ASHLEY R. WILLIAMS O.D.
406 DALLAS AVE
SELMA, AL. 36701
PHONE: 334-878-2020 FAX: 334-878-2025

In light of the Corona Virus (COVID-19), we have put in place protocols to ensure the health and safety of our patients, staff and families.

Please attest that the following DO NOT apply to you:

1.)You have a cough, cold, fever, or flu like symptoms.
2.)A family member or someone you have been exposed to exhibits a cough, cold, or flu like symptoms.
3.)You or someone you have been exposed to has been diagnosed with corona virus.

Patient name: _____ Date: _____

Witness: _____ Date: _____

Thank you for your understanding!

preferredeye.com
follow us on social:

Date:___/___/___

Name:_____ DOB:___/___/___ Age:_____

Gender: Male / Female Marital Status: Single / Married Social Security#:_____

Address: _____ City: _____ Zip: _____

Ph#: _____ Bus. Ph#: _____ Cell Ph#: _____

Email Address:_____

Initial one of the following statements:

_____ ***I AUTHORIZE*** Preferred Eye Care to contact me via text, email, phone or postal service regarding appointments, recalls, orders and other general information.

_____ ***I DO NOT AUTHORIZE*** Preferred Eye Care to contact me in the following manner (please list below):

Guarantor (if patient is under the age of 18):

Name: _____ DOB: ___/___/___

Social Security#: _____ Relationship: _____

Address: _____ City: _____ Zip: _____

Ph#: _____ Email Address:_____

Refraction Authorization:

"Refraction is an important and mandatory part of a comprehensive eye exam that determines your best possible vision. This procedure aids the doctor in determining the health of your eyes. It is also required for the determination of your eyeglasses and contact lens prescription. Since its creation in 1965, Medicare considers refraction a *non-covered* service. As Medicare providers, we are required by law to collect a reasonable fee from the patient for this service. Most medical insurance plans consider Refraction a *non-covered* service as well. The charge for this service is $25.00 (Twenty-Five). If you have any questions, please contact your insurance provider."

I consent to refraction and the associated charge: _____

Fundus Exam Consent:

One of the most important parts of your annual eye exam is a dilated fundus evaluation. Dilation allows Dr. Williams to examine your intraocular health which includes your retina, retinal blood vessels, optic nerve and macula among other structures. Glaucoma, cataracts, diabetic eye disease, high blood pressure eye disorders, macular degeneration and retinal disorders are some of the more common diseases detected with a fundus exam. Side effects of dilation can include high light sensitivity, difficulty see up close, increased glare and driving difficulties. If you choose to be dilated, you assume the the risk of the possible side effects and will not hold Preferred Eye Care, it's doctors and or associates libel.

____ I consent to dilation drops and understand it will cause light sensitivity and blurred vision for 4 to 6 hours.

____ I decline dilation. I understand by declining dilation, photographs will be taken of the inside of my eyes in order to aid in the determination of the health of my eyes. There is an extra charge for this service.

_____

Patient or Parent/ Guardian Signature: **Date:**

Please Initial the following:

_____ **Consent for care:** I hereby give my consent for treatment to Preferred Eye Care.

_____ **Photography Release:** I hereby authorize Preferred Eye Care the use images in marketing online and in print medias.

Employer:_____ Occupation:_____

Primary Physician:_____ Ph#:_____

_____ **Medical Insurance vs. Vision Plan:** If you have separate Vision insurance, this generally pays for an annual routine eye exam and contributes a certain amount of money toward glasses and contact lenses. Vision coverage does not cover an exam that involves a medical diagnoses. Your Medical insurance will be billed for the medical portion of your exam. You may then use vision coverage for materials purchased.

_____ **Eye Wellness Exam:** The iWellness exam is state-of-the-art technology that lets the doctor see beneath the surface of your retina, where signs of disease first appear. The iWellness exam is a quick and non-invasive scan of your eye that lets the doctor see the layers of your retina to aid in the diagnosis of sight threatening eye diseases. Traditional eye exams do not provide this level of detail. Regular iWellness exams can help the doctor detect common eye diseases such as Diabetic Retinopathy, which is damage to the blood vessels in the eye caused by complications of diabetes. Glaucoma, which is a disease where the nerve fibers suffer damage, and Macular Degeneration, which is an eye disorder that damages the center of the retina (macula), making it difficult to see fine details. There is a $25 (twenty-five) charge for the exam.

How did you learn about Preferred Eye Care? Was it from one of our patients, insurance, media, live in the area or referred?_____ If referred, by whom?_____

HIPAA Privacy Policy: Under the "Health Insurance Portability and Accountability Act" you have certain rights to privacy regarding protected health information. You are free to refer to the Notice of Privacy Practices before you sign this form. As described in the Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes only includes care and service provided here, but also the disclosures of your health information as may be necessary or approbate for your to receive follow-up care from another health professional. Similarity, the use and disclosure of you health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claim review, determination, of benefits and payment; (3) our submission to your health informant to auditors hired by third-party payers and insurers; and (4) other aspects of payment practices change. When you sign this consent document, you signify the you agree that way we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform health care operations. You have the right to ask us to restrict the uses of disclosures made for purposes of treatment, payment or healthcare operations, but as described in our Notice of Privacy Practices, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes howe to ask for a restriction. I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that i have either received or have access to the Notice of Privacy Practices Preferred Eye Care LLC.

Please provide a list below of individuals you are allowing us to share your health care information.

Name:_____ Relationship:_____ Ph#:_____

Name:_____ Relationship:_____ Ph#:_____

Name:_____ Relationship:_____ Ph#:_____

Name:_____ Relationship:_____ Ph#:_____

Statement of Financial Policy: It is customary to pay for all services an materials at the time of your visit, unless prior arrangements have been made. The includes co-pays, deductibles, and any cost not covered by insurance. While it is your responsibility, we will prepare and necessary forms to help you obtain the benefits of your insurance company. I understand that I am responsible for any costs not paid by my insurance. I hereby acknowledge and agree that if my account becomes delinquent and requires the service of a collection agent or attorney, I will pay reasonable collection fees, attorney fees, and all court costs for said collection. I have read and understand all of the above.

Signature of Responsibility Party:_____ **Date:**_____

OFFICE USE ONLY
____Refraction
____iWellness
____Retinal Photography
____Room

Date:____/____/____

Name:_____ DOB:__/__/____ Insurance:_____

Primary Physician:_____ Ph#:_____

Pharmacy:_____ Location:_____ Ph#: _____

Reason for visit:_____Age:_____

(If you have vision insurance, but have medical conditions related to your ocular health, your vision insurance can only be used towards glasses or contacts.)

Interested in contacts? Yes | No **Clear or colored lenses?** Clear | Colored **Interested in glasses?** Yes | No

Eye History:

- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Infection/Allergies
- ☐ Glaucoma
- ☐ Floaters/Flashes
- ☐ Diabetes Type: I or II
- ☐ Iritis/Uveitis
- ☐ Diabetic Retinopathy
- ☐ Retinal Degeneration
- ☐ Eye Turn/Lazy Eye
- ☐ Eye Trauma
- ☐ Eye Surgery/Laser Surgery
- ☐ Eye Pain
- ☐ Other:_____

Current Issues experienced in the last 6 months.

- ☐ Redness
- ☐ Watering
- ☐ Burning
- ☐ Discharge
- ☐ Itching
- ☐ Blurred Vision
- ☐ Headache
- ☐ Eye Strain
- ☐ Poor Night Vision
- ☐ Severe Light Sensitivity
- ☐ Double Vision
- ☐ Total Loss of Vision
- ☐ Night Glare
- ☐ Other:_____

Do you take: (please circle)
Topiramate or Topamax | Plaquenil or Hydroxychloroquine | Chloroquine | Tamoxifen | Oral Steroids | Nasal Steroids

Family History: (Has a family member been diagnosed with any of the following? Please indicate Mother, Father, Brother, Sister or Children. Use the first letter next to disease ex. M for Mother)

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Cancer
- ☐ Diabetes Type: I or II
- ☐ High Blood Pressure
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

Social History: Insurance contracts require us to collect the following information:

Street/ Recreational drug use: Yes | No | Former

Alcohol use: Yes | No | Former How Often _____ times per _____ week for _____ years.

Tobacco use: Yes | No | Former How Often _____ times per _____ week for _____ years.

Do you use: (please circle) Smokeless Tobacco | Cigarettes | Cigars | Pipe | Other:_____

Occupation: _____ Full-time | Part-Time | Retired

Review of Systems

Constitutional:
- ☐ Cancer
- ☐ Fatigue Syndrome
- ☐ Development Disorder

Ear/ Nose/ Throat :
- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis

Neurological:
- ☐ Multiple Sclerosis
- ☐ Seizures/ Epilepsy
- ☐ Cerebral Palsy
- ☐ Brain Tumor
- ☐ Stroke (CVA)
- ☐ Migraines/ Headaches
- ☐ Bell's Palsy
- ☐ Dementia
- ☐ Parkinson's Disease
- ☐ Meningitis

Psychiatric:
- ☐ Depression
- ☐ Attention Deficit Disorder
- ☐ Anxiety
- ☐ Bipolar Disorder

Cardiovascular:
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Heart Attack
- ☐ Congestive Heart Failure

Gastrointestinal:
- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcers
- ☐ Reflux/ Heartburn
- ☐ Celiac Disease

Genitourinary:
- ☐ Kidney Disease
- ☐ Prostate Disease/ Cancer
- ☐ STD - Herpes/ Chlamydia
- ☐ Benign Prostrate Hypertrophy
- ☐ Pregnant/ Nursing

Musculoskeletal:
- ☐ Osteoarthritis
- ☐ Arthritis
- ☐ Fibro/ Polymyalgia
- ☐ Muscular Dystrophy
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis
- ☐ Gout

Integumentary (Skin):
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Herpes Simplex/ Cold Sore
- ☐ Herpes Zostar/ Shingles

Endocrine:
- ☐ Type I Diabetes
- ☐ Type II Diabetes
- ☐ Thyroid Disease
- ☐ Hormonal Dysfunction
- ☐ Graves' Disease
- ☐ Pituitary Tumor

Respiratory:
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ COPD
- ☐ Lung Cancer
- ☐ Tuberculosis (TB)

Hematologic/ Lymphatic:
- ☐ Anemia
- ☐ Large Blood Volume Loss
- ☐ Ulcer
- ☐ High Cholesterol
- ☐ Leukemia
- ☐ Lyme Disease
- ☐ AIDS/ HIV
- ☐ Breast Cancer

Allergy/ Immune
- ☐ Drug Allergy
- ☐ Environmental Allergy
- ☐ Rheumatoid
- ☐ Lupus
- ☐ Sjogren's Syndrome

Other Medical Diseases: _____

_____

Patient or Parent/ Guardian Signature: **Date:**

Preferred EYE CARE

preferredeye.com
follow us on social:

Name:_____ Date:_____

Allergies ► **Are you allergic to latex? Yes / No**

I'm Allergic to The following	StartDate/ End Date	Severity: Mild/ Medium/ Severe	Type of Reaction	Treatment

Over the counter, vitamins/supplements, eye drops, pain relievers etc...

Over the Counter - Medications	Milligrams/ Milliters	Capsule/ Tablet/ Drop/ Liquid	Oral/ Topical/ Injection	How Often

____ I consent to have my medication list electronically synced into my health record. Therefore, I DO NOT have to list my medications below. Dr. Williams is able to obtain your medications directly from your pharmacy. Our ePrescribing system allows us to view your medication history and securely sync your medications directly into your medical record. You may revoke consent at any time by providing written documentation. Once received, electronic access will cease.

____ I do not consent to have my medication list electronically synced and will list them below:

Medical Tracker

Prescribed Medications	Milligrams/ Milliters	Capsule/ Tablet/ Drop/ Liquid	Oral/ Topical/ Injection	How Often

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CONTACT LENS FITTING AGREEMENT

THIS FORM NEEDS TO BE SIGNED IF YOU ARE A CONTACT LENS WEARER OR ARE INTERESTED IN WEARING CONTACT LENSES.

A contact lens fitting is a separate part of a comprehensive eye exam that requires additional testing which may no a covered benefit of your insurance. The fee is determined by the type of lenses that are deemed appropriate for yc vision needs. Preferred Eye Care is required to perform a contact lens fitting each year in order to prescribe contact lenses to a patient. Each contact lens prescription will expire one year from the date of the contact lens fitting. Eve patient has the right to refuse a contact lens fitting. If a contact lens wearing patient chooses not to have a contact fitting, refuses to pay for or submit the contact lens fitting to their insurance, the patient will not be able to purchas contact lenses by any vendor.

Examination and Follow-Up:

1. Patients wearing contact lenses will be charged for a contact lens evaluation each year. This fee covers the additi tests required for the fitting, any trial lenses and any follow-up visits related to contact lenses within a sixty-day per For new contact lens wearers, this fee also includes insertion and removal education.

2. Contact lens fitting fees are non-refundable once the fitting exam has started. This is regardless of whether or no patient decides to wear contact lenses. Again, the Contact Lens evaluation fee may or may not be covered by the Patient's insurance.

3. Our fitting fees are as follows:

Spherical Contact fit $80.00.

Toric (Astigmatic) Contact Lens Fit $100.00

Multifocal Contact Fit $125.00.

4. The patient may be scheduled for a follow-up CL appointment after the initial CL fitting. If a patient is required tc return for a CL appointment, his or her prescription will not be finalized by the doctor until the patient returns for t appointment. If a prescription is not finalized, a patient will not be able to place an order for contacts through any vendor.

5. If a patient is experiencing a problem with their contact lenses, they will not be charged for office visits within six days from the initial fit and if the problem is determined to be with the contact lens(es). If at any time, a patient ret for a contact lens exam with a medical problem (infection, ulcer, etc.), he or she will be charged a medical office vis

Contact prescriptions are valid for ONE year from the date of the exam. Patients will be given a copy of their Contac prescription once it has been finalized by the physician. All Contact Lens evaluation fees must be paid before the prescription is released.

Prescribed Guidelines for Contact Wear:

Contact lenses are prescribed medical devices. They are a wonderful option for vision correction. The vast majority o patients are able to wear contacts without ever encountering any problem. The following information is given in ord to help you properly take care of your contact lenses and maintain optimal ocular health.

*Do not allow other people to wear your contact lenses. They are fitted and prescribed just for you.

*Do not exceed the wearing schedule prescribed for you. Contact lenses are designed to last a specific amount of tir whether it be daily, two weeks, or monthly. Contact lenses are like sponges. They absorb debris in your tear film and become less breathable over time. Over wearing your lenses can cause allergic reactions to the debris, increase the of infection and alteration of normal, healthy, ocular tissues.

*Always clean your hands before handing your lenses.

*Clean, disinfect and store your lenses with the prescribed solution.

*Do not be careless with fumes, sprays, cleaners, and hand creams for the lenses will absorb these when in contact.

*Do not put contact lenses in your mouth.

*Do not force a contact lens that is stuck to your eye or lens case. Moisten the lens with saline, cleaner or artificial t and gently slide the lens.

****NEVER put your contacts in water***. Do not swim while opening your eyes under water with contact lenses in your e Either close your eyes while swimming underwater or wear swim goggles. Do not wear contact lenses when in hot t or steam rooms. ***Serious sight threatening infections can occur when contact lenses come into contact with water.***

*Please remember the majority of the problems encountered with contact lenses are due to improper cleaning and handling. Proper care is necessary for successful wear and good eye health. It is healthiest for your eyes and best fo your lenses to take them out every night in order to give your eyes the oxygen they need. ***Sleeping in your lenses increases the risk of eye problems by five times***. However, there are contact lenses approved by the FDA to be slep for prescribed periods of time. If you have a tendency to sleep in your contacts, the approved extended wear contac are your better option. If you have questions regarding sleeping in your currently prescribed contact lenses, please discuss with Dr. Williams.

*If you experience discomfort after insertion of a contact lens, promptly remove it and check the lens for nicks or te Do not wear lenses with defects, for your eyes will be more susceptible to infection.

If you experience any redness, pain or decreased vision while wearing your contact lenses, remove the lenses immediately and call our office to schedule an appointment. The majority of ocular problems caused while wearir contact lenses can be remedied quickly and without permanent ocular harm with prompt treatment.

*The above guidelines do not guarantee that an ocular problem, as a result of wearing contact lenses will not occur However, the guidelines do ensure the best care and prevention available for safe contact lens wear.

I have read the above contact lens agreement and understand the risks and benefits of wearing contact lenses.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

REQUEST FOR MEDICAL RECORD RELEASE OF INFORMATION

PATIENT NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____

DATE OF BIRTH: _____ **SSN:** _____

I HEREBY AUTHORIZE TO OBTAIN ANY AND ALL MEDICAL RECORDS, GLASSES AND CONTACT LENS PRESCRIPTIONS FROM _____

AND RELEASE TO PREFERRED EYE CARE, LLC. PLEASE FAX RECORDS TO 334-878-2025.

PATIENT SIGNATURE: _____ **DATE:** _____

WITNESS SIGNATURE: _____ **DATE:** _____

PREFERRED EYE CARE, LLC

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