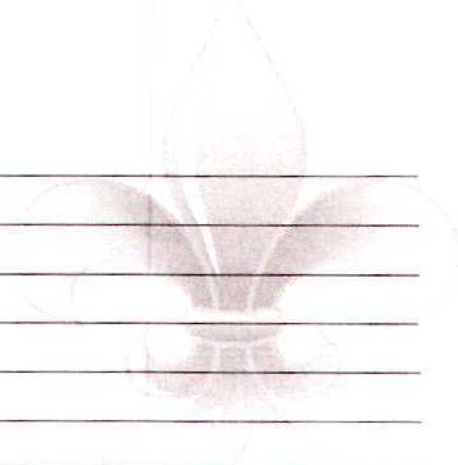


MEDICAL & OPTICAL QUESTIONNAIRE



REASON FOR THIS VISIT? : _____

WHEN WAS YOUR LAST EYE EXAM? : _____

PRIMARY CARE PHYSICIAN: _____

CURRENT MEDICATIONS: _____

ALLERGIES (INCLUDE MEDICATION ALLERGIES): _____

MAJOR SURGERIES (EYE OR OTHER): _____

ARE YOU INTERESTED IN LASIK EYE SURGERY? YES NO

DO YOU USE TOBACCO? YES NO SOCIAL

DO YOU DRINK ALCOHOL? YES NO SOCIAL

FAMILY MEDICAL HISTORY:

***PLEASE LIST ONLY IMMEDIATE RELATIVES IF APPLICABLE**

| | | | |
|----------------------|----------------|--------------------|----------------|
| CATARACTS | RELATIVE _____ | HEART DISEASE | RELATIVE _____ |
| GLAUCOMA | RELATIVE _____ | DIABETES | RELATIVE _____ |
| MACULAR DEGENERATION | RELATIVE _____ | BLINDNESS | RELATIVE _____ |
| RETINAL DETACHMENT | RELATIVE _____ | HIGH BLOODPRESSURE | RELATIVE _____ |
| HEART ATTACK | RELATIVE _____ | HIGH CHOLESTEROL | RELATIVE _____ |
| THYROID | RELATIVE _____ | CANCER | RELATIVE _____ |

DO YOU HAVE ANY OF THE FOLLOWING?

| | | |
|-----------------------------|-----|----|
| HEADACHES/MIGRANES | YES | NO |
| DOUBLE VISION | YES | NO |
| DRY/ BURNING EYES | YES | NO |
| ITCHY EYES (SEASONAL) | YES | NO |
| ALLERGIES | YES | NO |
| LAZY EYE | YES | NO |
| GLARE/ SENSITIVITY TO LIGHT | YES | NO |
| EYE SURGERY | YES | NO |
| FLOATERS/ FLASHES OF LIGHT | YES | NO |
| CATARACTS | YES | NO |
| GLAUCOMA | YES | NO |
| MACULAR DEGENERATION | YES | NO |
| DIABETES | YES | NO |
| HIGH BLOODPRESSURE | YES | NO |
| HIGH CHOLESTEROL | YES | NO |
| THYROID DISORDER | YES | NO |

CONTACT LENSES & DRY EYE QUESTIONNAIRE

- 1) WHAT TYPE OF CL DO YOU WEAR? _____
- 2) RATE YOUR COMFORT (1-5) _____
- 3) WHAT SOLUTION DO YOU USE? _____
- 4) DO THEY FEEL DRY NOW? _____
- 5) DO YOU PUT DROPS IN YOUR EYES? _____
- 6) WHAT DROPS DO YOU USE? _____
- 7) HOW MANY HOURS PER DAY ARE CL WORN? _____
- 8) DO YOUR EYES EVER ITCH, BURN, OR WATER? _____
- 9) HOURS OF COMPUTER USE PER DAY? _____

EYE WEAR QUESTIONNAIRE

- 1) DO YOU WEAR EYE GLASSES? _____
- 2) HOW OLD ARE YOUR GLASSES? _____
- 3) DO YOU OWN MORE THAN ONE PAIR OF GLASSES? _____
- 4) DO YOU PLAN TO LOOK FOR NEW GLASSES TODAY? _____
- 5) DO YOU SPEND A LOT OF TIME ON THE COMPUTER? _____
- 6) SPORTS/HOBBIES? _____

SHANNON VISION CARE
ACKNOWLEDGE OF FINANCIAL POLICY AND NOTICE OF PRIVACY POLICY

FINANCIAL POLICY

Shannon Vision Care is committed to caring for our patient's complete ocular health. Here at Shannon Vision Care our patients will receive a **COMPLETE EYE HEALTH EXAMINATION**. Dr. Shannon is trained to diagnosis and treat most ocular diseases.

Payment for services is due at the time the services are rendered unless other payment arrangements have been made and approved by our staff. **This includes services provided for a minor patient**. We prefer payment in full when ordering glasses or contacts. We accept cash, local checks, Visa, MasterCard, Discover and Care Credit.

We are panel providers and accept assignment on several vision and medical plans. This means that at the time of the exam, you will be responsible for any co-payments, deductibles or fees for non-covered services. We will bill and receive payment directly from your insurance company for covered services. **You will be responsible for any remaining balance**.

If you need a referral from your primary provider to see us, **it is your responsibility to obtain that referral prior to your examination**. A referral with an authorization number is not a promise to pay for that visit. If for some reason you were not eligible for services at the time of the examination, your HMO, PPO or IPA may deny payment and you will still be responsible. Please realize that: 1.) Your insurance coverage is a contract between you and your insurance company. 2.) Not all services are a covered benefit in all contracts and routine eye care and other selected procedures may be specifically excluded, making the patient responsible for the charges. We will try to furnish you with as much information as we can before you select a treatment option so that you can make the most informed decision possible. We don't like surprises either!

We must emphasize that as eye care professionals, our relationship is with you and not your insurance company. You are ultimately responsible for all fees for both services and materials delivered to you by this office. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or your insurance coverage, please do not hesitate to ask. We are here to help you. Thank You! Please sign below to acknowledge that you understand this policy.

PATIENT SIGNATURE

DATE

HIPAA NOTICE OF PRIVACY POLICY

The law requires that Dr. Bridget Shannon and Shannon Vision Care make every effort to inform you of your rights related to personal health information. Attached on your clipboard is our laminated **NOTICE of PRIVACY PRACTICES**.

I acknowledge that (Please check one option below):

- (AGREE)** I was given the opportunity to read Dr. Bridget Shannon and Shannon Vision Care's Notice of Privacy Practices and **do wish to continue in my care** under said terms.
- (DISAGREE)** I have read or had explained to me Dr. Bridget Shannon and Shannon Vision Care's Notice of Privacy Practices and **do not wish to continue my care** under said terms.

I HAVE READ AND UNDERSTAND OUR NOTICE OF PRIVACY PRACTICES. I AM SIGNING THIS VOLUNTARILY.

PATIENT SIGNATURE

DATE

Patient or parent if patient is a minor