Introduction

Welcome to 4Sight iCare's new Intake process. We want your visit to be about you and helping you SEE YOUR BEST, rather than spending time on paperwork at the office.

At 4Sight iCare every annual comprehensive eye exam is performed in conjunction with the doctor-cultivated, age-appropriate testing collectively referred to as the iHealth Wellness Exam.

☐ I acknowledge that an iHealth Wellness Exam shall be performed as part of the comprehensive visit. The details including your copay ranging from $0 to $78 are listed in the "Office Policies" section entitled YOUR RESPONSIBILITY INCLUDING PAYMENT METHOD AND GOOD FAITH ESTIMATE.

Interest in Refractive Surgery Co-management, Vision Shaping Treatment & Ocular Aesthetics

Are you interested in corrective vision surgery now or in the near future? ☐ Yes ☐ No

Would you like to know if you are a good candidate for vision correction WITHOUT surgery, glasses, or daytime contacts? ☐ Yes ☐ No

Would you like to know if there is something cosmetic that we can do to improve the appearance of your eyes? ☐ Yes ☐ No

Please mark the B4EP's below that interest you most and will therefore keep you coming back yearly for your ANNUAL comprehensive eye exam to maintain your Established Patient Status:

- ☐ $40 Instant Savings: Save instantly on select eyewear products and specialty services.
- ☐ 4EP (4 Easy Payments) Plan: Interest-free payment plans for complete eyewear or year supply of contact lenses.
- ☐ FF4M (Featured Frames 4 the Month): Staff selects a frame style, brand, size or type to feature each month for 40% OFF retail with the purchase of a lens that already carries $150 savings per lens package
- ☐ 1/4th OFF Non-Powered: Save 25% on any pre-fabricated Digital Device Lenses or Sunglasses prescribed for protection rather than correction.

How did you first learn about 4Sight iCare?

- ☐ Another local business
- ☐ Community function
- ☐ Doctor referral
- ☐ Friend/Family
- ☐ Insurance
- ☐ Mailing/Paper handout
- ☐ Online Google search
- ☐ Other online search
- ☐ Walking/Driving past

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Date ___/___/_____

Demographics

Pronouns ○ he/him ○ she/her ○ they/them

Preferred Name _____ Middle Name _____ Last Name _____

Suffix _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Assigned Gender ○ Male ○ Female

Cell phone _____ Home phone _____ Work phone _____

Email _____

Ethnicity _____

What is your position/occupation, grade in school, or number of years in retirement?

_____

Specialty Frame Technology Questionnaire

On a scale from 1 to 10, 10 being the most satisfied; how happy are you with your hearing?

_____

While browsing frames in our optical would it be of interest to know about special frames that offer built in Bluetooth connectivity, image capture, and open ear audio that leverages Artificial Intelligence?

☐ Yes ☐ No

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Insurance Information

Primary Insurance

Insurance Company Name _____

Policy Holder _____

Relationship of Policy Holder _____

Policy Holder Date of Birth _____

Policy Number _____

Secondary Insurance

Insurance Company Name _____

Policy Holder _____

Relationship of Policy Holder _____

Policy Holder Date of Birth _____

Policy Number _____

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Reason for Visit

If another provider sent you to us, who? _____

What's your main reason for this visit? ☐ Wellness Vision Visit ☐ Medical Eye Care

Eye Health History

When was your last eye exam? _____

If you're new to us, who was your previous eye doctor? _____

Have you ever had any eye injuries, surgeries for your eyes, or been diagnosed with an eye disease?

- ☐ No conditions
- ☐ Glaucoma suspect
- ☐ Glaucoma
- ☐ Cataract
- ☐ Age related macular degeneration
- ☐ Surgery
- ☐ Patching
- ☐ Inflammatory disorders
- ☐ Strabismus
- ☐ Amblyopia
- ☐ Retinal degeneration
- ☐ Retinal hole
- ☐ Retinal detachment
- ☐ Keratoconus
- ☐ Injury
- ☐ Dry eye
- ☐ Nystagmus
- ☐ Retinal/degeneration/ hole/detachment
- ☐ Other

When do you wear glasses?

- ☐ Never
- ☐ For far vision only
- ☐ All the time
- ☐ Only for protection (digital devices, sunglasses, safety glasses)
- ☐ While on computer only
- ☐ While reading only
- ☐ While on computer and reading

What, if anything, don't you like about your current eyeglasses? _____

_____

How old are your glasses? _____

Do you want a contact lens prescription (CLRx) at the end of this exam? ○ Yes ○ No

What brand of contact lenses have you used most recently? _____

Do you ever sleep in your contact lenses? ○ Yes ○ No

How often do you discard old and start a new pair of lenses? ○ Daily ○ Monthly ○ Quarterly ○ Other

What, if anything, don't you like about your current contact lenses? _____

_____

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How many times per week would you like to wear your contacts?

- ☐ Less than 3 times a week
- ☐ 3 to 4 times per week
- ☐ 5 times per week
- ☐ 6 or 7 times per week

What's the single most important detail about contact lens use to you?

- ☐ Eye health is preserved with a highly breathable material
- ☐ Comfort on the eye is optimized with the latest lens technologies
- ☐ Sharp vision is achieved at as many distances as possible
- ☐ Affordable price is quoted for a year

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Review of Systems

Allergy/Immunology
- ☐ Drug Allergies
- ☐ Environmental Allergies
- ☐ Rheumatoid Allergies
- ☐ Lupus
- ☐ Sjogren's Syndrome
- ☐ Other
- ☐ Negative

Hematology/Lymphatic
- ☐ Anemia
- ☐ Large Volume Blood Loss
- ☐ Ulcer
- ☐ Hypercholesteremia
- ☐ Other
- ☐ Negative

Cardiovascular
- ☐ Hypertension
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congestive Heart Failure
- ☐ Stroke/CVA
- ☐ Other
- ☐ Negative

Psychological
- ☐ Depression
- ☐ Attention Deficit
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Other
- ☐ Negative

Gastrointestinal
- ☐ Crohns
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflux
- ☐ Celiac Disease
- ☐ Other
- ☐ Negative

Neurological
- ☐ Multiple Sclerosis
- ☐ Cerebral Palsy
- ☐ Tumors
- ☐ Stroke/CVA
- ☐ Migraines
- ☐ Autism Spectrum Disorder
- ☐ Epilepsy
- ☐ Other
- ☐ Negative

Ear, Nose & Throat
- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis
- ☐ Other
- ☐ Negative

Integumentary (SKIN)
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Herpes Simplex/ Cold Sores
- ☐ Herpes Zoster/ Shingles
- ☐ Other
- ☐ Negative

Genitourinary
- ☐ Kidney Disease
- ☐ Prostate Disease
- ☐ STD-herpetic/chlamydia
- ☐ Benign Prostate Hypertrophy
- ☐ Pregnant
- ☐ Nursing
- ☐ Herpes
- ☐ Chlamydia
- ☐ Other
- ☐ Negative

Musculoskeletal
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Other
- ☐ Negative

Constitution
(e.g. fever, weight loss, etc)
- ☐ Developmental Disabilities
- ☐ Cancer
- ☐ Fatigue Syndrome
- ☐ Other
- ☐ Negative

Respiratory
- ☐ CigaretteSmoker
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Obstruction
- ☐ Sleep Apnea
- ☐ Other
- ☐ Negative

Endocrine
- ☐ Type 2 Diabetes Mellitus
- ☐ Type 1 Diabetes Mellitus
- ☐ Thyroid dysfunction
- ☐ Hormonal Dysfunction
- ☐ Other
- ☐ Negative

Comments:

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Medications

Do you take any prescription or non-prescription medications? ○ Yes ○ No

What is the name of the medication? Start typing medication name to see shorter list.	How often do you take this medication?

Please feel free to share any information about your medications here

Please list the name and address of your preferred pharmacy:

Allergies

Are you allergic to any Allergen Group? ○ Yes ○ No

What Allergen Group(s) are you allergic to?	How severe is your allergy?	

Are you allergic to any medications? ○ Yes ○ No

What medication(s) are you allergic to? Start typing medication name to see shorter list.	How severe is your allergy?	

Do you have any other allergies? ○ Yes ○ No

What other allergies do you have?	How severe is your allergy?	

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Past, Family and Social History

Who is your primary care physician? _____

Diabetes History

Do you have diabetes? ○ Yes ○ No

How long have you had diabetes? _____

What physician is treating your diabetes? _____

How frequently do you see your physician for diabetes care? _____

What was your last hemoglobin A1c reading in % (percent)? _____

Family Medical History

Does anyone in your family have any of the following medical conditions?

☐ None ☐ Hypertension ☐ Diabetes ☐ Cancer ☐ Thyroid ☐ Other

Does anyone in your family have any of the following eye conditions?

☐ None ☐ Severe Myopia ☐ Macular Degeneration ☐ Cataract ☐ Nystagmus
☐ Glaucoma suspect ☐ Severe Hyperopia ☐ Amblyopia ☐ Dry eye
☐ Glaucoma ☐ Strabismus ☐ Retinal Detachment ☐ Other

Social History

Do you drink alcohol? ○ Yes ○ No ○ Unknown

Please list any additional drug use here including cannabis:

_____

_____

Do you currently or have you ever smoked tobacco products?

☐ Smoker Current status unknown ☐ Never smoker ☐ Former smoker
☐ Current every day smoker ☐ Heavy tobacco smoker ☐ Light tobacco smoker
☐ Current some day smoker ☐ Unknown if ever smoked

How often do you use tobacco products? _____

Do you have any hobbies or play any sports? _____

Macular Pigment Questionnaire

Are you presently struggling with any of the following visual symptoms we can address by improving your macular pigment: Poor Night Vision, Bothersome Glare, or Light Sensitivity?

☐ Yes ☐ No

Are you presently active in a sport or other visually demanding activity that you'd want to maximize your visual performance like professional athletes and trained military personnel do on a regular basis?

☐ Yes ☐ No

Do you have a relative including extended family (aunt, uncle, grandparent) who suffered from AMD (Age-related Macular Degeneration)?

☐ Yes ☐ No ☐ Not that I know of, not sure.

Vision Training Questionnaire

Have you experienced any of the following challenges with your vision: difficulty reading at or above grade level, unable to finish tests on time, frequently losing your place while reading, headaches or eye strain while doing near tasks, any eye turn noticeable in pictures?

☐ Yes ☐ No

Do you currently participate in competitive sport or work in a vocation that requires intensive visual skills?

☐ Yes ☐ No

Dry Eye Questionnaire

WITHIN THE PAST 3 MONTHS how often have your eyes felt any of the following symptoms: Dryness, Grittiness, Scratchiness, Soreness, Irritation, Burning, Watering, Eye fatigue or Fluctuating vision?

- ☐ NONE of the time
- ☐ SOME of the time
- ☐ HALF of the time
- ☐ MOST of the time
- ☐ ALL of the time

HIPAA, Privacy Policy, Patient Responsibility, Good Faith Estimate including iHealth Wellness Exam

4SIGHT ICARE POLICIES effective July 2024 - review each section carefully especially the Good Faith Estimate of the iHealth Wellness Exam

NOTICE OF ANY PORTION DEEMED PATIENT RESPONSIBILITY BY THE PROVIDED INSURANCE CARRIER WILL BE BILLED TO THE PARTY LISTED HEREIN.

We respect our contractual obligations with all insurance and collect applicable copays and pre-determined patient responsibilities at the time of service. Medical insurance will generate an explanation of benefits to its member and the portion labeled "patient responsibility" will match the bill from our office or we will correct it. We will make every effort to discover any insurance plan for any patient but may not be able to reverse charges for services performed under the payer furnished by the patient. Any unpaid balances may be subject to credit collection through a third party after 90 days of non-payment.

YOUR RESPONSIBILITY INCLUDING PAYMENT METHOD & GOOD FAITH ESTIMATE

I, the undersigned am the responsible party for the patient account attached in this correspondence.

I authorize and request our insurance company pay directly to the doctor insurance benefits otherwise payable to me for any covered services that can be submitted to my carrier.

I acknowledge that whenever possible, medical insurance will be billed for medical office visits or medically coded examinations along with any associated procedures and that wellness visits will be billed to vision plans.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents, and if I choose to pay by credit card a secure offsite storage of my information may be used for future purchases or to pay any balance greater than 60 days from the date of service. 4Sight iCare believes strongly in the training and advancement of its team-members; the time spent providing me services has value and I understand that no product ordered at my doctor's office may be fully cancelled and/or refunded as these are professionals filling and dispensing prescriptions, not sales-persons selling commodities.

I understand that quotes for services and materials including glasses and contacts are made on a good faith basis, and that if insurance contributes more or less than the expected amount I may be notified of a balance due. Neglect to pick up any product greater than 90 days from its receipt at the office may result in a $40 shipping/storage charge; these funds are used to ship abandoned product to the address on file if approved for dispense - product not approved for dispense will be returned to the distributor without further recourse for retrieval of funds nor product by the party whom abandoned the product. A "no-notice fee" of $40 shall be assessed if a scheduled appointment is missed without providing at least 24 hour advanced notice of a schedule change. Likewise, any bad check, declined credit card transaction on a

scheduled payment, or dispute of an appropriate credit card transaction may result in a $40 fee due at the time of each infraction.

The iHealth Wellness Exam is part of every annual comprehensive eye exam at 4Sight iCare; it has been developed to help you SEE YOUR BEST for your lifetime. The doctor trusts his team to perform the proper examinations on each patient based on criteria designed by the doctor to align with this mission. **Anyone may ask for a one-time financial hardship exception at checkout (once per responsible party)**, but the testing is performed by a technician whose job it is to collect as much data as possible to help provide you the best eye care. Below is a good faith estimate based on the most impactful criteria determining which tests to perform.

The iHealth Wellness Exam performed at the Annual Comprehensive Eye Exam:

Ages 6-months to 3-years: Always $0. The Welch Allyn Spot Camera assists in accurate testing for eye alignment as well as vision in the developing eye, non-verbal patient, or anyone unable to use the machines with a chin and forehead rest; this equipment investment was so important to the doctor that he paid for the device out of his own funds so that every patient regardless of developmental/verbal status could achieve their best vision.

Age 4 and up: $58. 92250-52 ($39) Retina Photo, 92134-52 ($19) Retina Scan & 92025-52 ($0) Corneal Topography. Without -52 modifier for reduced service fee these expenses when ordered by the doctor are billable to medical insurance at $98, $82, and $44 respectively or $224 if ordered.

Age 14 and up: $78. All the tests performed on age 4 and up plus 99172-52 ($0) Contrast Sensitivity & 92082-52 ($20) Visual Field Test. When ordered medically, available for $58 and $44 respectively, or $326 if billed to medical insurance.

Additional testing at $0. 92499-52 ($0) Concussion Baseline and Saccadic Eye Movement Evaluation for ages 6 to 18. Meibomian Gland Evaluation for all 18+. When performed outside an annual visit these ordered test are available for $24 each.

This makes the value of the iHealth Wellness anywhere between $24 and $350 in tests performed annually at the appropriate nominal fee.

NOTICE OF PRIVACY PRACTICES THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

-YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. **Get an electronic or paper copy of your medical record.** You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will

provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. **Ask us to correct your medical record.** You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests. **Ask us to limit what we use or share.** You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).

Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. **Choose someone to act for you.** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting us at the number listed above. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/....** We will not retaliate against you for filing a complaint.

-YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: 1) Share information with your family, close friends, or others involved in your care. 2) Share information in a disaster relief situation. 3) Include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission: 1) Marketing purposes. 2) Sale of your information. 3) Fundraising - We may contact you for fundraising efforts, but you can tell us not to contact you again.

-OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways. 1) Treat you. We can use your health information and share it with other professionals who are treating you. 2) Run our organization. We can use and share your health information to run our practice, improve your care, and contact you when necessary. 3) Bill for your services. We can use and share your health information to bill and get payment from health plans or other entities.

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/....

Help with public health and safety. We can share health information about you for certain situations such as: 1) Preventing disease. 2) Helping with product recalls. 3) Reporting adverse reactions to medications. 4) Reporting suspected abuse, neglect, or domestic violence. 5) Preventing or reducing a serious threat to anyone's health or safety. **Do research.** We can use or share your information for health research.

Comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. **Respond to organ and tissue donation requests.** We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director. We can share health information with a coroner, medical examiner, or funeral director when an individual dies. **Address workers' compensation, law enforcement, and other government requests.** We can use or share health information about you: 1) For workers' compensation claims. 2) For law enforcement purposes or with a law enforcement official. 3) With health oversight agencies for activities authorized by law. 4) For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

-OUR RESPONSIBILITIES

1) We are required by law to maintain the privacy and security of your protected health information. 2) We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 3) We must follow the duties and privacy practices described in this notice and give you a copy of it. 4) We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. 5) For more information see: www.hhs.gov/ocr/privacy/hipaa/.... 6) Changes to the Terms of this Notice.

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new one in our office and have copies available in our office.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax, or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that in an attempt to be transparent while providing the ability to fill prescriptions with 4Sight iCare's optical and in compliance with federal regulations, a copy of all active eyeglass and/or contact lens prescriptions are available at 4Sight iCare's online patient portal best accessed at this weblink: https://www.4sighticare.com/patient-portal.html (printed copies are also available upon request). Additionally, I acknowledge that I have reviewed the above rights, responsibilities, and disclosures with my agreement:

Patient Name:_____

Signature:_____

Date:_____

Thank you for taking the time to give your Eye Exam at 4Sight iCare some 4-Thought.

Our mission is to help you SEE YOUR BEST!

Understanding your visual demands & eye-wear needs and what you want to get out of your annual eye exam helps us achieve our VISION of EYE CARE.

Thanks Again,

4Sight iCare