Lāna`i Community Health Center | LEE & LEONG | MAUI OPTIX | HĀNA HEALTH

Lana'i Kahului Pukalani Hāna

Name (Last, First, MI) _____ (Mr. / Mrs. / Ms. / Dr.) Date of Birth _____
Primary Care Physician _____ Last Medical Exam Date_____
Previous Eye Doctor _____ Last Eye Exam Date_____
Employer_____ Occupation_____
Preferred Language _____Ethnicity (Optional)_____ □Male □Female

Contact Information (Please check preferred method of contact)

□Email_____ □Address_____

□Cell _____ □Work _____□Home_____

Medical Insurance Medicare / Humana / HMSA / UHA / HMA / HMAA / VA / UHC / AlohaCare / Premier / Other_____

Vision Insurance VSP (subscriber's last 4 SSN_____)/ HMSA / UHA / EyeMed / Other_____

Preferred Pharmacy: _____ ***Location:*** _____

Emergency Contact / Policy Holder (If you are not the policy holder)

Name _____Phone _____Relation _____DOB _____

Notice of Privacy Practices

We do not share private information without your consent. A copy is posted and I am aware that a copy can be requested.

Dilated Eye Exam

I have been educated of the benefits and effects of a dilated exam, and (see clipboard for more information):

□**CHOOSE** to have dilated eye exam.

□**RESCHEDULE** the dilated eye exam.

□**REFUSE** the dilated eye exam. I take all responsibility for the consequences.

I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS OTHERWISE ARRANGED.

Release of Identifying Health Information

I authorize *Maui Optix & Drs. Lee & Leong* to release or request health information under the following terms:

1. The information released or requested is limited to details of an eye exam, including tests.
2. Information would only be released or requested for the patient's health interests.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization.

I HAVE READ AND UNDERSTAND THIS FORM.
I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED ABOVE.

PATIENT SIGNATURE: _____ Date: _____ TURN OVER

(Guardian if under 18 years old)

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Medications (if you have a list please give to staff) ☐NONE _____

_____

Major injuries or surgeries ☐NONE _____

Nursing or pregnant (if applicable) yes / no

General Health, Past or Present **CIRCLE** ***conditions applicable***	**Other / Describe**
Eyes: blur / pain / itch / vision loss/ discharge / dry eyes / LASIK / inflammation / injury	
Past Ocular History: glaucoma / cataract / macular degeneration / surgery / retina	
Headache	
Constitution: developmental disorders / cancer / fatigue syndrome	
Ears, Nose, Throat: hearing loss / sinusitis / dry mouth / laryngitis	
Neuro: multiple sclerosis / epilepsy / cerebral palsy / tumor / stroke / migraine	
Psych: depression / attention deficit / anxiety disorder / bipolar disorder	
Cardio: hypertension / heart disease / vascular disease / congestive heart failure	
Respiratory: cigarette smoker / asthma / bronchitis / emphysema / chronic obstruction / sleep apnea	
Gastrointestinal: chron's / colitis / ulcer / acid reflux / celiac disease	
Genitourinary: kidney / prostate disease/cancer / STD / herpes / chlamydia	
Musc/Skel: osteoarthritis / arthritis / fibromyalgia / muscular dystrophy / ankylosing spondylitis / osteoporosis / gout	
Integumentary: eczema, psoriasis, rosacea / shingles	
Endocrine: thyroid dysfunction / hormonal dysfunction	
Diabetes: Type I / Type II	
Hem/Lymph: anemia / large blood loss / ucler / cholesterol	
Allergic/Immunologic: drug allergies / environmental allergies / rheumatoid arthritis / lupus / sjogren's syndrome	
Family History	**CIRCLE** ***family applicable***
Cancer	Dad / Mom / Sister / Brother / Son / Daughter
Diabetes	Dad / Mom / Sister / Brother / Son / Daughter
High Blood Pressure / Stroke	Dad / Mom / Sister / Brother / Son / Daughter
Thyroid	Dad / Mom / Sister / Brother / Son / Daughter
Cataract	Dad / Mom / Sister / Brother / Son / Daughter
Macular degeneration	Dad / Mom / Sister / Brother / Son / Daughter
Glaucoma	Dad / Mom / Sister / Brother / Son / Daughter
Social History	
Do you or have you ever worn contacts? yes / no	If yes, brand?
Would you like to be evaluated for contacts? (additional fee may apply)yes /no	
Drink alcohol? yes / no	How often?
Do you smoke? yes - somedays / yes - everyday / former / no	
Hobbies:	

Who can we thank for referring you to our clinic? _____

PATIENT SIGNATURE: _____ **Date:** _____

(Guardian if under 18 years old)

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Why we recommend pupil dilation:

Pupil dilation is the standard of care and an essential part of a comprehensive eye examination. We use eye drops to make your pupils larger so that the Doctor can perform a more thorough retinal exam to check your eyes to check for the following:

- **Systemic Disease:** High Blood Pressure, Diabetes, Cancer, etc. that can harm the eyes without causing obvious symptoms to the patient.

- **Ocular Disease:** Glaucoma, Macular Degeneration, Cataracts, Retinal Detachments/Tears, etc., that can affect and harm your vision and cause permanent vision loss.

Normal side effects last for 2 - 4 hours, which include sensitivity to bright lights and difficulty focusing on near objects. Sunglasses are recommended after dilation (we offer disposable shades upon request). Most people will be able to drive, however, it is advised to bring a driver if you do not feel comfortable driving or have never driven with your pupils dilated.

In the case of Dilation Refusal:

Acting under my own will and judgement, I fully accept and understand all risks and consequences associated with refusing to have my eyes dilated. I understand that the Doctor may not be able to detect retinal diseases, cancerous growths, and many other vision threatening conditions. Therefore, I also understand that timely and effective treatment may not be possible without routine dilated examinations. I understand that these undetected conditions may result in permanent blindness.

Patient Name: _____ Date: _____

Patient Signature: _____

(Guardian if under 18 years old)

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About Your Insurance

There are two types of health insurance that will help pay for your eye care services and products. You may have both, and our practice accepts both:

1. Vision care plans (such as VSP and EyeMed)
2. Medical insurance (such as HMSA, BlueCross/Blue Shield and Medicare)

- Vision care plans only cover routine vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.

- Medical insurance must be used if you have eye health problems or systemic health problems that may affect your eyes. Your doctor will determine if these conditions apply to you, but some are determined by your health history.

- If you have both types of insurance plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.

- ***We will bill your insurance plan for services if we are participating providers for that plan. We will try to obtain advance authorization of your insurance benefits so we can tell you what may be covered. If some fees are not paid by your plan, you are responsible for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract. Non-covered services may include refraction and contact lens fitting/evaluation. Refraction is $42, Contact lens evaluation fee starts at $55 but may be higher depending on the difficulty of fitting or type of contact lens for your eyes.***

Payment is expected at the time of treatment. Any deductibles, co-payments and non-covered services must be paid at the time of visit. We accept Cash, MasterCard, Visa, Discover & American Express. We will gladly help you fill out any insurance forms that your plan may require.

I have read & agree to the Privacy Act (HIPAA), Advance Beneficiary Notice (ABN) and our insurance practices.

_____ _____

Patient Signature Date

(Parent Signature, if minor)

(Guardian if under 18 years old)

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Lana'i | Kahului | Pukalani | Hāna

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24 Kiopaa Street #102 ● Pukalani, HI 96768 ● 808.214.9074 ● mauioptix.com

CANCELLATION, NO SHOW & LATE ARRIVAL POLICY

At Drs Lee & Leong / Maui Optix we strive to share aloha through accessible, advanced eyecare. We understand that sometimes keeping appointments or being on time can be difficult, but in order to respect other patient's time, we have this policy.

CANCELLED APPOINTMENTS: We understand that situations arise in which you must cancel your appointment. It is requested that if you must cancel your appointment, you provide our office 24-hour notice. Appointments which are cancelled within less than 24 hours will be put on a list. After two (2) appointment cancellations that are done less than 24 hours, a **$25.00** cancellation fee will be charged per visit cancelled in less than 24 hours.

NO-SHOWS: Patients who do not show up for their appointment without a call to cancel the appointment will be considered a **NO-SHOW** and will be put on a list. After one (1) no show, a **$25.00** no show fee will be charged per missed appointment. **FAILURE TO KEEP SCHEDULED APPOINTMENTS** may result in the termination of physician-patient relationship.

LATE ARRIVALS: If you are running late, please call the office. Patients who arrive more than **10 minutes late** for their scheduled appointment may need to be rescheduled to allow the other patients to be seen in a timely fashion.

Cancellation and No-Show are non-refundable. The fees are the sole responsibility of the patient or responsible party and must be paid in full prior to the rescheduled appointment.

We understand special circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

By signing below you acknowledge that you have read, understand, and agree to this cancellation and no show policy.

_____ _____

Signature of Patient/Representative (Parent Signature if Minor) | Date

_____

Patient Name (Print)

(Guardian if under 18 years old)