COVID-19 Questionnaire

Due to recent events and concerns, we are taking precautionary measures such as sanitizing each area after patient use, ensuring use of face masks, and maintaining the 6 feet distance between patients to ensure the safety of our patients and ourselves.

Here are some steps you can take to protect ourselves and others:

- Wash your hands often with soap and water for at least 20 seconds, especially before eating
- Avoid close contact with people who are sick
- Avoid touching your eyes, nose, and mouth
- Stay home when you are sick
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash
- Clean and disinfect frequently touched objects and surfaces
- Wear a face mask or cover and gloves if available

Please read the information below and check the boxes off that apply.

[ ] I have been in close contact with someone who is ill

[ ] I am currently feeling ill

[ ] None of the above

I _____ acknowledge that I have read the information above, my responses are true, and I will do my part in taking precautionary measures to ensure everyone's safety. We are sorry for the inconvenience that this may cause. We are wishing you and your loved ones the best of health.

_____ _____

Signature **Date**

HUNSTVILLE FAMILY VISION

Welcome back!

PATIENT INFORMATION

Last Name:_____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____ Email:_____

Date Of Birth: ___/___/___ Employer: _____

Social Security #: _____

Medical Insurance: _____ Type: [ ] HMO [ ] PPO unfortunately we're not taking HMO right now, and we are unable to make exceptions.

Vision Insurance: _____

Primary Insurance Holder's Name and DOB: _____

Last 4 Number of SSN _____

Reason for visit: _____

Secondary reason:_____

Any changes in your medical history? _____

Have you worn contact lenses before? Yes / No

ADDITIONAL TESTING (These services are normally covered under medical)

[ ] **Dilation ($25 Charge**): It is recommended if you have not been dilated in the previous two years, you have any medical condition that can affect your vision, you are over 40, or you have a family history of glaucoma.

[ ] **GDX Screening**: **($30 Charge):** In glaucoma testing, the traditional pressure check does not always lead to proper diagnosis. This screening is a comfortable procedure that can test if any structural damage has been done to the eye.

By signing, I authorize Huntsville Family Vision to release information related to a medical provider in following up on treatment.
X_____

By signing, I understand that due to the policies in Walmart, vision products are NOT sold in our office; they may be purchased in vision centers of patient's choice. All payments made are fees for professional services and are non-refundable. Unfortunately, we are not able to bill third-party insurances at this time. I understand my insurance if applicable can be filed and I am financially responsible for payment whether it is with insurance or out of pocket. **X** _____

By signing, I recognize, the Health Insurance Portability and Accountability Act of 1996. The privacy rule standards address the use and disclosure of the protected health information. A major goal of the privacy rule is to assure the individuals' health information is properly protected while allowing the flow of health information needed to provide and promote the high-quality health care and to protect the public health and well-being. **X**_____

Contact lens patients only, I understand that I am solely responsible for the care and well-being of the contact lenses prescribed today. Contacts are to be disposed of properly according to your prescription. I understand that I am to be held accountable for any misuse of contacts and will exercise proper preventive measures. State laws require first time wearers to schedule a follow up appointment with the doctor to ensure proper use of the contacts. **X**_____

OFFICE USE ONLY

PP/INS/VISION _____/_____ Reason for visit: GLS CL MEDICAL COPAY_____

NCT: ___/____ HEIGHT: _____ WEIGHT: _____ AGE: _____

TEMP: _____ OLD RX OD: _____ OS: _____ ADD: _____ AGE RX: _____