# Please fill out the following:

Last Name _____ First Name _____ MI _____

Insurance (circle one): Medical Eye Services (MES) Spectera/United Healthcare VSP
Costco Employee Insurance Other: _____

Have you had an eye exam here? (circle one) YES NO

Martial Status (circle one) Single Married Divorced Separated Other

Birthdate: ___/___/_____ Age:_____ Gender M___ F___

Race: Caucasian___ Asian___ Black/African-American___ American Indian___
Pacific Islander___ Other_____

Ethnicity: Hispanic or Latino__ Not Hispanic or Latino__ Unknown__

Home Number (____)____-_____ Work Number (____)____-_____ Ext. _____

Mobile Number (____)____-_____

Preferred Contact Number(circle one) Home/Work/Mobile Ok to text message appt reminders? Yes / No

Is it okay to leave a message? Yes___ No ___ Ok to email exam info and appt reminders? Yes / No

Email Address: _____

Home Address:
Street_____
City_____ State_____ Zip_____

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Past Medical History:
Please select the following medical conditions you have:

__Anxiety
__Arthritis
__Asthma
__Artrial Fibrillation (irregular heartbeat)
__BPH
__Bone Marrow Transplantation
__Breast Cancer
__Colon Cancer
__COPD
__Coronary Artery Disease
__Depression
__Diabetes
__End Stage Renal Disease
__GERD
__Hearing Loss
__Hepatitis
__Hypertension
__HIV/AIDS
__Hypercholesterolemia
__Hyperthyroidism
__Hypothyroidism
__Leukemia
__Lung Cancer
__Lymphoma
__Prostate Cancer
__Radiation Treatment
__Seizures
__Stroke
__None

Other: _____

Past Surgeries:

Please Select Which Surgeries you have had:

__Appendix
__Bladder
__Breast
__Colon
__Gall Bladder
__Heart
__Joint/Hip/Knee
__None
__Kidney
__Ovaries
__Prostate
__Skin
__Spleen
__Testicles
__Uterus
Other_____

Ocular History: Do you have any of the following conditions?

__Allergies
__Cataracts
__Dry Eyes
__Glaucoma
__Macular Degeneration
__Retinal Detachment
__Cross Eye(s)
__Lazy Eye
__Floaters
__Flashes of Light

Have you had any ocular surgeries? No Yes Describe:_____

Please List Your Current Medications:

_____
_____
_____
_____

Do you have any allergies? No Yes Please explain:_____

Social History:

Do you smoke cigarettes?(circle one) Never Former Current

Do you drive? Daytime Only Nighttime Only Both Not Driving

Family History: Has there been any...

__Blindness
__Cancer
__Cataracts
__CVA
__Diabetes
__Glaucoma
__None
__Heart Disease
__Hypertension
__Macular Degeneration
__Migraine
__Retinal Detachment
__Strabismus
Other:_____

Would you like to be dilated today? NO YES

Dilation uses special drops to help open up your pupil, this then allows the doctor to see more inside your eye. This special test is recommended every 2 years and costs an extra $20.

What brings you in today?

Eye exam for: Glasses___ Contacts___ Both___ Red Eye___ Other_____

OPTOMETRY

DR. KEVIN R. SOLIS AND ASSOCIATES
895 EAST H ST.
CHULA VISTA, CA 91910
OFFICE: (619) 397-7955
FAX: (619) 397-7956

# 60-DAY PRESCRIPTION SERVICE GUARANTEE

From the date of your original eye exam we extend to you a courtesy **60-day Prescription Service Guarantee** for your new eyeglass and/or new contact lens prescription accuracy.

Although special care is taken during your exam to ensure that your prescription is as accurate as possible, on occasion your new lens prescription may not feel as comfortable or your vision may not be corrected as clearly as you expected. If you are experiencing difficulty with your new eyewear please observe the following:

For Eye Glasses: **60-day service guarantee from the date of original exam**
Return to the optical where purchased to verify lens alignment and Rx manufacturing accuracy, try to adapt for 2 weeks minimum if the lenses are verified as correct by the optician.
Schedule a follow-up with your prescribing Optometrist if after 2 weeks you continue to struggle with your eyeglass Rx within the 60-day period.

For Contact Lenses: **60-day service guarantee from the date of original exam**
Under most circumstances, trial disposable lenses with your prescription are dispensed before a disposable contact lens Rx is filled (with the exception of color contacts). Please do not open any purchased contact lenses until you try your trial lenses. Any difficulty you have with the courtesy trial lenses should be communicated to the prescribing doctor. **Please DO NOT open any purchased contact lens boxes if you have issues with the provided trial lenses.**
Schedule a follow-up readily with the original prescribing Optometrist to communicate or resolve your issue(s) within the 60-day period.

If procrastinating with the new Rx, or the new Rx for glasses or contacts is not obtained, but months later purchased and found to be problematic, re-exam and/or re-fitting fees apply to analyze why. Please understand that with elapsed time, as well as contributing conditions such as pregnancy, diabetes, dry eyes, cataracts, glaucoma, macular degeneration etc., vision or visual performance may be variable or may change and thus we are unable to extend the eyewear prescription guarantee.

**It is therefore incumbent on you to obtain your new eyeglasses in a timely manner (60 days), or try your trial prescription contact lenses, and schedule your complimentary follow-up(s) within 60 days of your exam if you experience any issues related to prescription accuracy,** please do not wait until the last minute to attend to your responsibility since multiple visits may be required.

**A minimum fee of $35 to maximum full exam fee applies for re-evaluations outside of the 60-day guarantee period. Fee amount is assessed at the discretion of the doctor and is relative to the nature of the complaint, the labor involved, and the time lapsed.**

Note: Red eye/ocular infection-related evaluations are excluded from the 60 day service guarantee and incur independent professional service fees for treatment and management, even if occurring within a new exam or contact lens fitting period.

| Signature of Acknowledgment | Printed Name | Date |
|---|---|---|

# HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.