TRINITY EyeCenter

For the safety and health of our patients and staff, please complete the following health screening:

1. Have you been diagnosed with COVID-19?

   YES or NO

   IF YES - I am permitted to discontinue isolation per guidelines from the Centers for Disease Control and Prevention ("CDC") and/or my treating physician.

   YES or NO

2. Are you currently exhibiting any COVID-19 symptoms, or have you exhibited any COVID-19 symptoms in the last 14 days, including cough, shortness of breath/difficulty breathing, headache, fever, chills, muscle pain, sore throat, loss of taste or smell, nausea, vomiting, or diarrhea?

   YES or NO

3. Do you currently have a fever over 100.4 degrees Fahrenheit?

   YES or NO

4. In the last 14 days, have you been in close contact (less than 6 feet) with anyone that has tested positive for COVID -19?

   YES or NO

5. Are you or someone in your household immunocompromised?

   YES or NO

   IF YES - do you require additional accomodations before, during, or after your examination?

   YES or NO

If you are experiencing any symptoms of illness, you will be asked to reschedule your visit until you are sympton-free.

Thank you for understanding and your cooperation as we try our best to limit the spread of the COVID-19.

Print Name:_____ Date:_____

Signature:_____

PATIENT REGISTRATION FORM

General Information

Patient's Name: (Mr. / Mrs. / Ms. / Dr.) (Last, First, MI) _____

Address:_____City_____State_____ZIP _____

Home Phone (_____)_____Cell Phone (_____)_____Email:_____

DOB___/___/___ Gender: [M / F] SSN_____-___-_____ Employer _____ Marital Status: [Single / Married /Other]

Parent/Legal Guardian:_____Phone:_____Alt. Phone:_____

Emergency Contact_____Relationship_____Phone:_____

Primary Physician: Dr._____Phone: _____Fax: _____

How did you hear about Trinity Eye Center? ☐ **Insurance** ☐ **Family/Friend** ☐ **TV** ☐ **Internet**

AS A COURTESY, WE WILL FILE MOST INSURANCE CLAIMS WHEN YOU COMPLETE THE SECTION BELOW AND PROVIDE THE FOLLOWING:

1. **Photocopies of the front and back of your valid insurance ID card.**
2. **Downloaded or printed description of your medical and/or vision benefits.**
3. **Authorization to file insurance claims and receive direct payment for services rendered.**

Primary Medical Insurance:_____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Name of Primary Insured:_____

Insured's D.O.B.: _____/_____/_____ **Insured's SSN:** _____-_____-_____

Insured's Address_____Phone #_____

Subscriber ID #:_____**Group #:**_____**Employer:**_____

Secondary Medical Insurance:_____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Name of Primary Insured:_____

Insured's D.O.B.: _____/_____/_____ **Insured's SSN:** _____-_____-_____

Insured's Address_____Phone #_____

Subscriber ID #:_____**Group #:**_____**Employer:**_____

Vision Plan:_____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent

Name of Primary Insured:_____

Insured's D.O.B.: _____/_____/_____ **Insured's SSN:** _____-_____-_____

Insured's Address_____Phone #_____

Subscriber ID #:_____**Group #:** _____**Employer:**_____

INFORMED CONSENT & TREATMENT AUTHORIZATION

- I have read or had explained to me the *Notice of Privacy Practices/HIPAA* for TRINITY VISION CENTER and agree to continue my care with TRINITY EYE CENTER under said terms.

- CONSENT FOR DILATION: In order to thoroughly examine the internal health of the eyes, we may need to place eye drops that enlarge your pupils. Side effects may include temporary blurred near vision and light sensitivity that last approximately 4 to 6 hours. For some individuals the distance vision may also be blurred, needing a separate driver for safety. This procedure may add 20 – 30 minutes to the complete examination time.

- I hereby authorize TRINITY EYE CENTER to provide a diagnosis & optometric treatment to my child or me. I further authorize the release of Protected Health Information to additional physicians or optometrists in order to facilitate continuity of care. I have read & understand the above information & am signing this form voluntarily.

X_____ _____

Patient or Legal Guardian's Signature Date

IMPORTANT FINANCIAL & INSURANCE FILING POLICY

- **All charges are your responsibility, whether or not your insurance company pays.**
  - ✓ *I understand that I am ultimately responsible for any bill incurred in this office. Should my account become delinquent, I will be responsible for any & all legal fees, court costs, & collection charges. There will be a service charge for each returned check.*
  - ✓ *Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We cannot become involved in disputes between you and your insurer regarding covered charges, deductible, or copay.*
  - ✓ ***Contact lens prescription requires doctor's fitting and evaluation, and the fee is always separate from comprehensive eye exam and refraction. Contact lens fee can vary depending on types of contact lenses and the level of difficulty. In most cases, Contact Lenses can be shipped within the United States at no charge. In the event there is a fee, I understand I am responsible for all necessary charges.***

- If TRINITY VISION CENTER is **out-of-network** for your medical insurance:
  - ✓ *It is your responsibility to pay the full usual and customary fee at the time services are rendered, in order to file the claim to your insurance.*
  - ✓ *Under your approval, TRINITY VISION CENTER will submit the claim for you and reimburse you the amount paid back by your insurance company, which may be different from our usual and customary fees.*
  - ✓ *If you haven't met your deductible, your payment will be applied toward your deductible.*
  - ✓ *In case where you accept discount on services offered by TRINITY VISION CENTER, neither you nor TRINITY VISION CENTER will be allowed to file the insurance claim for the services rendered.*

- If TRINITY VISION CENTER is **in- network** with your medical insurance:
  - ✓ *If your insurance company does not pay your claim within 30 days, it is your responsibility to contact them to expedite payment. If your insurance company refuses to pay, you are responsible for payment.*
  - ✓ *Payment for copay and/or deductible is due at the time services are rendered.*
  - ✓ *In the event that refraction is not covered by your insurance you will be charged a fee in addition to your copay and/or deductible.*

- Vision Plans:
  - ✓ *I understand that vision plans (VSP, Eyemed, etc.) cover only for routine annual/biannual vision exams and **DO NOT** cover for medical eye problems. I also understand that in case where medical eye problem is detected during a routine examination, TRINITY VISION CENTER is allowed to bill my medical insurance or myself directly for the services rendered.*

- **AUTHORIZATION TO RELEASE HEALTH INFORMATION & ASSIGN BENEFITS**
  - ✓ *I authorize the release of all necessary Protected Health Information & assign all medical & vision benefits to **TRINITY VISION CENTER.** I also request that payment of authorized Medicare (if applicable) benefits be made on my behalf to **TRINITY VISION CENTER** for any services furnished to me by **TRINITY VISION CENTER.***
  - ✓ *I authorize any holder of medical information related to me to release to the Centers for Medicare & Medicaid Services (CMS) & its agents, any information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests that payment be made & authorizes release of medical information necessary to pay the claim.*

- This authorization & assignment will remain in effect until revoked by me in writing. A photocopy/scanned image of this authorization & assignment is to be considered as valid as the original. I request that you file my insurance & I have agreed to, and completed, all of the conditions listed above. I have read & understood this information & I am signing voluntarily.

Name: (please print):_____

X_____

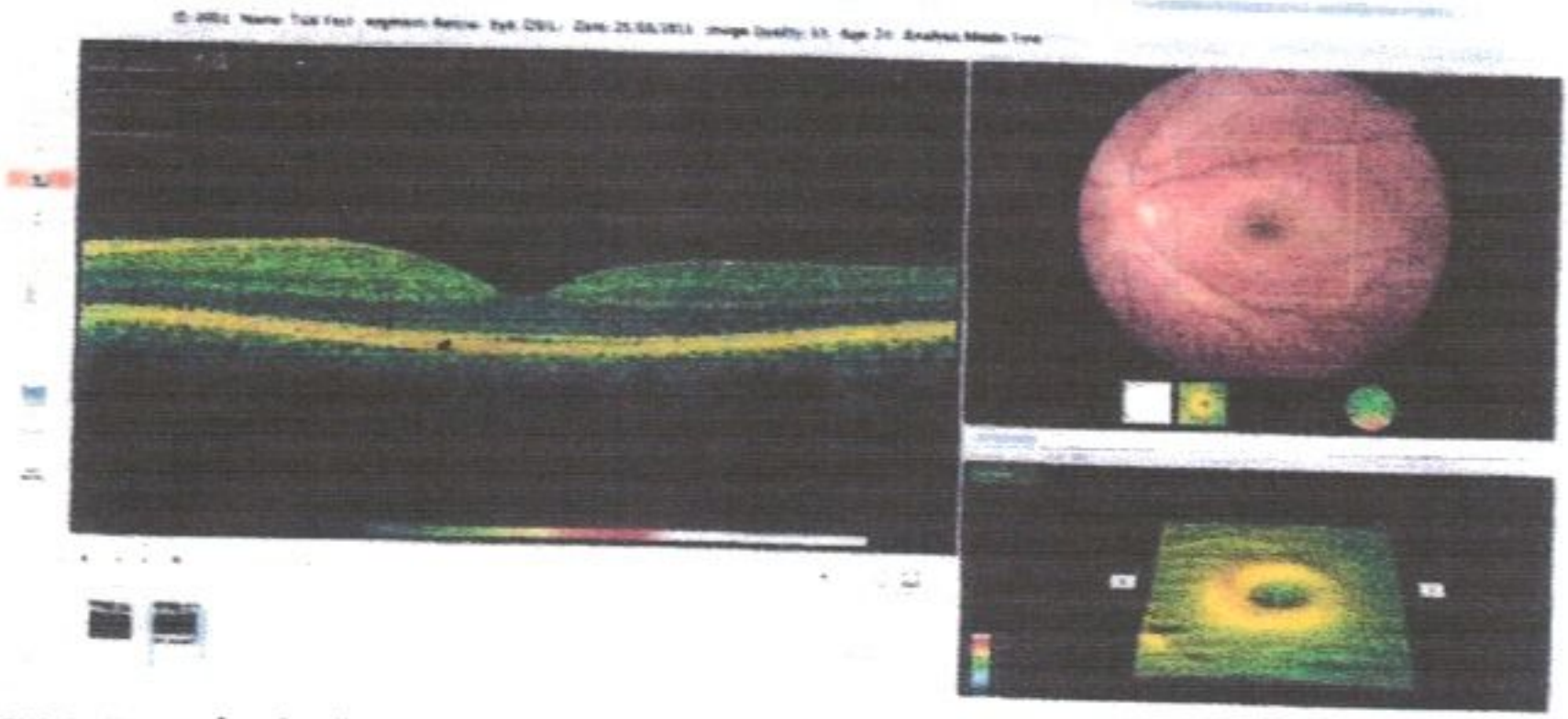
Patient or Legal Guardian's Signature Date

TRINITY EyeCenter

3-D RETINA WELLNESS SCREENING CONSENT FORM

Dr. Justin M. Kim O.D. and Associates are proud to provide our patients with the most advanced technology in retinal imaging today. This test aids in early detection of many eye diseases such as:

- **Glaucoma**
- **Macular** eye diseases
- **Retinal and Vitreous** detachments
- **Tumors** of the eye
- Eye damage caused by **diabetes, strokes, high blood pressure** and other systemic conditions



If you have a **personal or family history** or any physical examination findings consistent with any of these conditions, or take high risk medications, it may be necessary to perform this eye imaging studies.

Dr. Kim recommends *ALL* of his patients to have the 3-D Retina Wellness Screening annually. It is important to note that this is not a substitution for a dilated retinal exam, but provides a more extensive look than examination alone. The 3-D Retina Wellness Screening is fast (a couple of minutes), easy and comfortable, and Dr. Kim will personally review the results with you at today's visit.

Insurance typically does not cover any advanced screening technology beyond the general exam, and the fee of **$39** is due at the time of service.

Please mark your preference below, sign and date

[ ] Yes, I want the 3-D Retina Wellness Screening today.

[ ] No, I elect to decline the 3-D Retina Wellness Screening exam.

_____ _____

Patient/Guardian Signature Date

TRINITY EyeCenter

PATIENT HEALTH HISTORY FORM (EMR USE)

I. **Glasses Currently Owned:** ☐Distance ☐Reading ☐Driving ☐Bifocal ☐Trifocal ☐Progressive ☐Sunglass ☐Safety

II. **Contacts Currently Worn:** ☐Soft Lenses ☐RGP lenses ☐Toric lenses ☐Multifocal lenses

☐I do **NOT** currently wear contact lenses but would like to try.

(Note: Evaluation and/or fitting fee will be applied, for any contact lens prescription. Fees vary depending on CL types. Cost of the contact lens material is always separate..)

III. **Please tell us what you are currently experiencing. Please check all appropriate boxes..**

☐Blurry vision	☐Headache around eyes	☐Dryness	☐Foreign Body Sensation
☐Double Vision	☐Tearing/Watery eyes	☐Distorted Vision	☐Sandy/Gritty feeling
☐Floaters	☐Mucous Discharge	☐Redness in eye	☐Redness around eye
☐Flashes of Light	☐Fluctuating Vision	☐Eye pain	☐Eye soreness

☐Other:_____

_____

IV. **Please review your current/History medical conditions. Check all appropriate boxes.**

☐Ear,Nose,Throat ☐Cardiovascular ☐Neurological ☐Musculoskeletal ☐Cancer

☐Gastrointestinal ☐Lung Disease ☐Hypertension ☐Respiratory ☐Integumentary(skin)

☐Endocrine ☐Arthritis ☐Allergic ☐Psychiatric ☐Other_____

Explain:_____

_____

V. **Patient Eye History:** ☐Glaucoma ☐Cataract ☐Macular Degeneration

☐Injuries:_____

☐Surgery:_____

VI. **List of Current Medications (including any eye drops):**_____

_____

VII. **Medication allergies/reactions:** _____

_____

VIII. **Hobbies/Sports:** ☐Golf ☐Tennis ☐Computer ☐Reading ☐Jogging ☐Swimming ☐Bike Riding

☐Sewing/Crafts ☐Soccer/baseball ☐Other:_____

IX. **Family History:** ☐Hypertension ☐Diabetes ☐Cataract ☐Glaucoma ☐Macular Degeneration

☐Other:_____

X. **Social History:** ☐Cigarette Smoking Frequency_____ ☐Alcohol Frequency_____

What are you hoping to achieve from today's visit?_____

_____

Sign:_____ Date:_____