

# UONG EYE CARE, P.A.

Patient Name \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date \_\_\_\_\_  
(Mr/Mrs/Ms/Miss/Dr)

Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Age \_\_\_\_\_ Sex: M / F

Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_

Email \_\_\_\_\_ SS# \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Hobbies \_\_\_\_\_ Hours spent on comp per day? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Person Referred \_\_\_\_\_

Health/Medical Insurance: \_\_\_\_\_ Vision Insurance/ID#: \_\_\_\_\_

Health Insurance ID# \_\_\_\_\_ Primary DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Primary/Insured's Name: \_\_\_\_\_ Primary SS# \_\_\_\_\_

This examination is for: ☐ Glasses ☐ Contacts ☐ Both ☐ Others

## VISUAL HISTORY:

Date of last eye exam? \_\_\_\_\_ How old are your glasses if applicable? \_\_\_\_\_

Y N If Yes, Please specify:

<b>Do you wear contact lenses?</b>			<b>Brand:</b>
Do you have any of the following eye problems such as: Glaucoma, Cataract, Macula Degeneration, Retinal Detachment, or Lazy eye, and etc.?			
Does anyone in your family have any of the above listed?			
Have you ever had eye surgery?			

## MEDICAL HISTORY:

Y N If Yes, Please specify:

Are you taking any medications?			
Are you allergic to any medications?			
Do you have any of the following conditions: Diabetes, High Blood Pressure, Stroke, Heart Diseases, High Cholesterol, Thyroid, Sickle Cell, Asthma, COPD, Headaches, Migraines, or Pregnant?			
Do any of your family members have the <u>above</u> conditions?			

Do you want your eyes to be dilated? ☐ Yes ☐ No ☐ Reschedule

Dilation is part of the examination. It allows your doctor to view a larger area in the back of your eyes. It is highly recommended for patients with diabetes, glaucoma, systemic diseases, high prescription, and those over 55 years old. However, certain side effects may occur such as blurry vision, stinging upon instillation, light sensitive, nausea, and dry mouth. Your eyes will remain dilated for ~4-6 hours. A designated driver is highly recommended.

Signature \_\_\_\_\_

## **Lifestyle Questions**

Your answers to these questions will guide us in recommending the best products to meet your eyewear needs.

Which of the following do you do regularly?

- ☐ Work on a computer
- ☐ Drive at night
- ☐ Work outdoors Work under florescent lighting
- ☐ Read for long period of time
- ☐ Frequently alternate between indoors and outdoors

List all sports and hobbies you participate in:

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## **Contact Lens Policy**

For contact lens wearer, your prescription will not be finalized until you give approval of vision and comfort with the lenses. Follow ups are included anytime within the first 30 days at no charge. If you have not returned to the office within the first 30 days to finalize there will be a charge of \$50 to be refit. If it has been more than 60 days since your initial visit, there will be a charge for full fitting cost to change lenses. I understand that there will be no refund on open boxes, expired contact lenses, or doctor's fees.

## **Office Policies and Procedures**

Your insurance is not a guarantee of payment. You are responsible in advance for co-pays, co-insurance, and any deductibles after services have been rendered. Upon submission of your services, your insurance will inform us if any further payment is due. If this occurs, a bill will be sent to you which payment will be due upon receipt. By signing this statement, I agree to be financially responsible for all charges. I authorize any release of my records to any insurance company or otherwise to assist in receiving payment for my services.

I understand that there will be no refunds given on any materials or professional services.

I have reviewed a copy of Uong Eye Care's Notice of Privacy Practices. A copy is available upon request.

I, \_\_\_\_\_, have read and understand the above sections.  
(Print Name)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

## UONG EYE CARE OFFICE POLICY

Effective 1/01/2017

- Balance must be paid in full for services rendered and prior to picking up any products purchased and ordered. Any balances not paid after 3 months will be given notices and be sent to Collections after 6 months. Patient must sign or initial Intent of Forfeiture (below) for merchandise before 180 days to prevent balance sent to Collections. A copy of your receipt will be needed to pick up merchandise. Merchandise not paid in full by 6 months will automatically forfeit their product. Patient will be responsible for all fees of services and products not paid by insurance, even claims submitted and denied.

- Our office and/or labs will not be responsible for any damages to frames or lenses not purchased at our office on and during eyeglass processing and shipments. Our office will not be liable for any damages towards fixing or repairing glasses. Please initial to acknowledge (policy applies regardless of initials – it is the responsibility of patients to read policy): Our office will not be responsible for any damages due to repair on frames or lens.

- Patients requesting email copies of receipts, medical information and/or prescriptions will not hold Uong Eye Care accountable for any reason. Must have signature and email a scan copy of this document to acknowledge understanding email rights, please email back, send a phone picture copy, or fax to Uong Eye Care. Please visit HIPAA website for more info. Requested info will be processed within 24 hours.

- Merchandise Refund and Exchange Policy:

### 1. Frames:

Refund on frames permitted with 50% restocking fee within 30 days. No refunds after 30 days. Purchases through insurance will be applied and calculated based on insurance reimbursements at time of purchase. Any conditions of damage be evaluated by both our office and frame manufacturer and subject to limited manufacturer's warranty on all frames within 30 days. No replacements on frames after 30 days. No frame exchanges once eyeglass order has been placed and lab has started the order.

#### Frame Warranty:

Frame warranty can be purchased for \$50 which will cover for 1 year from date of purchase. Lost frame is excluded from frame warranty.

### 2. Lens:

No refunds on lenses due to lenses being a customized item. One lens redo permitted and is subject to lab policies. Applies to patients with medical conditions (ie: Diabetes, cataracts, etc) that causes changes in vision. Applies to lens options as well. For patients who cannot adapt to progressive lens (PALs), credit will be applied to patient's choice of either distance or reading lenses into the same frame with all lens option(s) in place prior to redo. Additional lens option may be added to new orders.

### 3. Contacts:

Refund permitted on contact lens with 50% restocking fee on contact lens order within 30 days of order arrival of contacts for unopened boxes. No refunds on marked, expired, and open boxes. Exchanges permitted on all unopened boxes within 90 days. Credit will be applied to only contact lens (no glasses or services). Exchanges must be ordered within 30 days of date of exchange order. Purchases through insurance will be applied and calculated based on insurance reimbursements at time of purchase. Excludes CRT or specialty Lenses.

Note: All eyeglass orders normally take 7-14 business days at time of order. Our office will inform patients of any delays due to lab or frame manufacturer issues. Contact lens orders will be processed on the following Tuesdays or Fridays and patients should receive orders 3-5 business days from date of office ordering. Shipping charges will be a flat rate of \$20 to any patient's address in FL, additional \$5 to any state in the continental united states, and \$10 to Alaska and Hawaii. Shipping orders to outside United States will be subject to international rates.

**UONG EYE CARE OFFICE POLICY**  
Effective 1/01/2017

- While we can appreciate the difficulties of allergies to certain materials (ie: metals), we will not be held responsible for any allergic reactions caused by the materials we dispense. It is the patient's responsibility to inform and to disclose that information prior to purchasing merchandise at our office. Full exchanges will be made for those who can present medical notes of their allergies based on the materials dispense within 90 days of purchase.
- Uong Eye Care does it's best to protect patients' privacy and information. In the event patient's information has been compromised, we will work with both patient and law enforcements to rectify the issue. We will not be held responsible financially for any incursions due to lose of patient's info.

Print Name: \_\_\_\_\_

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

Extra Notes:

- Management reserves rights to make any changes to office policies at any time without patient notice.
- All rules and policies apply regardless of signature and/or loss of this receipt.
- It is the responsibility of the patient to read the policies before contacting Uong Eye Care.

Policies may change without notice. Please contact our office for current updates.

# PATIENT LIFESTYLE QUESTIONNAIRE

WE CARE about you and your vision.

Please take a few moments to answer some questions so we may better serve you.

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

CHECK WHICH VISION AIDS YOU  
CURRENTLY WEAR, AND CIRCLE THE  
ONE YOU WEAR MOST OFTEN:

- ☐ Contacts
- ☐ Clear Prescription Glasses
- ☐ Prescription Sunglasses
- ☐ Non-Prescription Sunglasses
- ☐ Safety Glasses
- ☐ Sport Specific Glasses

CHECK IF YOU EXPERIENCE DIFFICULTY WITH ANY OF THE FOLLOWING:

- ☐ Near vision
- ☐ Distance vision
- ☐ Computer vision
- ☐ Night vision
- ☐ Headaches
- ☐ Blurred vision
- ☐ Sensitive skin
- ☐ Night glare (halos from streetlamps & cars)
- ☐ Glare from the sun
- ☐ Sensitivity to bright light
- ☐ Seeing in dim light
- ☐ Dry eyes
- ☐ Tired eyes
- ☐ Other \_\_\_\_\_

*Please specify*

OCCUPATION: \_\_\_\_\_

HOW MANY HOURS A WEEK DO YOU SPEND.... at a computer \_\_\_\_\_ driving \_\_\_\_\_ in the sun \_\_\_\_\_

## INDOOR HOBBIES / ACTIVITIES

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## OUTDOOR HOBBIES / ACTIVITIES

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## EYEWEAR: SATISFACTION AND DESIRES

If you could, would you prefer to not wear glasses?  
☐ yes ☐ no ☐ sometimes

Do you experience any of the following problems with  
your current eyewear (please check all that apply):

- ☐ Poor fit / they slip down ☐ yes ☐ no
- ☐ Frequent readjustment ☐ yes ☐ no
- ☐ Screws fall out ☐ yes ☐ no
- ☐ Rims/temples interfere with vision ☐ yes ☐ no
- ☐ Outdated look ☐ yes ☐ no
- ☐ Look doesn't go with everything ☐ yes ☐ no
- ☐ Frame dominates my face ☐ yes ☐ no
- ☐ Too heavy (pain & pressure) ☐ yes ☐ no
- ☐ Not durable/needs frequent repair ☐ yes ☐ no
- ☐ Bifocal lines are bothersome ☐ yes ☐ no
- ☐ Not enough reading space in lens ☐ yes ☐ no

SOME THINGS CAN AFFECT HOW THE SUN IMPACTS YOUR  
VISION. PLEASE CHECK IF YOU...

- ☐ Have family history of macular degeneration \_\_\_\_\_
- ☐ Smoke / are around second-hand smoke \_\_\_\_\_
- ☐ Exercise regularly \_\_\_\_\_
- ☐ Take anti-oxidant or ocular supplements \_\_\_\_\_
- ☐ Are female \_\_\_\_\_
- ☐ Are fair-skinned / have light-colored eyes \_\_\_\_\_

## CONTACTS: SATISFACTION AND DESIRES

- ☐ Do you experience dry or itchy eyes  
when wearing contacts ☐ yes ☐ no
- ☐ Do you have Rx frames as back-up ☐ yes ☐ no
- ☐ Do you wear with non-Rx sunwear ☐ yes ☐ no
- ☐ Is the progressive (no-line) design  
adequate ☐ yes ☐ no

This Lifestyle Survey is brought to you by Silhouette Optical and your Independent Eyecare Practitioner



## UONG EYE CARE'S 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. Please review carefully.

Uong Eye Care respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information without your authorization or unless the law authorizes or requires us.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information (PHI) includes your symptoms, test results, diagnoses, treatments, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your PHI for purposes of treatment, health care operations and to disclose this information for payment purposes.

### Examples of Use and Disclosure of PHI for Treatment, Payment, and Health Operations

#### For Treatment:

1. Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
2. We may also provide information to others providing your care. This will help them stay informed about your care.

#### For Payment:

1. If we request payment from your health insurance plan, health plans need information from us about your medical care. Information provided to health plans may include your diagnosis procedures performed, or recommended care.

#### For Health Care Operation:

1. We use your medical record to assess quality and improve services.
2. We may use and disclose medical records to review the qualification and performance of our health care providers and to train our staff.
3. We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
4. We may contact you to raise funds.
5. We may use and disclose your information to conduct or arrange for services, including:
  - Medical quality review by your health plan
  - Accounting, legal, risk management, and insurance services
  - Audit functions, including fraud and abuse detection and compliance programs.

### Your Health Information Rights:

The health and billing records we create and store are the property of Uong Eye Care. The PHI in it, however, generally belongs to you. You have a right to:

1. Receive, read, and ask questions about this Notice;
2. Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request;
3. Request and receive from us a paper copy of the most current Notice of Privacy Practices for PHI;
4. Request that you receive a copy of your PHI. You must make this request in writing. You may receive this information without charge once every 12 months. We will notify you of this cost if you request this information more than once in 12 months;
5. Have us review a denial of access to your health information;
6. Ask us to amend your health information. You must give us this request in writing. Review of such requests may take up to 60 days to implement. We are not required to grant the request. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included with any release of your records.

7. Request that you receive a list of disclosures of your health information. The list will not include disclosures to third-party payers. You may receive this information without once every 12 months. We will notify you of the cost involved if you request this information more than 12 months.
8. Ask that your health information be given to you by another means or at another location. You must make this request in writing.
9. Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Authorization requests cannot be cancelled if its purpose was to obtain insurance.

### **Our Responsibilities**

#### **We are required to:**

1. Keep your PHI private;
2. Give you this Notice;
3. Follow the terms of this Notice.

### **Other Disclosures and Uses of PHI**

#### **Notification of Family and Others**

1. Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to assist in disaster relief efforts.

We may use and disclose your PHI without your authorization as follow:

1. With Medical Researchers-if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
2. To the Food and Drug Administration relating to problems with food, supplement, and products.
3. To comply with Workers' Compensation Laws-if you make a workers' compensation claim.
4. For Public Health and Safety Purposes as Allowed or Required by Law:
  - 4.1. To prevent or reduce a serious, immediate threat to the health of safety of a person
  - 4.2. To public health or legal authorities
    - 4.2.1. To protect public health and safety
    - 4.2.2. To prevent or control disease, injury, or disability
    - 4.2.3. To report vital statistics such as births or deaths
5. To Report Suspected Abuse or Neglect to public authorities.
6. To Correctional Institutions if you are in jail or prison.
7. For Law Enforcement Purpose such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
8. For Health and Safety Oversight Activities.
9. For Disaster Relief Purposes. For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
10. For Work-Related conditions that could affect employee health.
11. To the Military Authorities of U.S. and Foreign Military Personnel
12. In the Course of Judicial/Administrative Proceedings at your request.
13. For Specialized Government Functions.

### **Other Uses and Disclosures of PHI**

1. Uses and disclosures not in the Notice will be made only as allowed or required by law.

#### **Effective Date:**

1. The effective date of this Notice is April 13, 2013