

# Introduction

**Welcome to 4Sight iCare.** This e-Intake stores information you update yearly before your visit so we can efficiently help you **SEE YOUR BEST!**

Patients used to ask why different eye exams cost the same: an infant exams obviously differs from that of an adolescent which evolves into a teen eye exam, and adults require more eye health testing...

The iHealth Wellness Exam's technologies grow with you based on visual development, clinical risk, and practical application. The iHWE structure is explained in detail in the section called "Your Responsibility Including Payment Method & Good Faith Estimate."

I acknowledge that the iHWE cost ranges from \$0 to \$98. The doctor prefers the iHWE so strongly that the technician is instructed to perform those tests on all new patients, but I may request at checkout to be charged for only what my insurance lists as "covered with a copay" at my first visit (one-time waiver). Staff is confident; after experiencing the iHWE, I'll only ever want eye exams that include these tests!

**Initials:** \_\_\_\_\_

## Refractive Surgery Co-Management, VST & Ocular Aesthetics

- Do you want refractive surgery (like LASIK) now or in the future?  Yes  No
- Interested in vision correction without daytime contacts, glasses, or surgery?  Yes  No
- Do you want to know about cosmetic improvements to your eyes' appearance?  Yes  No

## Established Patient Status

Please mark all **B4EP's (Benefits 4 Established Patients)** besides reduced paperwork because this will all be saved) that interest you enough to keep you coming back yearly for your **ANNUAL** comprehensive eye exam to maintain your established patient benefits:

- \$40 Instant Savings:** Save instantly on select eyewear products and specialty services.
- 4EP (4 Easy Payments) Plan:** Interest-free payments on complete eyewear/year-supply of contacts.
- Featured Frames 4 the Month & 1/4th OFF Prescribed Non-Power:** Monthly, staff selects a frame style/brand/type to highlight at **40% OFF** when paired with a lens package already **discounted by \$150**. Doctor routinely prescribes protection from UV and blue-violet light with Sunglasses and Digital Device Lenses; when prescribed in non-power, pre-fabricated protective eyewear is **25% OFF** retail.
- iCare Plan Memberships (NEW):** plans that empower you to pay \$0 out of pocket the day of your annual eye exam with the iHealth Wellness Exam and even new eyewear included in some plan options.

## What made you decide to give 4Sight iCare a try?

- |  |  |
|--|--|
| <input type="checkbox"/> Doctor Referral     | <input type="checkbox"/> Friend/Family (named: _____)    |
| <input type="checkbox"/> Mailer/Social Media | <input type="checkbox"/> Walk or drive by _____          |
| <input type="checkbox"/> Google Search       | <input type="checkbox"/> Insurance                       |
| <input type="checkbox"/> Other online search | <input type="checkbox"/> A local business (named: _____) |

# Patient Demographics

Date \_\_\_/\_\_\_/\_\_\_

Pronouns  he/him  she/her  they/them

Preferred Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Last Name \_\_\_\_\_ Suffix \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Assigned Gender  Male  Female Ethnicity \_\_\_\_\_

Cell phone \_\_\_\_\_ Home phone \_\_\_\_\_

Email \_\_\_\_\_ Work phone \_\_\_\_\_

Position/occupation, school grade, or number of years retired? \_\_\_\_\_

## 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 \_\_\_\_\_

# Reason for Visit

If another provider referred you, who and why? \_\_\_\_\_

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

## Eye Health & Vision History

When was your last eye exam? \_\_\_\_\_

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

Have you ever had eye injuries, surgeries, or been diagnosed with an eye disease?

- None of these**
- Age-related Macular Degeneration
- Amblyopia
- Cataract
- Dry eye
- Glaucoma
- Glaucoma suspect
- Inflammatory disorders
- Injury
- Keratoconus
- Nystagmus
- Patching
- Retinal hole/degeneration/detachment
- Retinal surgery
- Strabismus (eye turn)
- Surgery of the eye muscles
- Other: \_\_\_\_\_

When do you wear glasses?

- Never**
- All the time
- Far vision only
- Only while reading
- Only on computer
- On computer & reading
- Protection only (digital device/sunglass/safety)

How old are your current glasses?     Less than a year     1 to 2 years     More than 3 years old

What, if anything, don't you like about them? \_\_\_\_\_

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

What brand are your most recent CL's? \_\_\_\_\_

Do you ever routinely sleep in your CL's?       Yes     No

How often to discard old & start new CL's?       Daily     Monthly     Quarterly     Other

What, if anything, don't you like about your CL's? \_\_\_\_\_

On average, how many days/week do you want to wear CL's?       All     Half     Once

If you had to choose just one, what's the single most important detail about your contact lenses?

- Eye health, breathable material
- Comfort on the eye even with dry eye
- Sharpest vision at all distances
- Affordable price quote for the year



# 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 (Chol.)
- Other
- Negative**

## Cardiovascular

- Hypertension (high BP)
- 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

- 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 (explain "Other"):

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# Dilation & MEC (Medical Eye Care)

**Dilation drops are used with your consent when either of the following 2 criteria are met:**

- 1) They widen the view into the eye at a wellness visit. The most common reasons to elect for pupil dilation as a screening test include but are not limited to: high myopia, recent trauma, family history, etc... Basically anytime you want peace of mind even though it lacks medical necessity. We don't typically dilate patients who are pregnant, nursing, or allergic to the drops (proparacaine, phenylephrine, hydroxy-amphetamine hydrobromide, & tropicamide). We also offer "completion of service" within 90 days if today isn't convenient but you want dilation.
- 2) The most common reasons doctors order dilation as part of a Medical Eye Care visit include but are not limited to: diabetes, acute flashes/floaters, hypertension, use of a drug with ocular side effects, etc... Basically, whenever deemed medically necessary to evaluate a medical diagnosis. When Medical Eye Care is performed Medical Insurance may be billed.

**Side Effects:** Dilation drops have the following side effects: blurred near vision and sensitivity to light for up to 6 hours; the eye drops will add 20 to 30 minutes to your exam time in order to take effect. Please only ever drive with clear, comfortable vision. Sunshields will be provided.

**Medical Eye Care:** Failing to attend any Medical Eye Care visit with an Eye Care Professional (ECP) can be detrimental to your eye health and vision, particularly if dilation is part of the evaluation and management of a medical diagnosis.

**Please indicate which statement best represents your wishes:**

- Please, no dilation drops today. If ordered, I'll attend a Medical Eye Care with an ECP.
- I'd like to discuss dilation more, beyond what's been provided.

\*Please initial here that you understand or shall ask questions about your choice above: \_\_\_\_\_  
(\*Required)

## Medications & Allergies

List any/all (or attach a list of) medications (start typing for dropdown list) and frequency used:

Med: _____	How often? _____
Med: _____	How often? _____
Med: _____	How often? _____
Med: _____	How often? _____
Med: _____	How often? _____
Med: _____	How often? _____

List any/all medication allergies and the type of allergic reaction (ie: sulfa, hives):

Allergy: _____	Reaction? _____
Allergy: _____	Reaction? _____

List any/all other allergies you have and the severity of your allergic reaction (ie: seasonal, mild):

Allergy: _____	Severity? _____
Allergy: _____	Severity? _____

# Questionnaires

## 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

Experiencing 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, or any eye turn noticeable in pictures?

Yes     No

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

Yes     No

## Dry Eye Questionnaire

**Frequency:** Please choose how often, on average, your eyes feel dry and/or irritated:

Rarely     Sometimes     Often     Most times     All the time

**Severity:** Please choose how severe, on average, you feel your symptoms of dryness/irritation:

Very mild     Mild     Moderate     Severe     Very Severe

## Specialty Frame Technology Questionnaire

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

1\_\_\_\_\_ 2\_\_\_\_\_ 3\_\_\_\_\_ 4\_\_\_\_\_ 5\_\_\_\_\_ 6\_\_\_\_\_ 7\_\_\_\_\_ 8\_\_\_\_\_ 9\_\_\_\_\_ 10

While browsing frames would you like to demo or be quoted frame technology that offers built-in Bluetooth connectivity, image capture, and open ear audio that leverages Artificial Intelligence?

Yes     No

## **HIPAA, PRIVACY POLICY, PATIENT RESPONSIBILITY, & GOOD FAITH ESTIMATE INCLUDING IHEALTH WELLNESS EXAM**

4SIGHT ICARE POLICIES effective June 2026 - review each section carefully including 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 parted 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 under-agreed, 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 dependent; if I pay by credit card up to a 3% transaction processing fee may be added and secure offsite storage of my card information may be used for future purchases or to pay any balance greater than 60 days from the invoice's date of service. 4Sight iCare believes strongly in the training & advancement of its team; the time spent providing services has value and I understand that no product ordered at my doctor's office may be cancelled and/or refunded as these are professionals filling and dispensing prescriptions, not sales-people 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 plan, or dispute of an appropriate credit card transaction may result in a \$40 fee due at the time of each infraction.

I also understand that the iHealth Wellness Exam is part of every annual comprehensive eye exam at 4Sight iCare; it has been developed to help me see my personal best for my lifetime. The doctor trusts his team to perform the proper examinations on each patient based on criteria aligned with this mission in search of healthy, clear, comfortable, and balanced vision. 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 provide me the best eye care. Below is a good faith estimate based on the most impactful criteria determining which tests to perform: age of the patient.

**The iHealth Wellness Exam performed at the Annual Comprehensive Eye Exam depends on the stage of life for each patient:**

**Stage 1: Ages 6-months to 3-years: \$0.** The Welch Allyn Spot Camera assists in accurate testing of eye alignment and vision in infants' and developing eyes, assessing non-verbal patients, and testing anyone unable to use a chin and forehead rest. Valued at \$48 per test.

**Stage 2: Age 4 & up: \$58.** 92250-52 (\$39) Retina Photo & 76511-52 (\$19) Axial length of growing eyes. Without -52 modifier for a reduced service fee these expenses when ordered by the doctor are billable to medical insurance at \$98 & \$100 respectively or a \$246 total value.

**Stage 3: Age 14 & up: \$78.** All the tests performed on age 4 and up plus 92134-52 (\$20) OCT Retina Scan; \$82 when ordered for a total value of \$328. At age 24 Axial Length measure is replaced with lower lid meibomian gland imaging at no extra cost.

**Stage 4: Age 34 & up: \$98.** All testing for 24 and up plus 92082-52 (\$20) Visual Field Test. 92082 is an \$84 medical test bringing the total value to \$352.

Additional **testing reduced to \$0** when performed as part of the iHealth Wellness Exam. Concussion Baseline and Saccadic Eye Movement Evaluation for ages 6 to 24. Corneal Topography for ages 4 and up. Contrast Sensitivity and eye coordination at near and far focus in a virtual reality headset for ages 9 and up. Each of these tests are valued at \$24, \$44, and \$58 respectively.

This makes the total value of the iHealth Wellness Exam between \$48 for babies and \$454 for patients at the peak of their eye care, nominal fee that varies between \$0 and \$98.

## **NOTICE OF PRIVACY PRACTICES: HOW YOUR MEDICAL INFORMATION MAY BE USED/DISCLOSED AND HOW YOU CAN ACCESS 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/...](http://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 to fundraise, 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/...](http://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're required by law to maintain the privacy & 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 & privacy practices described in this

notice and give you a copy. 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/](http://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.

### **ACKNOWLEDGEMENT OF RECEIPT**

I acknowledge that in an attempt to be transparent in providing both services and the ability to fill prescriptions with 4Sight iCare's optical and in compliance with recent federal regulations, a copy of all active eyeglass and/or contact lens prescriptions are always available via 4Sight iCare's online patient portal best accessed at this weblink: <https://www.4sighticare.com/patient-portal/> (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 of Guarantor: \_\_\_\_\_ Date: \_\_\_\_\_

Name of guarantor, if not the patient: \_\_\_\_\_