Dear New Patient:

Welcome to our practice! We appreciate your trust and want you to know that we are committed to providing you with the highest quality eye care available today.

Enclosed is our practice information brochure to help acquaint you with our office. Also included are our new patient information forms. We request that you please take a moment to fill out the forms completely and bring them with you to your appointment, as this can expedite your check-in process. Keep in mind that the time spent in our office for a comprehensive new patient exam can be up to 2-3 hours.

On the day of your examination, please bring your health insurance and/or Medicare card, a photo ID, a list of your current medications, and your current eyeglasses. Be prepared to pay any co-payment required by your insurance company. If you are uninsured, please come prepared to pay for your visit.

Should your insurance company require an authorization prior to your appointment, please bring the authorization with you or have it faxed to our office at 775-322-1050. You may need to coordinate this with your primary care physician.

If the examination is for a child, please ensure that a parent or legal guardian is able to accompany them.

For your convenience, we have enclosed a card as a reminder of your scheduled appointment.

We look forward to meeting you soon. Please do not hesitate to contact us if you have any questions prior to your visit at our office.

Drs. Mills, Conklin, Mirbaha,
and the staff of Eye Care Professionals

10685 Professional Cir. Suite A • Reno, NV 89521
Web: renoeyecare.com • Fax: 775.322.1050 • Tel: 775.322.1000 • Toll Free: 800.231.4010

Matthew B. Mills, M.D. *Board Certified Ophthalmologist*
Tam Conklin, M.D. *Board Certified Ophthalmologist*
Leyla Mirbaha, O.D. *Optometrist*

EYE CARE PROFESSIONALS

PATIENT INFORMATION FORM

Legal Name of Patient:

Last:______________ First:______________ Middle:______________ Nickname:______________

Race: ___ Caucasian ___ American Indian ___ Alaska Native ___ Asian ___ African American ___ Native Hawaiian ___ Refuse to Answer ___ Unknown

Ethnicity: ___ Hispanic or Latino ___ Not Hispanic or Latino ___ Refuse to Answer ___ Unknown

Sex: ___ M ___ F Social Security No:______________ E-Mail Address:______________

Home Address:______________ Marital Status: S M W D

Mailing Address:______________ City, State, Zip:______________

Home Phone:______________ Cell Phone:______________ Work Phone:______________

Employer:______________ Occupation:______________ Date of Birth:______________

Primary Care Physician:______________ Interest In Refractive Surgery: ___ Optometrist:______________

How were you referred to Eye Care Professionals: (Check all that apply) ___ Patient ___ Optometrist ___ Internet ___ TV ___ Primary Care Doctor ___ Insurance Provider ___ Radio ___ NV Wolfpack Game ___ Telephone Directory ___ Family ___ Friend

Person Referring You:______________

Preferred Language:______________ Preferred Method Of Contact: ___ Home Phone ___ Cell Phone

MEDICAL and VISION INSURANCE INFORMATION

PRIMARY MEDICAL INS. CO: ______________

Name of Insured:______________ Patient Relationship of Insured: ___ Self ___ Spouse ___ Other

Insured's Date of Birth:______________ Insured's Social Security No:______________

Employer:______________ Work Telephone No:______________

SECONDARY MEDICAL INS. CO: ______________

Name of Insured:______________ Patient Relationship of Insured: ___ Self ___ Spouse ___ Other

Insured's Date of Birth:______________ Insured's Social Security No:______________

Employer:______________ Work Telephone No:______________

RESPONSIBLE PARTY IF MINOR OR EMERGENCY CONTACT

Name:______________ Social Security No:______________

Address:______________ Date of Birth:______________

Employer:______________ Occupation:______________

______________ Work Telephone No:______________

To whom may we release your Medical information:

Name:______________ Relationship:______________ Phone Number:______________

Name:______________ Relationship:______________ Phone Number:______________

NOTICE TO PATIENTS: Payment is required at the time service is rendered unless special arrangements have been made with our Business Office. This should be done prior to seeing your doctor. I hereby authorize Matthew B. Mills, M.D. and Leyla Mirbaha, O.D. to furnish information to the insurance carriers, and my doctors concerning my illness and treatment and I hereby assign to the above doctors all payments for medical services rendered to myself or my dependents. I understand I am responsible for all services, including any amount not covered by insurance. I have received a copy of Eye Care Professional's Privacy and Confidentiality Guidelines.

SIGNATURE: ______________ DATE: ______________

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PATIENT PRIVACY AND CONFIDENTIALITY GUIDELINES

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) to not disclose to anyone any personal health or identifiable information about our patients without their authorization. We may be required to disclose health and personal information about you in your treatment, to bill for our services and to collect payment from you or your insurance company or to review the quality of service to you. We may disclose information about you for the benefit of governmental benefit programs or in response to a warrant or subpoena. We may be required to provide health information about you to outside business associates such as our transcriptionist. These business associates are required to sign a contract with us stating that any information they come in contact with must be held in the strictest of confidence. We may be required to disclose personal information about you to contact you as a reminder of an appointment, to renew or prescribe medications or for alternative treatment options. We also may need to release medical information about you to your spouse and family members.

Eye Care Professionals will make every effort to protect your health and personal information, however many instances in a medical practice require us to divulge this type of information. If a breach of confidentiality should occur we will notify you immediately. Your personal information will never be disclosed to anyone for marketing purposes.

We have instituted a number of measures to protect you from identity theft. In accordance with the Fair and Accurate Credit Transactions (FACT) Act, we identify, detect and respond to red flags in the handling of patient information. This includes limiting access to patient financial information. In the event that we find any cause f0r concern, we will notify you immediately.

Eye Care Professionals has my permission to release information concerning my personal health or identifiable information for, but not limited to, the information above.

Printed Name of Patient: ______________________________ **Signature:** ______________________

Date: ____________________ **Signature of Parent of Guardian:** ____________________________

We reserve the right to make changes to this notice at any time. In the event there is a material change to this notice, the revised notice will be posted.

If you have any complaints concerning our privacy practices you may contact our Privacy Officer,
Tracy Waltmon by mail at the above address or email her at: tracy@renoeyecare.com

PATIENT PRIVACY AND CONFIDENTIALITY GUIDELINES
ADDENDUM A

A comprehensive exam requires a list of all medications that a patient is currently taking. We will be obtaining a list of your medications electronically. By signing the original Patient and Confidentiality Guidelines form, you are authorizing us to obtain this information.

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EYE CARE PROFESSIONALS INFORMATION AND CONSENT FOR DILATED EYE EXAMINATION

Patient Name: ____

Dear Eye Care Professionals Patient:

In the course of your care, whether today or in the future, it is important for your doctor to evaluate your retina with a dilated exam. Dilating eye drops are used to enlarge the pupils of the eye to allow the physician to obtain a better view of the inside of your eyes.

Dilation frequently changes vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for us to predict to what degree your vision will be affected. Driving may be difficult immediately after the examination. If you are concerned about these problems, you may wish to make alternative transportation arrangements. The majority of patients do drive after dilation with the assistance of temporary sunglasses, which we can provide after your dilation.

Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize the physician and/or such assistants as may be designated by him to administer dilating eye drops. The eye drops are necessary to perform a complete exam of the retina and the back of the eye. This may reveal the presence of a serious systemic condition as well as eye conditions.

I have read and understand the above information regarding my dilated eye exam.

Patient's Signature: ____ **Date:** ________________________

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CANCELLATION OR NO SHOW POLICY FOR DOCTOR APPOINTMENTS

Patient Name: ____

1. **Cancellation/No Show Policy for Doctor Appointment**

   We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

   If an appointment is not canceled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance.

2. **Scheduled Appointments**

   We understand that delays can happen. However, we must try to keep the other patients and doctors on time.

   If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

3. **Account Balances**

   We will require that patients with self-pay balances do pay their account balances to zero (0) and patients with payment plans must be current prior to receiving further services by our practice.
   Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

   Patients with balances over $100 must make payment arrangements prior to future appointment being made.

Patient/Guardian Signature: ______________________________ **Date:** ____________________

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EYE CARE
PROFESSIONALS

EYE CARE PROFESSIONALS LIFESTYLE QUESTIONNAIRE

Patient Name: ______________________________

VISUAL FUNCTIONING

Do you have difficulty, even with glasses, with the following activities:

	YES	NO
1. Driving?	❑	❑
2. Reading small print, such as labels on medicine bottles, telephone books, or food labels?	❑	❑
3. Reading a newspaper or book?	❑	❑
4. Reading large print book, large numbers on a telephone?	❑	❑
5. Seeing steps, stairs, or curbs?	❑	❑
6. Reading traffic signs, street signs or store signs?	❑	❑
7. Doing fine handwork like sewing, knitting, crocheting or carpentry?	❑	❑
8. Writing checks or filling out forms?	❑	❑
9. Playing games such as bingo, dominos, or card games?	❑	❑
10. Taking part in sports like bowling, tennis or golf?	❑	❑
11. Cooking?	❑	❑
12. Watching television?	❑	❑
13. Working on the computer?	❑	❑

SYMPTOMS

Have you been bothered by:

	YES	NO
1. Poor night vision?	❑	❑
2. Seeing ring or halos around lights?	❑	❑
3. Glare caused by headlights or bright sunlight?	❑	❑
4. Hazy and/or blurry vision?	❑	❑
5. Seeing well in poor or dim light?	❑	❑
6. Poor color vision?	❑	❑
7. Double vision?	❑	❑
8. My vision is worse in one eye than it is in the other eye.	❑	❑

Patient's Signature: ______________________________ **Date:** ____________________

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EYE CARE
PROFESSIONALS

HEALTH AND MEDICATION HISTORY

Name: ____________________

Referring doctor: ____________________

What symptoms are you experiencing with your eyes?

____

____

Which eye? ____________________

How long? ____________________

Have you ever been diagnosed with any eye diseases or problems?

____

Have you ever had eye surgeries/laser treatments or injuries?

____

Which eye and when? ____________________

Name of doctor or clinic that did your eye surgery: ____________________

Family history of eye problems? ____________________

Preferred pharmacy: ____________________

Current prescription medications and dosage/include over the counter medications, vitamins, supplements and eye drops:

____

____

Allergy to medications? ____________________

Past or current health problems? ____________________

____

Have you ever had any surgeries and in what year?

____

____

Are you a former or current smoker? ____________________

Do you drink alcohol? ____________________

Do you use recreational drugs? ____________________

Current occupation? ____________________

***Please be as detailed as possible with your answers**

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