# Alexandra Vlad OD LLC

*Florida Board Licensed Optometrist*
**675 Tatonka Terrace, The Villages, FL 32162**
**(407)269-9438**

**Patient's Printed Name:**_____ **Today's Date:**_____
**Date of Birth:** _____ **Age:**_____ **Gender:**_____
**Address:**_____
**City:** _____ **State:**_____ **Zip:**_____
**Cell Phone: (  )**_____ **-** _____ **E-mail:** _____
**How did you hear about us?** _____

**ROS**: Select the medical conditions that apply to you:

| | |
|---|---|
| **CN:** _ Cancer | **GU**: _ Kidney _ Prostate _ Urinary _ Pregnant |
| **ENT:** _ Hearing loss _ Sinusitis | **Musc**: _ Arthritis _ Fibromyalgia _ Ankylosing |
| **Neuro**:_ MS _ Epilepsy _ Paralysis _ Stroke _ Autism | **Integ**: _ Eczema _ Rosacea _ Psoriasis |
| **Psych**: _ Depression _ Anxiety _ Bipolar _ ADHD | **Endo**: _ Diabetes _ Thyroid _ Hormonal dysfunction |
| **Cardio**: _ Hypertension _ Heart _ Vascular disease | **Hem/Lymph**: _ Anemia _ High Cholesterol |
| **Resp**: _ Asthma _ Bronchitis _ Emphysema _ Apnea | **Immune**: _ RA _ Lupus _ Sjogren's |
| **GI**: _ Crohn's _ Colitis _ Ulcer | |

**Medications (including eye drops and vitamins)** _ Yes _ No
If YES: please list name and reason it is taken, if you have a prepared list please allow a copy:

_____

**Allergies**:
_ Sulfa _ Penicillin _ Latex _ Environmental _ Medication:_____

**PFSH (Past Ocular History):** Do you have any of the following **eye** conditions? Please mark all that apply.

| | | |
|---|---|---|
| ___Glaucoma | ___Strabismus | ___Eye Injury |
| ___Glaucoma Suspect | ___Amblyopia | ___Dry Eyes |
| ___Cataract | ___Retinal Hole/Detachment | ___Nystagmus |
| ___Macular Degeneration | ___Retinal Degeneration | ___Diabetic Retinopathy |
| ___Eye Surgery | ___Retinal Hole | ___Other: _____ |
| ___Eye Patching | ___Retinal Detachment | |
| ___Inflammatory Disorder | ___Keratoconus | |

**PFSH (Family History):** Which conditions apply to **family members**? (_ Unknown) (_ None)

| **Medical** | | | | **Ocular** | | | |
|---|---|---|---|---|---|---|---|
| Hypertension: | _ Mother | _ Father | _ Sibling | Cataracts: | _ Mother | _ Father | _ Sibling |
| Diabetes: | _ Mother | _ Father | _ Sibling | Glaucoma: | _ Mother | _ Father | _ Sibling |
| Cancer: | _ Mother | _ Father | _ Sibling | Macular Degeneration: | _ Mother | _ Father | _ Sibling |
| Thyroid issues: | _ Mother | _ Father | _ Sibling | Strabismus: | _ Mother | _ Father | _ Sibling |
| | | | | Blindness: | _ Mother | _ Father | _ Sibling |



OVER. PLEASE

**1. Consent for Care: CONSENT FOR CARE AND TREATMENT**
By signing below, I, the undersigned, do hereby voluntarily consent to such optometric care involving routine diagnostic procedures and non-invasive treatments as deemed necessary by the licensed optometrist(s) at Alexandra Vlad OD LLC. I understand and acknowledge that no specific outcomes or results can be guaranteed regarding my treatment. I understand that I have the right to refuse any procedure or treatment. I have the right to ask questions and be informed of my diagnosis, treatment options, risks, and benefits.

**2. Privacy Acknowledgment (HIPAA): NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT**
By signing below, I acknowledge that I have received and/or been offered a copy of the Notice of Privacy Practices for Alexandra Vlad OD LLC. This notice provides information about how my medical information may be used and disclosed, and how I can access this information. I understand that this office is required by law to maintain the privacy of my protected health information and will follow the terms outlined in the notice.

**3. Financial Policy**
By signing below, I acknowledge that I have read, understood and will comply with the Alexandra Vlad OD LLC's financial policies:
1. Payment is due at the time of service upon check in, unless prior arrangements have been made.
2. Alexandra Vlad OD LLC accepts cash, credit/debit cards, and HSA/FSA cards, NO checks.
3. If and or when applicable, Alexandra Vlad OD LLC may bill my insurance. However, I am ultimately responsible for any balance not paid by my insurance provider.
4. Accounts past due over 60 days may be subject to collections and additional fees.
6. It is my responsibility to verify my insurance coverage and benefits prior to my visit.

**4. Assignment of Benefits & Release of Information**
By signing below, I hereby authorize payment of vision and/or medical benefits directly to Alexandra Vlad OD LLC for services rendered. I understand that I am financially responsible for charges not covered by my insurance plan. I authorize Alexandra Vlad OD LLC to release any necessary medical information to my insurance company, third-party payers, or other physicians involved in my care, as required for claims processing and care coordination. This authorization will remain in effect until revoked in writing.

**5. Eyeglass and Contact Lens Consent and Acknowledgment of Receipt of Prescription(s) to comply with the Federal Trade Commission (FTC) Eyeglass Rule and Contact Lens Rule**
*Your Rights Under Federal Law, According to the Federal Trade Commission (FTC):*
*After a comprehensive eye examination, you are entitled to receive a copy of your glasses prescription at no extra charge, whether you ask for it or not and whether it exists or not. If you are fitted for contact lenses, you have the right to receive your contact lens prescription after the contact lens fitting is complete. We are prohibited by law from requiring you to purchase glasses or contact lenses from us as a condition of receiving your prescription*.
By signing below, I acknowledge that I have been informed of my right to receive a copy of my glasses and/or contact lens prescription(s) at no extra charge as a printed prescription; and I understand that *if* I am fitted for contact lenses, the fitting may require follow-up visits and must be completed before a finalized prescription is issued. I also understand that I am not required to purchase glasses or contact lenses from Alexandra Vlad OD LLC in order to receive my prescription(s).

| | |
|---|---|
| Printed Name: | |
| **SIGNATURE** | |
| Date: | |

## Dilation, Options & Authorization

The purpose of dilating the pupils is to get a more thorough view of the inside of the eyes at the back most tissue called the retina thereby allowing your doctor to view tissue which otherwise may not be viewable. This procedure is free of cost to you. *Side effects include light sensitivity and blurry vision from 3-5+ hours.*

If you decide dilation is not for you: our office offers an imaging bundle that includes *dilation-free* retinal photos and deep retinal scans for an *additional $20 fee and is NOT covered by insurance*. Imaging provides an 82% view of the inside of the eyes and the scans allow more in-depth screening of deeper layers to screen for things that may appear normal on the surface but in reality are not and thus can be often misdiagnosed or missed altogether with dilation alone. These imaging technologies assist your doctor to detect earlier signs of diseases like diabetic retinopathy, macular degeneration and glaucoma (among many other insidious and blinding conditions).

## Imaging is always *recommended* by your doctor.

Please select from the following options:

___ I accept dilation and accept the side effects.
___ I accept the imaging option for the additional cost, ($20).
___ I decline dilation due to the side effects.
___ I decline the imaging option.

| | |
|---|---|
| Printed Name: | |
| **SIGNATURE** | |
| Date: | |