness Exam™** today.

_____ **NO,** I would only like to have a routine eye exam today.

_____ _____ _____

Print Name Date Signature