EYEDENTITY eyewear

Williams & Associates Eyecare

2200 Forum Blvd., Suite 102
Columbia, MO 65203

Today's Date: _____

Patient Name: _____

DOB: _____ **Sex: M / F** **SSN:** _____

Race: _____ **Ethnicity: Hispanic Not Hispanic Native Hawaiian**

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Marital Status:** _____ **Spouse/Other:** _____

Employer/School: _____

Occupation/Grade: _____

Activities/Hobbies: _____

Email: _____

***Texting is our primary method of contact. If you do not wish to be contacted in this way, please circle two numbers where you prefer to be reached.**

1st: Cell / Home / Work 2nd: Cell / Home / Work

How did you choose our office for your needs? (please circle) ***Another Dr., Friend/Family, Drive By, Insurance Listing, Media, Other*** _____

Who may we thank for referring you to our office? _____

_____

Primary Name on Insurance (if different from Patient):

_____

Relationship: _____ **DOB:** _____ **SSN:** _____

Address (if different from patient): _____

City: _____ **State:** _____ **Zip Code:** _____

Employer: _____ **Occupation:** _____

H#: _____ **W#:** _____ **C#:** _____

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At Williams & Associates Eyecare / Eyedentity Eyewear, we want to assist you with all your visual and medical needs. Please review and select the options which best suits you. If you have any questions, please contact our Billing Specialist and they will be happy to assist you.

I, _____ choose the following method of payment for my visual/medical care and/or the care of my dependents. I understand that if I have insurance there may still be a balance on my accounts. I understand my glasses and/or contact lens supply will be ordered when half of the amount due is received. The remaining half will be due at time of pick up.

Options (select all that apply):

_____ I elect to pay Cash, Check, Debit, Discover, American Express, Visa, Master Card, Care Credit.

_____ If a payment plan is needed through our office, I will pay the balance in full within 45 days from the date of service.

_____ (Minors/Students Only) – I will contact my parent/guardian for payment arrangements before I leave the office.

Patient Signature: _____ Date: _____

ZenVision Eye-Q™

Intelligent AMD Risk Management

MACULAR DEGENERATION RISK ASSESSMENT

Patient Name: _____

DOB: _____

Exam Date: _____

Risk Factors
(Please check all that apply)

- ☐ **Family History of:**
  - ☐ Macular Degeneration
  - ☐ Cataract
- ☐ **Smoker (current or prior)**
- ☐ **If You have:**
  - ☐ Cataract(s)
  - ☐ Cataract Surgery ○ Right ○ Left
  - ☐ Diabetes
  - ☐ Macular Degeneration
  - ☐ Cardiovascular disease
- ☐ **Light eyes**
- ☐ **Light skin**
- ☐ **Light sensitivity**
- ☐ **Extensive outdoor exposure**

Age-Related Macular Degeneration (AMD) is a leading cause of blindness in adults. Its effects are both permanent and irreversible, and only in some cases can it be treated. *When detected early, AMD is best managed with the use of dietary supplements, and careful monitoring by your doctor.*

You can now take measures to reduce your risk of developing this disease. The QuantifEye® exam is a light response test that only takes a few minutes. We now screen **all** patients *21 years and older*, and obtain a baseline measurement that allows us to track any changes over time.

Insurance does not cover this exam however we consider it very important. The cost of the exam is $15 and we feel it's well worth the cost as it may offer additional protection against a very devastating disease.

_____ **Accept** _____ **Discuss with Doctor**

For Office Use

Patient Risk Determination

MPOD Score _____ **L / R**

☐ ☐

< .45 Lower Range **> .45 Higher Range**

Receipt of Notice of Privacy Policies & Consent Form

Shelley Williams, O.D., P.C.

Williams & Associates Eyecare
2200 Forum Boulevard, Suite 102, Columbia, MO 65203
doctorseyecare@myeyedentityeyewear.com
(573) 445-8780

Patient Name: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The ***Notive of Privacy Practices*** you have been given describes the uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As describes in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy here at the office or from our website at www.eyefinity.com/drswilliams.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices***.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Williams & Associates Eyecare.

_____ _____
Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____
Relationship to Patient Print Name

Source of Authority: _____