This form has been developed specifically for Preschool and School Age Children

Race: ◘ American Indian/Alaska Native ◘ African American ◘ Asian ◘ Caucasian ◘ Middle Eastern ◘Other
Preferred Language: _____

PLEASE CHECK OFF THOSE THAT APPLY TO YOUR CHILD:

PHYSICAL APPEARANCE OF EYES	Yes	No	EYE TEAMING	Yes	No
One Eye Turns			Repeats letters within words		
Red Eyes or Lids			Covers one eye when reading		
Eyes Tear Excessively			Tilts head while working at desk		
Encrusted Lids			Odd posture while working at near		
Frequent Styes on Lids			**EYE HAND COORDINATION**		
COMPLAINTS			Poor handwriting		
Headaches			Repeatedly confuses left and right		
Burning or itching after close work			**OTHER**		
Seeing Double			Quickly loses interest in reading		
Print blurs after reading for a short time			Blinks excessively when reading		
Words move or "swim"			Holds books too close (7" – 8")		
BEHAVIORAL SIGNS			Squints to see at a distance		
Head turns as reading across a page			Rubs eyes a lot		
Loses place frequently during reading			Poor Grades		
Needs finger or marker to keep place			**OTHER CONCERNS NOT LISTED ABOVE**		
Short attention span when reading					
Rereads or skips lines					
Frequent rubbing or blinking eyes					

EYE HISTORY Please note any conditions (Self, Parents, Grandparents, Siblings; living or deceased):

CONDITION / DISEASE	Y	N	Who	CONDITION / DISEASE	Y	N	Who
Blindness				Glaucoma			
Cataract				"Lazy Eye" / Ambloypia			
Crossed Eyes / Eye Turn				Macular Degeneration			
Eye Surgery / Infection / Injury				Retinal Detachment / Disease			

List any medications you take (including for the eyes, aspirin, over-the-counter medications, and home remedies):

_____

_____

MEDICAL HISTORY Please note any conditions (Self, Parents, Grandparents, Siblings; living or deceased):

CONDITION / DISEASE	Y	N	Who	CONDITION / DISEASE	Y	N	Who
Cancer (Constitution)				**Muscles / Skeletal**			
Ear/Nose/Throat				Arthritis			
Hearing				Gout			
Sinusitis				Fibromyalgia			
Neurological				Osteoporosis			
Headaches				**Skin (Integumentary)**			
Migraine Headache				Rosacae			
Seizures				Eczema / Psoriasis			
Multiple Sclerosis				Shingles (HZ)			
Psychiatric				Cold Sores (HS)			
Anxiety / Depression				**Endocrine**			
Attention Deficit / Hyperactivity				Thyroid			
Cardiovascular				Diabetes			
Stroke / CVA				**Hematologic / Lymphatic**			
Heart Disease				High Cholesterol			
High Blood Pressure				Anemia			

CONDITION / DISEASE	Y	N	Who	CONDITION / DISEASE	Y	N	Who
Respiratory				**Allergy / Immune System**			
Asthma				Rheumatoid Arthritis			
Emphysema				Lupus			
Sleep Apnea				Sjrogrens' Syndrome			
Cigarette Smoker				Environmental Allergies			
Gastrointestinal (GI)							
Crohn's Disease				**Drug Allergies**			
Genitourinary (GU)							
Pregnant / Nursing							
Kidneys				**Other Conditions Not Listed:**			
Prostate							
Sexually Transmitted (STD)							

INSURANCE SIGNATURE ON FILE:

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor as to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits. I authorize payment of these benefits directly to DrsThelen, PC; Courtney D. Thelen, O.D. and /or Michelle E. Thelen, O.D. (dba: Annandale EyeCare) for any services and materials furnished. I authorize any holder or medical information about me to be released to Health Care Financing Administration (HCFA), Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. If I have other insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorized release of the above medical information to the insurer or agency shown, and above authorizes my doctor to act as my agent as above.

Patient Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been given a copy of Annandale EyeCare, Member of Vision Source, Courtney D. Thelen, O.D. and Michelle E. Thelen O.D.'s Notice of Privacy Practices ("Notice"), which describes how my health information is used and shared. I understand that the office has the right to change this Notice at any time. I may obtain a current copy by contacting the office Privacy Officer, or by visiting the Office web site at www.AnnandaleEyeCare.com.

Is there anyone you would like us to give access to your record besides yourself? ◯ Yes ◯ No
If, Yes, Please write their name:_____

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices or have otherwise been directed to a copy for me to read:

_____ _____ _____
Signature of Patient or Personal Representative Print Name Date

_____
Personal Representative's Title (e.g., Guardian, Executor of Estate, Etc.)

FOR OFFICE USE ONLY: COMPLETE THIS SECTION IF YOU ARE UNABLE TO OBTAIN A SIGNATURE

1. If the patient or personal representative is unable or unwilling to sign this Acknowledgment, or the Acknowledgment is not signed for any other reason, state the reason: _____
_____

2. Describe the steps taken to obtain the patient's (or personal representative's) signature on the Acknowledgment:_____
_____

_____ _____ _____
Signature of Office Representative Print Name Date

OFFICE FINANCIAL RESPONSIBILITY

- Payment in full is due at the time of service unless an arrangement has been made prior to your scheduled appointment. ***We accept cash, check, Visa, MasterCard, American Express, Discover, Care Credit, and HSA/FSA cards.***
- All checks returned by the bank for insufficient funds will incur a $40.00 bank fee. After we notify you, you have three (3) days to remit payment in full, plus the additional $40.00. Failure to do so will result in your account immediately being turned over to a collection agency. You will be charged an additional collections fee of $50.00, which will be added to your balance owed.
- Understand that should your account balance become past due and is required to be placed with a collections agency, you will be charged a collections fee of $50.00, which will be added to your balance owed.
- **We require full payment for materials (glasses and contact lenses) at the time the order is placed. If you cancel that order after it has been processed you will be charged a return fee of 25% of the original order amount.**
- If you require a **referral** for your medical insurance you are responsible for arriving with the referral from your Primary Care Physician (PCP) or you will be responsible for paying in-full for all services rendered at the time of the examination.
- Understand that all patients wearing contact lenses receive tests and follow-up care above and beyond a comprehensive exam. This contact lens medical evaluation is performed every 12 months whether or not new contact lenses are purchased. I understand there is an additional charge for this service, called a "Contact Lens Evaluation." Most insurance companies consider contact lenses "cosmetic" and not "medically necessary;" therefore, **services related to contact lenses are not covered and will be my responsibility.** If you do not wish to incur any contact lens charges, please inform our staff **before** your examination and remove your contact lenses before your examination begins. However, if this is your choice we will not be able to dispense any contact lenses to you, write a prescription for contact lenses, or be responsible for any contact lenses you might continue to wear.
- During the course of the examination, the Doctor may request further specialized tests due to medical history, family history or to better diagnose any potential eye health problems. In many cases these tests are covered by your major medical plan. If your plan should not cover the recommended testing these charges will be your responsibility and due at the time of your appointment.
- As your eye care provider it is our responsibility to provide you and your family with the best possible eye health care. Please remember, your insurance policy is an agreement arrived at between you and your insurance company and not between your insurance company and your provider (Annandale EyeCare). Each insurance company has dozens of plans; all different. It is impossible for our staff to have complete knowledge of each one. **For our insurance patients**:
    - ***If you plan to use your insurance as a form of payment*** you must present a current insurance ID card to our staff no later than at the time of your appointment; if your **vision plan** is not listed on your major medical insurance card you must inform us of the vision plan's name so we can research and determine your coverage. ***If you have not presented your insurance information prior to the completion of your examination we will not be able to provide refunds, order cancellations or adjustment to fees AFTER services have been rendered and/or your order for glasses and/or contact lenses have been placed.*** You may be able to file for reimbursement on your own.
    - Although we pre-authorize services and materials prior to your arrival, we are told by your insurance company that they will not guarantee payment of the claim until they have processed your individual claim. If your insurance company declines the claim submitted, you will be responsible for the balance owed.
    - If your deductible has not been met, your visit will not be covered by your insurance company and you **will** be charged today. We will file the claim with your insurance company so that the amount you paid today is credited toward your deductible amount.
    - We require any and all known co-payments be paid at the time of your visit. You may have a deductible, additional co-pay or co-insurance amount, or declined services balance due after your insurance company processes your claim. This amount will be billed to you immediately upon our receipt of your explanation of benefits (EOB). The balance owed is due within 30-days of the date the bill is sent to you.
- If there are any questions concerning your bill, either today or when received by mail, it is your responsibility to ask. If we do not hear from you we will assume that you understand, and agree to pay the charges listed.
- This office maintains your patient record for a period of 5 years from last date of patient encounter, or until a minor patient reaches the age of 18. After that time, this office will destroy the records in a manner which protects patient confidentiality.
- ***Your signature indicates that you have read, understand and agree to all of the above policies, and are responsible for payment of services rendered.***

Signature: _____ Date: _____

(Person Responsible for the Account)

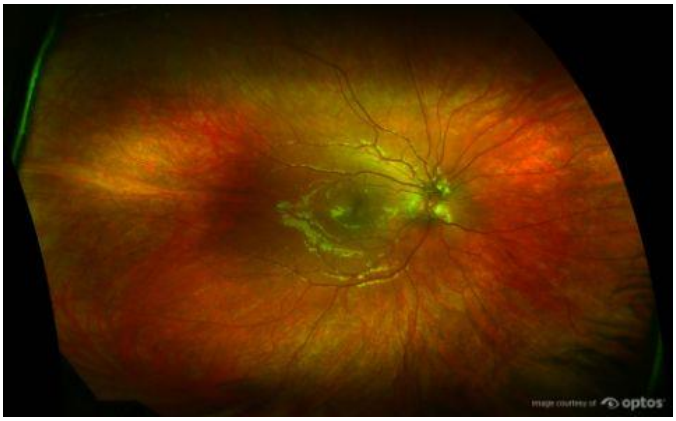
Your eyesight is priceless and we are here to protect it!

Vision threatening diseases such as glaucoma, macular degeneration, diabetic retinopathy and others often have no outward signs or symptoms, which is why eye exams, including a thorough retinal evaluation, are important to protect vision. In an effort to provide a more thorough eye exam, our practice has incorporated the iWellnessExam™ SD - OCT retinal scan and Optomap® ultra-wide digital retinal imaging.

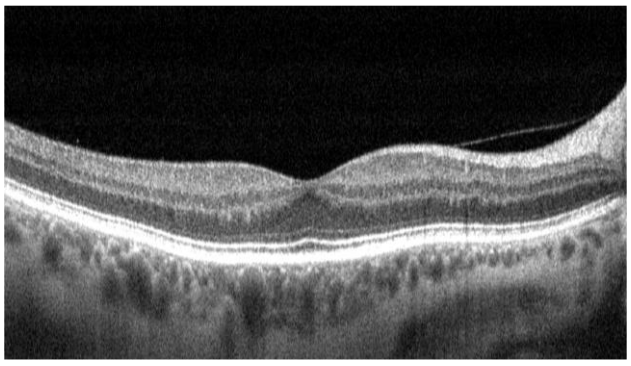
The iWellnessExam™ is a quick, non-invasive scan that allows our doctors to see beneath the surface of your retina. This unique technology can help our doctors detect vision threatening and systemic diseases in their very early stages, when they are most treatable. The Optomap utilizes scanning lasers to create a high definition image of 80-90% of the human retina. This allows the viewing of parts of the retina difficult to see under normal conditions.

As part of your pre-exam testing, our technician will perform the iWellnessExam which your doctor will review with you during your examination today. The $49 charge is not covered by your vision or medical insurance, so this will be added to the balance of your visit. Any questions you have about iWellnessExam and the results of the test can be discus with the doctor during your examination.

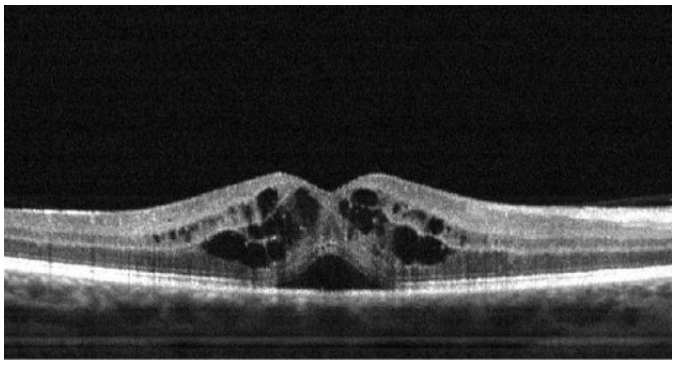
Thank you for choosing our practice to protect the health of your eyes!



Normal Wide field retinal image on the Optomap



Normal retinal cross section iWellness OCT



Diseased retina visible to iWellness OCT exam often invisible to photos and ophthalmoscopy

As part of your examination today, our Doctors need for you to have an Optos Widefield Digital photograph of your retinas and iWellness OCT Retinal Scan. These photographs help our doctors view the health of your eye and also monitor for any potentially vision threatening conditions. The digital screening photos are only $49 and are not covered by medical insurance or vision discount plans. This charge will be added to balance of your visit.

Patient Signature_____ Date _____

(Person Responsible for the Account)