ERDEY SEARCY EYE GROUP PATIENT FORMS & HELP GUIDE

Carefully read and fill out the following forms:

We understand this is a lot of information, but it will help us efficiently, quickly, and safely diagnose your eye care needs. This will also help speed your registration process once you reach our office.

1. **Patient Letter**: Please read.

2. **Patient Information Form**: All Patients
   Please fill in the fields of this form while still on your computer screen (or fill out by hand after first printing it), print the completed form and *bring to your scheduled appointment*.

3. **Assignment of Benefits**: New Patients **ONLY**
   Please complete, sign, and *bring to your scheduled appointment*.

4. **Health Questionnaire**: All Patients
   Please fill in the fields of this form and sign while still on your computer screen (or fill out by hand after first printing it), then print the completed form and *bring to your scheduled appointment*.

5. **HIPAA Notice of Privacy Practices**: Please read and keep.

6. **Visual Functional Status Form**: Cataract Surgery Patients ONLY

7. **Visual Assessment Form**: Laser Vision Correction / Refractive Surgery Patients **ONLY**

8. **Map/Directions**: Please refer to the “location” section of our website to obtain printable directions to our office.

If you have any further questions contact our office (614) 863-3937.

Thank You,

ERDEY SEARCY EYE GROUP

ERDEY SEARCY EYE GROUP
Vision For Life

RICHARD A. ERDEY, M.D.
Cataract, Corneal and Refractive Surgery
GREGORY D. SEARCY, M.D.
Comprehensive Ophthalmology
DARYL D. KASWINKEL, M.D.
Cataract, Corneal and Refractive Surgery
PATRICK A. JANSON, O.D.
Optometric Services
PHILIP N. ARNER, O.D.
Optometric Services
KASEY J. EPPLEY, O.D.
Optometric Services
XUAN PHAM, O.D.
Optometric Services
MELANIE J. BALLARD, O.D.
Optometric Services
JOCELYN DANIEL, O.D.
Optometric Services

Cataract Surgery
Refractive Surgery
Corneal Transplants
Eyelid Surgery
Cosmetic Facial Surgery
Diabetes
Glaucoma
General Eye Exams
Consultative Ophthalmology

50 McNaughten Road, Suite 200
Columbus, Ohio 43213
614.863.EYES (3937)
Fax 614.863.5010
bestvision@icanseeclearly.com
www.icanseeclearly.com

Affiliated with:
EAST COLUMBUS SURGERY CENTER
www.ECSC.md

Dear Patient,

WELCOME! We appreciate your selection of our office for your eye care needs.

Examination

Your visit will take approximately 2 hours. **Dilation** of your eyes will probably be required for the examination. Since dilation can take a few hours to wear off, it is best that you not plan on driving immediately after the appointment. **Sunglasses** will be provided to you before you leave the office, or you may use your own. Depending on the light sensitivity of your eyes, you may be more comfortable having a friend or family member drive you home from your appointment.

Forms

Several forms follow this letter. Fill in the PATIENT INFORMATION FORM & ASSIGNMENT OF BENEFITS form. If you are a NEW patient you also need to complete the HEALTH QUESTIONNAIRE form. If you are new Laser Vision Correction or Refractive Surgery patient, you must also fill out the VISUAL ASSESSMENT FORM. Please thoroughly complete these forms at home, and bring them with you to your appointment. Filling these out in advance will save you significant time at your appointment.

Medications, Eyeglasses, and Contact Lenses, etc

Please also bring with you a **list of your current medications** (including eye drops), and your **eyeglasses.** Bring your IOL card if you have had cataract surgery elsewhere. If you wear **contact lenses**, please bring the foil wrapper (disposable contacts) or the bottle with the printed label containing the prescription.

Insurance Cards

Be sure you have all of your **insurance cards** with you when you come to the office. Additionally, if your insurance company requires claims to be submitted on its own forms please bring that form with you to your appointment. We will bill your medical insurance for you.

Payment

Applicable co-payments and deductibles will be collected from you for all insurance plans with which we participate**. Payment** is required at the time of the office visit for any co-payments or non-covered insurance services – SUCH AS REFRACTIONS - and may be made in cash, by check or credit card (Visa, MasterCard, Discover, and American Express).

Referrals

Some insurance companies require **referrals** from your primary care physician. Please check with your insurance carrier - if a referral is needed, it must be obtained by you, the patient, before your appointment.

If you have any **questions**, please call us at 614.863.EYES (3937) and ask to speak with a Patient Care Coordinator. Feel free to visit our web site at **icanseeclearly.com** or to email us at **bestvision@icanseeclearly.com**.

We look forward to your visit with us!

Sincerely,

ERDEY SEARCY EYE GROUP

ERDEY SEARCY EYE GROUP PATIENT INFORMATION FORM

Answer ALL of the following to assist us in processing your account accurately. Please PRINT. Thank you.

PATIENT INFORMATION

Last Name: First Name:

Middle Initial: ☐Mr. ☐Mrs. ☐Ms. ☐Dr.

Address:

City, State, Zip:

Telephone Numbers:
Please Place Check (X) Beside Preferred Daytime Number
☐Home ( )
☐Work ( )
☐Mobile ( )

E-Mail Address:

Soc. Sec. #:

Birth Date: Age:

Gender: ☐F ☐M Marital Status: ☐S ☐M ☐W ☐D

Employer: Occupation:

Emp Address:

Emp City, State, Zip:

Spouse's Name:

Sp's Employer:

Sp's Work Telephone: ( )

Family Physician:

Telephone: ( )

PERSON RESPONSIBLE FOR BILL

Complete if someone other than the patient is responsible for the bill.

Last Name: First Name:

Middle Initial: ☐Mr. ☐Mrs. ☐Ms. ☐Dr.

Address:

City, State, Zip:

Telephone Numbers:
Please Place Check (X) Beside Preferred Daytime Number
☐Home ( )
☐Work ( )
☐Mobile ( )

E-Mail Address:

Soc. Sec. #:

Birth Date: Age:

Gender: ☐F ☐M Marital Status: ☐S ☐M ☐W ☐D

Employer:

Emp Address:

Emp City, State, Zip:

Relationship to Patient: ☐Self ☐Spouse ☐Child ☐Other:

Has anyone in your family been seen here before: ☐YES ☐NO

Name of family member:

IN CASE OF EMERGENCY NOTIFY (other than spouse):

Name:

Relationship:

Telephone Numbers:
Please Place Check (X) Beside Preferred Daytime Number
☐ Home ( )
☐ Work ( )
☐ Mobile ( )

HOW DID YOU HEAR ABOUT OUR OFFICE?

Physician: Optometrist:

Relative/Friend: Church Bulletin:

Yellow Pages: Other:

Internet [search engine/key word(s) used]:

PRIMARY INSURANCE INFORMATION

Plan Name:

Copay? ☐YES ☐NO Amount: $

POLICY HOLDER'S NAME:

Relationship to Pt: ☐Self ☐Spouse ☐Child ☐Other

Policy Holder's SS#:

Policy Holder's DOB:

Policy Holder's Address:

City, State, Zip:

Home Telephone: ( )

Work Telephone: ( )

Employer:

Emp Address:

Emp City, State, Zip:

Gender: ☐F ☐M Marital Status: ☐S ☐M ☐W ☐D

SECONDARY INSURANCE INFORMATION

Plan Name:

Copay? ☐YES ☐NO Amount: $

POLICY HOLDER'S NAME:

Relationship to Pt: ☐Self ☐Spouse ☐Child ☐Other

Policy Holder's SS#:

Policy Holder's DOB:

Policy Holder's Address:

City, State, Zip:

Home Telephone: ( )

Work Telephone: ( )

Employer:

Emp Address:

Emp City, State, Zip:

Gender: ☐F ☐M Marital Status: ☐S ☐M ☐W ☐D

ERDEY SEARCY EYE GROUP
ASSIGNMENT OF BENEFITS / FINANCIAL POLICY / RELEASE OF INFORMATION FORM

<u>All Patients</u>, Read and sign this section →	FINANCIAL POLICY: By signing below I indicate that I understand that all patients must complete the Erdey Eye Group Patient Registration & Medical History forms before seeing the doctor. Payment of my bill is considered a part of my treatment. If I have insurance, I need to bring my insurance card(s) with me to every visit and update us if there are demographic changes. ERDEY SEARCY EYE GROUP will send my claim to my insurance company. A statement will be sent to me for any balance covered and not paid by insurance. Co-pays and deductibles are due at the time of service. Insurance referrals are my responsibility and need to be obtained *prior* to my visit. If I do not have insurance coverage, payment in full is expected at the time of service. Ultimately, I am responsible for payment of my bill. _____ Signature of Patient Date of Signature _____ Printed Name of Patient
If you have MEDICARE, Read and sign this section →	I request that payment of authorized MEDICARE benefits be made on my behalf to ERDEY SEARCY, M.D., Inc. for any services furnished to me by The ERDEY SEARCY EYE GROUP. I further authorize any holder of medical information about me to release to the HEALTH CARE FINANCING ADMINISTRATION and its agents any information needed to determine these benefits or the benefits payable for related services. _____ Signature of Patient Date of Signature _____ Printed Name of Patient
If you have *INSURANCE OTHER THAN MEDICARE* (including *SUPPLEMENTAL, MEDICAP* and *SECONDARY INSURANCE*) read and sign this section →	I request that payment from_____ Insurance Name of Insurance Carrier(s) Company be made on my behalf to ERDEY SEARCY MD., Inc. for any services furnished to me by The ERDEY SEARCY EYE GROUP. I further authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services. _____ Signature of Patient Date of Signature _____ Printed Name of Patient
<u>All Patients</u> Read and sign ONE of the two areas to the right	I **authorize** ERDEY SEARCY, M.D., Inc. to use my photograph and/or written testimonial in ERDEY SEARCY EYE GROUP educational/informational materials, including, but not limited to: video, slides, web page, office/patient presentations, brochures, public seminars and teaching sessions. _____ Signature of Patient Date of Signature _____ Printed Name of Patient
	I **do not authorize** ERDEY SEARCY, M.D., Inc. to use my photograph and/or written testimonial in ERDEY SEARCY EYE GROUP educational/informational materials, including, but not limited to: video, slides, web page, office/patient presentations, brochures, public seminars and teaching sessions. _____ Signature of Patient Date of Signature _____ Printed Name of Patient

ERDEY SEARCY EYE GROUP HEALTH QUESTIONNAIRE

Patient Name:_____ **Date:** _____ **DOB:** _____

Exam	Main Reason for today's exam:			
	Last exam Date:_____ Eye Doctor:_____			
Glasses	Do you wear glasses? Yes☐ No☐ How old are they?_____ Percentage of day wearing glasses?_____% What activities do you use them for? _____			
Contacts	Have you ever worn contacts? Yes☐ No☐ Last time worn:_____ If discontinued, why?:_____ Type: Soft☐ Hard/RGP☐ Monovision☐ Bifocal☐ Brand:_____ Solutions used:_____ Prescription Rt. Eye:_____ Left Eye: _____ Total years worn:_____ How many days per week:_____ How many hours per day:_____ _____ _____ Do you sleep in them? Yes ☐ No☐ If yes, how many nights per week?_____			
Refractive Surgery	Laser vision correction, contact lens implantation, and other refractive procedures can reduce or eliminate your dependence on glasses and contacts. Would you like to discuss your options today? Yes☐ No☐			
Medications	Medications:			
	Eye Medications:			
Surgeries	Eye surgery (list date, type, eye, and surgeon)			
	List all other surgeries:			
Allergies	Are you allergic to any medications? Yes☐ No☐ List:_____ Are you allergic to latex? Yes ☐ No☐ What type of allergic reaction did you have to medication?_____			
Eye Information	Do you have any of the following (please check):			
	☐Blurry vision ☐Burning ☐Color vision loss ☐Distorted vision ☐Double vision ☐Dry eyes	☐Excessive tearing ☐Eye pain ☐Eyelid drooping ☐Tired eyes/fatigued ☐Flashes of lights ☐Floaters	☐ Foreign body sensation ☐ Glare/halos ☐ Infection ☐Loss of central vision ☐Loss of side vision	☐Mucous discharge ☐Redness ☐Scratchy, sandy, gritty feeling
	Have you ever been diagnosed with(please check):			
	☐Cataract ☐Eye trauma ☐Eye tumor	☐Glaucoma ☐Keratoconus ☐Lazy eye/amblyopia	☐Macular degeneration ☐Retinal detachment ☐Strabismus (eye turn)	☐Other:_____
Medical History	Have you ever been diagnosed with(please check):			
	☐ AIDS or HIV ☐ Alzheimer's ☐ Arthritis Type:_____ ☐ Asthma ☐ Blood transfusion (past) ☐ Cancer Type:_____ ☐ COPD ☐ Dementia	☐ Diabetes Onset_____ ☐ Head trauma ☐ Heart disease ☐ Hepatitis Type:_____ ☐ Herpes ☐ High blood pressure ☐ Low blood pressure ☐ Lupus ☐ Migraine headaches	☐ Multiple sclerosis ☐ Parkinson's disease ☐ Rosacea ☐ Raynaud's phenomenon ☐ Sarcoidosis ☐ Seizure disorder ☐ Sinus disorder ☐ Sleep apnea ☐ Sjogren's syndrome ☐ Stroke or TIA	☐ Syphilis ☐ STD Type:_____ ☐ Thyroid disease Type:_____ ☐ Tuberculosis ☐ Other:_____
Family History	Have any blood relatives been diagnosed with the following (list relation):			
	☐ Amblyopia (lazy eye) ☐ Blindness ☐ Diabetes ☐ Eye Tumor	_____ _____ _____ _____	☐ Glaucoma ☐ Macular degeneration ☐ Retinal detachment ☐ Strabismus (eye turn)	_____ _____ _____ _____

Please complete other side of form.

ERDEY SEARCY EYE GROUP HEALTH QUESTIONNAIRE

Patient Name:_____ **Date:** _____ __ _____

	Yes	No		Yes	No	
Social History	☐	☐	Do you use tobacco? Or Chew (circ le one) Packs per day _____ Years_____ _____	☐	☐	Do you drive?
	☐	☐	Do you use alcohol? _____ Drinks per day_____	☐	☐	Are you pregnant?
	☐	☐	Have you been on long-term steroid treatment?	☐	☐	Do you do heavy weight lifting?
				☐	☐	Do you play a brass or woodwind musical instrument?

	Do you have any of the following? (Please circle)				
Review of Systems	*Constitutional*	Fatigue	Fever	Weakness	Weight loss
	HEENT	Vertigo	Hearing loss	Sinus problems	Sore throat
	Respiratory	Asthma	Cough	Dyspnea(short of breath)	Wheezing
	Cardiovascular	Chest pain	Irregular heartbeat	Leg swelling	Calf Pain
	Gastrointestinal	Change in appetite	Heartburn	Nausea	Vomiting
	Metabolic/Endocrine	Increased appetite(polyphagia)	Heat intolerance	Cold intolerance	Thirst(polydipsia)
	Genitourinary	Blood in urine(hematuria)	Incontinence	Irregular menstrual cycle	Painful urination(dysuria)
	Neurological	Balance disturbances	Headache	Memory difficulty	Numbness of extremities
	Psychiatric	Depression	Insomnia	Nervousness	Stress
	Integumentary	Hives	Itching skin	Rash	Sores
	Musculoskeletal	Back pain	Joint stiffness	Muscle cramping	Muscle weakness
	Hematologic/Lymphatic	swollen lymph node(lymphadenopathy)	Bleeding easily	Bruising easily	Tender lymph nodes
	Immunologic	Contact dermatitis	Environmental allergies	Food allergies	Seasonal allergies

PHARMACY INFORMATION:

PHARMACY NAME: _____

ADDRESS_____

CITY_____ **ZIP CODE:** _____

PHONE NUMBER_____

HAVE YOU EVER TRIED MONOVISION? _____

AT WHAT AGE DID YOU FIRST START TO WEAR GLASSES? _____ **CONTACTS?**_____

Please complete other side of form.

ERDEY SEARCY EYE GROUP

Notice of Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY!

This office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information ("PHI") is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services. This notice describes our responsibilities in keeping your PHI private and confidential. This notice also describes your rights in relation to your PHI.

Examples of uses of your health information for treatment purposes are:

- A staff member obtains treatment information about you and records it in a health record.
- During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input. Also, this specialist may need such information so that he/she may directly provide you with treatment.

Example of use of your health information for payment purposes:

- We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the care given and possibly to obtain approval in advance for treatment we would like to provide to you.

Example of use of your information for Health Care Operations:

- We obtain services from our insurers and other third parties, some being business associates with whom we have contracted which may include services such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical/client review, transcription, billing, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the doctor's office. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request on our form to our office – we are not required to grant the request but we will comply with any request granted;
- Obtain a paper copy at any time of this Notice of Privacy Practices for PHI ("Notice") by making a request at our office. This is true even if you have previously received this Notice electronically;
- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request in writing to our office using the form we provide to you upon request. We are not obligated to agree to all requests; if we don't, we will tell you why. You may be charged for such a copy if we agree to your request.
- Appeal a denial of access to your PHI except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office using the form we provide to you upon request. (The physician or other health care provider is not required to make such amendments);
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your PHI;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. An accounting will not include internal uses of information for treatment, payment, or health care operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we give you upon request; and,

If you want to exercise any of the above rights, please contact Pamela J. Andrews in person or in writing, during normal hours. She will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

The office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the PHI we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information or want to report a problem regarding the handling of your information, you may contact our Practice Administrator at (614) 863-3937.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to ERDEY SEARCY EYE GROUP, 5965 East Broad Street, Columbus, Ohio 43213, Attention: Privacy Officer. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address is 1200 Independence Avenue, S.W., Washington, D.C. 20201.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses

Appointments and Reminders

- We may use and disclose your PHI to contact you to remind you that you have an appointment with us.

Notification

- Unless you object, we may use or disclose your PHI to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death. We may further disclose, using our best judgment to a family member, other relative, close personal friend, or any other person you identify, to whom health information may be relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency situation.

Research

- We may disclose information to researchers other than us when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Disaster Relief

- We may use and disclose your PHI to assist in disaster relief efforts.
- We may disclose your PHI to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.

Organ Procurement Organizations

- Consistent with applicable law, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing and Fund Raising

- We may contact you to provide you with appointment reminders, with information about treatment alternatives, information about other health-related benefits and services that may be of interest to you, or as part of a fund raising effort.

Food and Drug Administration (FDA)

- We may disclose to the FDA your PHI relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

- If you are seeking compensation through Workers Compensation, we may disclose your PHI to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

- As required by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect

- We may disclose your PHI to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions

- If you are an inmate of a correctional institution, we may disclose to the institution or its agents the PHI necessary for your health and the health and safety of other individuals.

Law Enforcement

- We may disclose your PHI for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight

- Federal law allows us to release your PHI to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

- We may disclose your PHI in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.
- To avert a serious threat to health or safety, we may disclose your PHI consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Government Functions

- We may disclose your PHI for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Other Uses

- All other uses and disclosures must be made pursuant to your written authorization. You may revoke authorizations by delivering a written revocation notice to your office.

Website

- If we maintain a website that provides information about our entity, this Notice will be on the website.

VISUAL FUNCTIONAL STATUS FORM

(Cataract Surgery Patients ONLY: Please Complete)

Patient Name: _____

Today's Date: _____

1. Do you have any difficulty, even with glasses, reading small print such as labels on medicine bottles, a telephone book or food labels?
_____ Yes _____ No _____ Not applicable
If yes, how much difficulty do you currently have?
1. A little
2. A moderate amount
3. A great deal
4. Are you unable to do the activity?

2. Do you have any difficulty, even with glasses, reading a newspaper or book?
_____ Yes _____ No _____ Not applicable
If yes, how much difficulty do you currently have?
1. A little
2. A moderate amount
3. A great deal
4. Are you unable to do the activity?

3. Do you have any difficulty, even with glasses, seeing steps, stairs or curbs?
_____ Yes _____ No _____ Not applicable
If yes, how much difficulty do you currently have?
1. A little
2. A moderate amount
3. A great deal
4. Are you unable to do the activity?

4. Do you have any difficulty, even with glasses, reading traffic signs, street signs or store signs?
_____ Yes _____ No _____ Not applicable
If yes, how much difficulty do you currently have?
1. A little
2. A moderate amount
3. A great deal
4. Are you unable to do the activity?

5. Do you have any difficulty, even with glasses, doing fine handwork like sewing, knitting, crocheting or carpentry?
_____ Yes _____ No _____ Not applicable
If yes, how much difficulty do you currently have?
1. A little
2. A moderate amount
3. A great deal
4. Are you unable to do the activity?

6. Do you have any difficulty, even with glasses, writing checks or filling out forms?
_____ Yes _____ No _____ Not applicable
If yes, how much difficulty do you currently have?
1. A little
2. A moderate amount
3. A great deal
4. Are you unable to do the activity?

7. Do you have any difficulty, even with glasses, playing games such as bingo, dominos, card games or mahjong?
_____ Yes _____ No _____ Not applicable
If yes, how much difficulty do you currently have?
1. A little
2. A moderate amount
3. A great deal
4. Are you unable to do the activity?

8. Do you have any difficulty, even with glasses, watching television?
_____ Yes _____ No _____ Not applicable
If yes, how much difficulty do you currently have?
1. A little
2. A moderate amount
3. A great deal
4. Are you unable to do the activity?

Patient Signature: _____

Witness: _____

VISUAL ASSESSMENT FORM

(Laser Vision Correction and Refractive Surgery Patients ONLY: Please Complete)

Name _____

Telephone - Home _____

Telephone - Work _____

E-mail Address _____

Does your occupation have minimum requirements for vision correction without corrective lenses? (i.e. Police, Fire, Paramedic, Pilot, Armed Services, etc.) ☐ Yes ☐ No

Why are you interested in Laser Vision Surgery? _____

How long have you been thinking about having surgery? _____

Why have you not had it done? _____

Have you previously attended any refractive surgery seminars or consultation visits? ☐ Yes ☐ No

Contact Lenses

Do you currently wear, or have you worn contact lenses? ☐ Yes ☐ No

Have you experienced any problems wearing contact lenses? ☐ Yes ☐ No

If yes, explain:

Spectacles

Have you experienced any problems wearing your eyeglasses? ☐ Yes ☐ No

If yes, explain:

Activity Restrictions

Are there any activities you have not been able to participate in because of your vision? ☐ Yes ☐ No

If yes, explain:

Your Expectations / Goals Of Refractive Surgery

What are the most important things you expect to gain from refractive eye surgery?

- ☐ Appearance
- ☐ Freedom from the hassle
- ☐ Meet occupational requirements
- ☐ Improved peripheral vision
- ☐ Safety
- ☐ Sports/Extracurricular Activities

MEDICATION HISTORY CONSENT FORM

By signing below I give permission for **Erdey Searcy Eye Group, Inc** to access my pharmacy benefits data electronically through RxHub. This consent will enable **Erdey Searcy Eye Group, Inc** to:

- Determine the pharmacy benefits and drug co pays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers using RxHub. This consent may be terminated at any time by Patient.

_____ _____

Patient Name (Print) Birthdate

_____ _____

Patient Signature Date