Marvin Howell, OD and Associates

4101 Roswell Rd, NE Ste 905
Marietta, GA 30062
770.565.3970

5230 Windward Pkwy Ste 101
Alpharetta, GA 30004
678.537.0002

HIPAA Privacy Acknowledgment

I, _____ (Print full legal name here; the "Patient" or "Patient's Legal Representative") have been provided with the Notice of Privacy Policy (the "policy") of the provider and have been offered a copy of such policy for my records.

_____ (Initial here) I hereby acknowledge that I have been offered a copy of the Policy.

OR

_____ (Initial here) I hereby refuse to acknowledge receipt of the Policy. I understand that even though I may refuse to sign this acknowledgment, my provider may still provide services.

Billing Consent and Authorization

I hereby authorize *Marvin Howell, OD and Associates* to use or disclose my medical health information when billing my insurance for all charges incurred in connection with the diagnosis, care, and treatment of my visit. I understand that a payment may be required at the time of services, and that I will be billed and held accountable for payment of any charges that are not paid by my insurer. Should any complications with my insurance occur, I authorize *Marvin Howell, OD and Associates* the right to dispute by appealing denials or other adverse decisions on my behalf as they deem necessary.

_____ _____

Patient Signature Date

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DILATION--RETINAL IMAGING--VISUAL FIELD CONSENT FORM

Dilation is an important part of a complete eye exam. The purpose of a dilated exam is to enhance the detection of any ocular pathology, such as cataracts, glaucoma, retinal hemorrhages, retinal detachments, malignant growths, or any other ocular conditions. It is especially important for patients with a history of diabetes, high blood pressure, headaches, migraines, floaters, high spectacle prescriptions, retinal problems, glaucoma, or family history of eye disease. There are some temporary minor side effects associated with dilation. These include: Sensitivity to light, Blurred vision, Mild burning on installation of the drops and an inability to focus and do near work. These side effects usually last approximately 3-5 hours. Some patients find if difficult to drive after being dilated, and thus bring a driver with them.

I understand the risk and benefits of pupil dilation and request to:
_____ Have my eyes dilated today
_____ Not have my eyes dilated today
_____ Take responsibility to reschedule my dilation

Retinal imaging allows instant viewing of the back of the eye without pupil dilation in most cases. While taking the retinal photo does not replace the need to have your eyes dilated, it is strongly recommended that you have photos taken if you plan on declining dilation at today's visit. However, because this is a screening procedure, it cannot be billed to vision insurance. In some cases we may be able to bill your medical insurance for the cost.

_____ **I would like to have retinal images taken** instead of dilation. I understand I may be charged **$35.00** for a screening fee if the photos are not covered by my insurance.
_____ I would like to have retinal images **and** dilation performed.
_____ I understand the importance of the retinal imaging; however, I decline the procedure.

Visual Field Analysis allows for the early detection of glaucoma, retinal degeneration, tumors and vascular problems. It gives the optometrist an important baseline diagnostic finding. It is recommended that all patients receive this test. It is important for those who have a history of glaucoma, diabetes, high blood pressure, headaches, flashes of light or floaters. However, because this is a screening procedure, it cannot be billed to vision insurance. In some cases we may be able to bill your medical insurance for the cost.

_____ **I would like to have the FDT visual field screening.** I understand I may be charged **$25.00** for the screening if it is not covered by my insurance.
_____ I understand the importance of the FDT visual field screening;however,I decline the additional test at this time.

_____ _____
Patient/Legal Guardian Signature Date

WELCOME TO OUR OFFICE

Last Name	First Name	Date	Social Security #

Address	City	State	Zip

Home Phone	Business Phone	Cell Phone	E-mail Address

Employer	Occupation	Birth Date	Age	Sex M☐ F☐

Medical Insurance and I.D.	Vision Insurance and I.D.	Primary Insured and Birth Date

Form of Payment: Cash Check Credit Card	Date of the last examination

Whom may we thank for referring you?

Reason for your office visit today: (Check all that apply)

- ☐ Lost or broken eyeglasses
- ☐ Want new glasses
- ☐ Want new contact lenses
  - ☐ Soft
  - ☐ Hard
  - ☐ Colored
  - ☐ Disposable
- ☐ Yearly eye exam
- ☐ Problems with current contact lenses
- ☐ Blurred distance vision
- ☐ Blurred near vision
- ☐ Problems with night driving
- ☐ Eyes water
- ☐ Eyes itch
- ☐ Eyes feel dry
- ☐ Pain in eyes
- ☐ Headaches
- ☐ Eyestrain
- ☐ Droopy eyelid
- ☐ Eyes burning
- ☐ Eyes feel tired
- ☐ "Spots" or floaters/flashes
- ☐ Double Vision
- ☐ Sensitive to light
- ☐ Other _____

Personal Medical History: (Check all that apply to YOU)

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Heart disease
- ☐ Arthritis
- ☐ Cancer
- ☐ Stroke
- ☐ Thyroid
- ☐ HIV/AIDS
- ☐ Blindness
- ☐ Glaucoma
- ☐ Cataracts
- ☐ "Lazy Eye"
- ☐ Eye Surgery
- ☐ Eye Injuries
- ☐ Retinal Problems
- ☐ Blood Transfusion?
- ☐ Age Related Macular Degeneration
- ☐ Refractive Surgery
- ☐ Other _____

Family Medical History: (Check all that apply to immediate family members)

- ☐ High Blood Pressure
- ☐ Heart disease
- ☐ Diabetes
- ☐ Cancer
- ☐ Stroke
- ☐ Blindness
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Retinal Disorders
- ☐ Age Related Macular Degeneration

Social History:

- ☐ Do you smoke? No Yes 1-5 per day 1 pack/day more
- ☐ Do you drink? No Yes 1 per day 2-3/week more

Current Medications:

_____

_____

List activities in which you participate:

Computers: How many hours per day? _____

Sports: _____

Hobbies: _____

Are you pregnant: Yes No

If yes, months: _____

Allergies to medications: Yes No

If yes, which ones:

_____

_____

_____

Allergies to contact lens solutions: Yes No

If yes, which ones:

_____

_____

_____

"While we will make every effort to verify and confirm your insurance, it is your responsibility to understand the terms and conditions of your insurance. Payment for co-pays and non-insured services are expected at the time of service. Thank you for allowing us to serve your eye care needs"

Patient Signature/Legal Guardian _____