

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 past and present:

CN: _ Cancer ENT: _ Hearing loss _ Sinusitis Neuro: _ MS _ Epilepsy _ Paralysis _ Stroke _ Autism Psych: _ Depression _ Anxiety _ Bipolar _ ADHD Cardio: _ Hypertension _ Heart _ Vascular disease Resp: _ Asthma _ Bronchitis _ Emphysema _ Apnea GI: _ Crohn's _ Colitis _ Ulcer	GU: _ Kidney _ Prostate _ Urinary _ Pregnant Musc: _ Arthritis _ Fibromyalgia _ Ankylosing Integ: _ Eczema _ Rosacea _ Psoriasis Endo: _ Diabetes _ Thyroid _ Hormonal dysfunction Hem/Lymph: _ Anemia _ High Cholesterol Immune: _ RA _ Lupus _ Sjogren's
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Medications (including eye drops & 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 _ Glaucoma Suspect _ Cataract _ Macular Degeneration _ Eye Surgery _ Eye Patching _ Inflammatory Disorder	_ Strabismus _ Amblyopia _ Retinal Hole/Detachment _ Retinal Degeneration _ Retinal Hole _ Retinal Detachment _ Keratoconus	_ Eye Injury _ Dry Eyes _ Nystagmus _ Diabetic Retinopathy _ Other: _____
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PFSH (Family History): Which conditions apply to family members? (_ Unknown) (_ None)

<u>Medical</u>	<u>Ocular</u>
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

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 the *Notice of Privacy Practices* for Alexandra Vlad OD LLC is available to me to read today (it is located on the wall at check in) and/or can be issued to me in a paper copy upon my request to take home. 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/digital 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:	



Retinal Examination Options

The retina is a very important tissue lining the back of your eye. Examining it allows the doctor to screen for blinding conditions like diabetic retinopathy, macular degeneration, and glaucoma, among many eye diseases, that can affect how you see with or without glasses and/or contacts.

It is done as a part of a normal comprehensive eye exam.

We offer two ways to examine retinal health with the doctor:

Option 1: Dilating Eye Drops

- **Cost:** *Free / Included with your exam.*
- **Side Effects:** Light sensitivity and blurry vision lasting 3 - 5+ hours. Driving/working comfort depends on the person and their individual sensitivity to dilation effects.

Option 2: Retinal Imaging Bundle (Always recommended by the doctor for a deeper view than dilation)

- **Cost:** \$20 out-of-pocket fee (*Not covered by insurance*).
- **Benefits:** Dilation-free retinal photos and deep structural scans. Provides an immediate view of the retina and its deep layers to help catch underlying disease layers that surface-level dilated exams alone can miss. No blurred vision or light sensitivity.

IMAGING IS ALWAYS RECOMMENDED BY THE 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:	