WELCOME TO CIVANO EYECARE

We would like to welcome you to our office. Our goal is to make every visit pleasant and educational. We strive to teach good care that will enable clear and comfortable vision that lasts a lifetime

Patient Information:

Name: _____
Last First MI

Birth Date: _____ Social Security Number: _____--_____--_____ (Tricare: FULL SSN, All else: last 4 digits)

Male: _____ Female: _____ Email Address: _____

Primary Phone Number (_____)_____ Secondary Phone Number (_____)_____

Home Address: _____
Street City/State Zip Code

Occupation: _____ Employer: _____

Vision Insurance Plan: ☐ VSP ☐ Eyemed ☐ Tricare ☐ Self Pay

Primary Insurance Provider Information / Financial Responsible Party (if different from above):

Name: _____
Last First MI

Birth Date: _____ Social Security Number: _____--_____--_____ (Tricare: FULL SSN, All else: last 4 digits)

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Parent/ Legal Guardian

Emergency Contact Information and to whom I give permission to pick up contacts, eye glasses if I am unable to:

Name: _____
Last First MI

Email Address: _____ Phone Number (_____)_____

Primary Physician Information:

Name: _____
Last First MI

Name of Practice: _____ Phone Number (_____)_____

Date of Last Visit: _____

I understand that payment is required at the time services are rendered. Furthermore, if utilizing vision insurance, all benefits quoted to me are not a guarantee of payment by my insurance company, and final determination can only be made when the claim is processed. As such, I understand that if some fees are not paid by my insurance, I am still responsible and will be billed for them. I have also read the HIPAA notice of privacy policies.

_____ _____
Signature of Patient or Guardian Date

_____ _____
Signature of Patient or Guardian Date

_____ _____
Signature of Patient or Guardian Date

_____ _____
Signature of Patient or Guardian Date

Who may we thank for referring you to us? _____

Glasses
Do you currently wear glasses? _____
How long have you worn glasses? _____
How old are your current pair of glasses? _____
Describe any problems you have with your glasses.
_____

Last Optometrist Visit Date: _____
Date of Visit: _____ Dilated? Y __ N __
Physician: _____
Phone # _____

Contacts
Do you currently wear contacts? _____
What type of contacts? Soft RGP Hrs/Day _____
Do you sleep with contacts? _____
How long have you worn contacts? _____
Age of current pair: _____
How often do you change your lenses? _____
What solution do you currently use with your lenses?
_____
Describe any problems you have with your contacts?
_____

PERSONAL HEALTH HISTORY Have you now or have you ever had?

	Yes	No		Yes	No		Yes	No
Eye Injury			Turned Eye			Head Injury		
Lazy Eye			Infection			Sinus Problems		
Double Vision			Flashes			Surgery		
Floaters			Dry Eyes			Hospitalizations		
Color Vision Loss			Vision Loss			HIV		
Poor Night Vision			Itchy Eyes			Arthritis		
Headache			Eye Surgery			Syphilis		
Burn/Water			Dizzy Spells			Back Pain		

FAMILIAL CONDITIONS

	You	Family		You	Family		You	Family
Glaucoma			Retina Detachment			Retinal Disease		
Cataract			Diabetes			High Blood Pressure		
Heart Disease			Tuberculosis			Asthma		
Shingles			Kidney Conditions			Cancer		
Epilepsy			Heart Attack			Stroke		
Hemophilia			Alzheimer's			Lung Condition		
Seizures			Migraines			Lupus		
Sickle Cell Anemia			Thyroid			Toxoplasmosis		
Other								

Are you pregnant? _____ Breastfeeding? _____ Menopausal? _____ Post-Menopausal? _____
Please list all current medications, both prescription and over the counter _____

_____
Please list all allergies to medications _____
Do you suffer from seasonal allergies? _____

Privacy Policy. We do not, in any way, sell or distribute patient information to other businesses or insurance companies. Records are provided to other medical professionals only when necessary for patient care.

SPECIAL TASKS INFORMATION
Do you participate in any of the following?
- ☐ Night Driving
- ☐ Fine detailed work (sewing/needlepoint)
- ☐ Extended reading
- ☐ Computer use
  How many hours/day? _____
- ☐ Home repair / Yard work
- ☐ Dangerous work environment (Safety RX)
- ☐ Play music instrument
  Which one? _____

SUN AND SPORTS INFORMATION
How many hours/day are you outside in the sun? _____
Do you wear sunglasses while outside? _____
In what activities do you participate?
- ☐ Outside work (Occupation) _____
- ☐ Golf/Racquet Sports
- ☐ Swimming/ Fishing/Boating/Sailing
- ☐ Baseball/Softball
- ☐ Football/Basketball
- ☐ Running/Rollerblade/Biking
- ☐ Skiing/Snowboarding
- ☐ Other. Please list _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information, and it contains a patient's rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change at any time. If so, you will be notified at your next visit to update your signature/date.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? …… YES NO

May we leave a message on your answering machine at home or on your cell phone?.. YES NO

May we discuss your medical condition with any member of your family?..... YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____

COVID-19 WAIVER AND RELEASE

Carolyn Finnell, OD, PPLC, DBA Civano EyeCare is committed to the health and safety of its patients and presently intends to continue eye care services to its patients unless and until prohibited from doing so by governmental order or other circumstances. We have initiated a number of additional techniques and procedures to ensure the health and safety of our patients, including cleaning and disinfection in addition to those we typically undertake, the separation of patients from one another, and the disinfection of the air in the practice premises using an ozone generator. However, we are cognizant of what we do not know about the mechanisms by which the coronavirus that causes COVID-19 is spread and we understand that it is possible that a patient may become infected while on the practice premises despite our best efforts. Accordingly, those patients who do not wish to cancel their appointment and who wish to receive treatment during the period of time during which the outbreak is continuing are asked to sign this waiver, acknowledging the possibility of infection and waiving any claims against Carolyn Finnell, OD, PLLC, DBA Civano EyeCare, and Dr. Finnell and her staff. Patients who do not sign this waiver will be rescheduled for treatment at a later date.

Please initial the following statements to indicate your agreement with and adoption of each statement:

_____ I understand that it is possible that I may become infected by the coronavirus that causes the COVID-19 illness while on the premises of Civano EyeCare, and I knowingly and intentionally accept the risk of such infection.

_____ I am aware that I have the right to reschedule or cancel my appointment for treatment and that any applicable cancellation fees will be waived until further notice.

_____ I hereby release Carolyn Finnell, OD, PLLC, DBA Civano EyeCare and her staff from all responsibility for any ill effects that may result from my decision to receive treatment, medication, examination or procedures.

_____ I certify that I have read and understand this waiver and release and that I sign the same as my free and informed act.

_____ Date: _____

Patient or Legal Representative Signature

Relationship to Patient: _____

PATIENT FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing ***Civano Eyecare*** to serve you and your family's eye care needs. We are honored to participate in your health care and look forward to establishing a lasting relationship. As part of this relationship, we have outlined our expectations for your financial responsibility in our *Patient Financial Responsibility Policy*. At the time of your appointment, you will be asked to sign a copy of the *Patient Financial Responsibility Policy*. The original form will be filed along with your medical records. Please read this document thoroughly

At ***Civano Eyecare***, we strive to provide quality individualized eye care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients in need of vision care.

When you make an appointment, we reserve time specifically for you. Unfortunately, when a patient does not show for their scheduled appointment, another patient loses an opportunity to be seen. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to our vision care. To cancel appointments, please call (520) 777-3515 or email us at info@civanoeyecare.com. If you do not reach the receptionist, you may leave a detailed message on our voicemail. If you would like to reschedule your appointment, please leave your phone number and we will return your call as soon as possible. Late cancellations (less than 24-hour notice) will be considered as a "No Show".

A "No Show" is a missed appointment without 24 hours' notice. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "No Show." If you are more than 15 minutes late without any communication to our office, it will also be considered as a "No Show." The fee schedule for missed appointments, late cancellations, or "No Show" is as follows:

- First missed appointment "No Show": $75 fee will be billed to your account and must be paid prior to your next scheduled appointment.
- Second missed appointment "No Show": $100 fee will be billed to your account and must be paid prior to your next scheduled appointment, which will be double booked with a possible longer wait time.

I hereby acknowledge that I am aware and accept the financial responsibility for fees assessed to my account for failing to provide a 24-hour cancellation notice of any scheduled appointment at ***Civano Eyecare***. I understand that this fee is ***not*** reimbursable by my insurance carrier.

Signature: _____ Date: _____

As a courtesy to you, ***Civano Eyecare*** will bill your insurance company directly for services rendered. If problems arise regarding coverage issues, we will attempt to work with your insurance company to help resolve them prior to making it your responsibility. However, please be advised that you are ultimately financially responsible for payment of medical services rendered by this ***Civano Eyecare***. If we contact your insurance carrier regarding benefits or authorization on your behalf, we are not responsible for inaccurate information provided to us by your carrier. The information regarding your plan that we relay to you is in good faith. If your insurance requires you to pay a co-payment and/or deductible, you will be required to pay that portion of the cost at the time of service. If you do not pay your co-payment at the time of service, we will bill you for this, along with a processing fee to offset the cost of sending the statement. Please bring your insurance card (if applicable) with you each visit and notify our staff of any changes in your coverage. Insurance deductibles and fees for services not covered by your insurance policy, if known, are due at the time the service is rendered. We will ask you for payment on any outstanding balances. ***Civano Eyecare*** accepts cash, checks and major credit cards. Checks that are returned to us unpaid from your account will be assessed an additional $35 fee, and your account will be placed on a "cash-only basis." We will accept payments only by cash or credit card until the balance is cleared.

I have read and understand ***Civano Eyecare*** Statement of Patient Financial Responsibility. I agree to assign insurance benefits to ***Civano Eyecare*** whenever necessary. I authorize ***Civano Eyecare*** to release information to a collection agency or attorney. In the event of nonpayment or default, I am responsible for all costs and reasonable collection and/or attorney fees. ***Civano Eyecare*** reserves the right to change or amend this statement at any time and at its discretion.

Patient name: _____ Patient date of birth: _____

Signature: _____ Date: _____

INFORMED CONSENT REGARDING DILATION OF THE PUPIL OF THE EYE

The purpose of the dilation is to widen the pupil of the eye to allow greater view of the retina. This allows us to look for peripheral retinal tears, holes, blockages or ruptures of the blood vessels. Dilation of the pupil is achieved by placing a drop or two in each eye.

CONDITIONS IN WHICH DILATION IS HIGHLY RECOMMENDED

Cataract	Lens Implants	Unexplained Headache	Myopia -6.00 or Greater
Aphakia	Ocular Trauma	Metastatic Cancer	Past Retinal Detachment
Diabetes	Sudden Vision Loss	Visual Field Loss	New Flashes / Floaters
HIV	Glaucoma	Macular Degeneration	High Blood Pressure

The pupil will remain dilated for about 4 to 6 hours. You may experience reduced vision and light sensitivity. This may affect your ability to walk safely, drive a car, and/or operate machinery. We will provide you with protective glasses to wear.

There is an additional fee of $30.00 for the dilation exam, unless covered by insurance.

If you oppose dilation and/or photos, you release Dr. Finnell of the responsibility to detect disease or abnormalities in the peripheral retina of your eyes.

- □ YES, dilate my pupils today.
- □ NO, do not dilate my pupils today.
- □ Do not dilate my pupils today, but I would like to schedule an appointment at a later date.
- □ I prefer ultra-wide field photos with a fee of $45 which I understand is not covered by insurance

_____ _____

Name of Patient / Guardian Signature Patient / Guardian

_____

Date

Name _____ Date _____

Please take a moment to complete this questionnaire.

Once completed, Dr. Finnell will be more familiar with your work environment and better able to determine if you are at risk of developing Computer Vision Syndrome, or if you'll need special computer glasses.

General Information

1. **Indicate time spent:**
   On a computer at work _____**Hrs/Day**
   On a computer at home _____**Hrs/Day**
   On a handheld device _____ **Hrs/Day**

2. **Desktop or laptop computer use** (circle)

   My work computer is a: desktop laptop
   My home computer is a: desktop laptop

3. **Lighting in work area** (please describe)
   Overhead/desk
   _____

   Incandescent/Fluorescent
   _____

4. **Are you experiencing any of the following symptoms while at your computer monitor?**
   Check where appropriate
   - ☐ Headaches
   - ☐ Sore or tired eyes (eye strain)
   - ☐ Blurred near vision
   - ☐ Glare (light) sensitivity
   - ☐ Blurred distant vision
   - ☐ Dry or watery eyes
   - ☐ Burning, itching, or red eyes (distant to near and back)
   - ☐ Back pain
   - ☐ Neck and/or shoulder pain
   - ☐ Double vision

5. **Do you wear glasses while working at the computer?**
   - ☐ Yes (please bring them to your eye exam)
   - ☐ No

6. **Do you wear contact lenses while working at the computer?**
   - ☐ Yes (please wear them for your exam)
   - ☐ No

7. **Do you view reference material while working at the computer?**
   - ☐ Yes
   - ☐ No

In order for Dr. Finnell to accurately assess your computer vision needs and possible appropriate eyewear, the following must also be completed

Distances / Direction

8. **Viewing distance (eye to computer screen)** is _____ inches.

9. **Viewing distance (eye to keyboard)** is _____ inches.

10. **Viewing distance (eye to keyboard)** is _____ inches.

11. **The center of the computer screen** is (circle one)

    above eye level equal to eye level below eye level

    if above or below, by how many inches? _____

12. **Reference material** is (circle one)

    above eye level equal to eye level below eye level

    if above or below, by how many inches? _____

CIVANO EYECARE

10501 E. 7 Generations Way, Suite 101, Tucson, AZ 85747 (520) 777-3515 Fax (877) 395-0856

Patient Name: _____

How many servings of fruits and vegetables do you eat per day? _____

Do you eat leafy greens, orange peppers, broccoli, brussel sprouts, green beans, and peas? YES ___ NO ___

How many servings of fish (not fried) do you consume per week? _____

How many hours per week do you engage in moderate to strenuous physical activity? _____

Fruits and Veggie Color List: Evalution of Dietary Carrtenoids and Antioxidants. Circle all that you regularly

RED FRUITS
Red Apples
Blood Oranges
Cherries
Cranberries
Red Grapes
Pink/Red Grapefruit
Red Pears
Pomengranates
Raspberries
Strawberries
Watermelon

RED VEGETABLES
Beets
Red Peppers
Radishes
Radicchio
Red Onions
Red Potatoes
Rhubarb
Tomatoes

GREEN FRUITS
Avocados
Green Apples
Green Grapes
Honeydew
Kiwifruit
Limes

GREEN VEGETABLES
Artichokes
Arugula
Asparagus
Broccoflower
Broccoli
Broccoli Rabe
Brussels Sprouts
Chinese Cabbage
Green Beans
Green Cabbage
Green Peas
Celery
Chayote Squash
Cucumbers
Endive
Leafy Greens
Hatch Chile
Green Chiles (Jalapeños, serranos, poblanos, etc)
Tea

YELLOW/ORANGE FRUITS
Yellow Apples
Apricots
Cape Gooseberries
Canteloupe
Yellow Figs
Grapefruit
Golden Kiwifruit
Lemons
Mangoes
Nectarines
Oranges
Papayas
Peaches
Yellow Pears
Persimmons
Pinapples
Tangerines
Yellow Watermelon

YELLOW/ORANGE VEGETABLES
Yellow Beets
Butternut Squash
Carrots
Yellow Peppers
Yellow Potatoes
Pumpkin
Rutabagas
Summer Squash
Sweet Corn
Sweet Potatoes
Yellow Tomatoes
Winter Squash
Tea

WHITE/TAN/BROWN FRUITS
Bananas
Dates
White Nectarines
White Peaches
White Pears

WHITE/TAN/BROWN VEGETABLES
Cauliflower
Garlic
Ginger
Jerusalem Artichokes
Jicama
Kohlrabi
Mushrooms
Onions
Parsnips
Potatoes (white fleshed)
Shallots
Turnips
White Corn
Tea
Coffee

BLUE/PURPLE FRUITS
Blackberries
Blueberries
Black Currants
Concord Grapes
Dried Plums
Elderberries
Unsweetened (100%) Grape Fruit
Purple Figs
Purple Grapes
Plums
Raisins

BLUE/PURPLE VEGETABLES
Black Olives
Purple Asparagus
Purple Cabbage
Purple Carrots
Eggplant
Purple Belgian Endive
Purple Peppers
Potatoes (purple fleshed)
Tea
Purple/Black Rice

UNC Dry Eye Management Scale

Instruction:
Your dry eye symptoms may include: *pain*, *burning*, *tearing*, *grittiness*, *"feeling like something is in your eye"*, and/or *sensitivity to light*.

We want to know how bad your dry eye symptoms are and how they affect your daily life and the things you want to do like reading, driving, working with a computer, watching TV, or doing things you enjoy.

Please circle the number (1-10) that ***best describes*** your dry eye symptoms and how **they affect** your daily life over the past week.

1 2 3 4 5 6 7 8 9 10

[1 - 2]
My symptoms are *not* a problem.

My dry eye *does not* affect my daily life at all.

[3 - 4]
My symptoms are *mild* and easily tolerable.

My dry eye *hardly* affects my daily life.

[5 - 6]
My symptoms are *moderately* bothersome.

My dry eye *sometimes* affects my daily life.

[7 - 8]
My symptoms are *very bothersome*.

My dry eye *frequently* affects my daily life.

[9 - 10]
My symptoms are *severe* and I need immediate medical care.

My dry eye *greatly* affects my daily life.

Is there anything else you would like your doctor to know about your eyes?

_____

_____