FULL SPECTRUM OPTOMETRY

9805 N. May Ave.
The Village, OK 73120
P: (405) 749-2020
F: (405) 492-6446

Please submit all insurance cards and a valid I.D. at check-in.

Date:_____/_____/_____

How did you become aware of our practice?

☐ Google ☐ Facebook ☐Advertisement ☐Drove By ☐Family/Friend _____ ☐Other_____
☐ Yelp ☐Instagram ☐Postcard ☐Insurance ☐Previous Patient _____ _____

First Name:_____M.I._____
Last Name:_____
Birth Date:_____
SSN#: _____
(SSN# required for billing if you do not have A unique ID# or we are unable to pull up your Policy.)

Address:_____
City:_____State: _____Zip:_____
Email:_____
Do you give permission to text you? ☐ Yes ☐No
Mobile Phone: _____
AlternatePhone: _____

If you choose not to provide a full SSN#, you may pay the full fee for the appointment and a receipt will be provided for you to file a claim with your insurance.

Emergency Contact _____ Phone_____

If patient is a minor
Mother's Name _____ Phone_____
Father's Name _____ Phone_____
Legal Guardian _____ Phone_____
(Documentation must be provided of legal guardianship

BOX 1 OR BOX 2 MUST BE COMPLETED BY PATIENTS OR GUARDIAN

BOX 1 : VISION INSURANCE EXAM

These reasons may be covered under **VISION INSURANCE** and will be filed accordingly. Examples of vision insurance include Vision Service Plan (VSP) or Children's Medicaid/ Soonercare.

☐ I may need a glasses prescription
☐ I want a new contacts prescription
☐ I want new glasses prescription
☐ I want to try contacts for the 1st time
☐ I need a routine wellness exam

DO NOT MARK IN BOTH BOXES

BOX 2: MEDICAL EXAM

These conditions may be covered under **MEDICAL INSURANCE** and wwill be filed accordingly. Examples of medical insurance include Adult Medicaid, BCBS, United Health Care, Medicare, HealthChoice

☐Red Eye ☐Dry Eye
☐Itchy Eyes ☐Sudden Vision Loss
☐Cataracts ☐Glaucoma
☐Eye Turn/Lazy Eye ☐Double Vision
☐Diabetes ☐Floaters
☐Macular Degeneration ☐Eye Pain or Pressure
☐Other (please explain)

DO NOT MARK IN BOTH BOXES

** If you have a medical condition and need a glasses/contact lens prescription, please be aware that your insurance may or may not cover that portion of the exam.
** While the doctor may diagnose a medical condition during a routine wellness exam, a second visit may be needed after the medical condition has been treated and resolved for an accurate glasses/contact lens prescription.

☐ I UNDERSTAND ONCE MY INSURANCE HAS BEEN FILED, THE DIAGNOSIS CODES AND EXAM CODES WILL NOT BE ALTERED DUE TO DENIED COVERAGE.

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Health History Form

Patient's Full Name _____ Birth Date _____ Appointment Date _____

Patients Medical History

☐Yes ☐ No Allergies
☐ Yes ☐ No Apnea
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Asthma
☐ Yes ☐ No Autism
☐ Yes ☐ No Cold Sores/Shingles
☐ Yes ☐ No Dev. Disorders
☐ Yes ☐ No Emphysema
☐ Yes ☐ No Epilepsy
☐ Yes ☐ No GI Disorder
☐ Yes ☐ No Hearing Loss
☐ Yes ☐ No Heart Disease
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No High Cholesterol
☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Lupus
☐ Yes ☐ No Migraine/Headaches
☐ Yes ☐ No Multiple Sclerosis
☐ Yes ☐ No Rosacea
☐ Yes ☐ No Stroke
☐ Yes ☐ No Thyroid Condition
☐ Yes ☐ No Vascular Disease
☐ Yes ☐ No Other Unlisted Condition :_____
☐ Yes ☐ No Are you currently nursing?
☐ Yes ☐ No Are you currently pregnant?
Term _____ Due Date _____
☐ Yes ☐ No Cancer
Type _____
Diagnosis Date _____
Remission: Yes / No

☐ Yes ☐ No Diabetes
☐ Type 1 ☐ Type 2
Diagnosis Date _____
Last A1C_____ Last A1C Date _____
Ave Blood Sugar? _____ Today's Blood Sugar _____

Immediate Family History Please List Mother/Father/Brother/Sister/Son/Daughter

☐Yes ☐ No ☐Unknown	Blindness	_____
☐Yes ☐ No ☐Unknown	Strabismus (Eye turn)	_____
☐Yes ☐ No ☐Unknown	Amblyopia (lazy eye)	_____
☐ Yes ☐ No ☐Unknown	Macular Degeneration	_____
☐ Yes ☐ No ☐Unknown	Retinal Detachment	_____
☐ Yes ☐ No ☐Unknown	Glaucoma	_____
☐ Yes ☐ No ☐Unknown	Cataracts	_____
☐ Yes ☐ No ☐Unknown	Other Eye Condition _____	_____
☐ Yes ☐ No ☐Unknown	Diabetes Type 1	_____
☐ Yes ☐ No ☐Unknown	Diabetes Type 2	_____
☐ Yes ☐ No ☐Unknown	Heart Disease	_____
☐ Yes ☐ No ☐Unknown	High Blood Pressure	_____
☐ Yes ☐ No ☐Unknown	Thyroid Condition	_____
☐ Yes ☐ No ☐Unknown	Hypothyroid Condition	_____
☐ Yes ☐ No ☐Unknown	Cancer /Type _____	_____
☐ Yes ☐ No ☐Unknown	Other Medical Condition_____	_____

Do you use tobacco products?
☐Never Smoked ☐Former Smoker Packs/day _____ ☐Current Smoker Packs/day____ ☐Smokeless tobacco Amt/day_____

Do you drink alcohol?
☐ Yes ☐ No If yes, # of drinks per week: _____

Do you use recreational drugs? (You may discuss this privately with the doctor) ☐ Yes ☐ No

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Medical Health History Form

Primary Care Doctor _____
Location _____ **Last Visit** _____

Additional Co-managing Doctors:
-Doctor _____ **Specialty** _____
Location _____ **Last Visit** _____
-Doctor _____ **Specialty** _____
Location _____ **Last Visit** _____

History of EYE Surgeries

Eye	Type of Surgery	Date	Surgeon
☐Right Eye ☐Left Eye		/ /	
☐Right Eye ☐Left Eye		/ /	
☐Right Eye ☐Left Eye		/ /	
☐Right Eye ☐Left Eye		/ /	

IF YOU HAVE A MEDICATION LIST - WE CAN ADD TO YOUR CHART FOR YOU.

List ALL Current Prescribed & OTC Medications	Prescribing Doctor / Location
	/
	/
	/
	/
	/
	/
	/
	/
	/

ALLERGIES (Please list any medications, food or environmental allergies and the **associated allergic response**)

_____ ☐Trouble Breathing ☐Nausea/Vomiting ☐Rash/Hives ☐Swelling ☐Other_____
_____ ☐Trouble Breathing ☐Nausea/Vomiting ☐Rash/Hives ☐Swelling ☐Other_____
_____ ☐Trouble Breathing ☐Nausea/Vomiting ☐Rash/Hives ☐Swelling ☐Other_____
_____ ☐Trouble Breathing ☐Nausea/Vomiting ☐Rash/Hives ☐Swelling ☐Other_____
_____ ☐Trouble Breathing ☐Nausea/Vomiting ☐Rash/Hives ☐Swelling ☐Other_____
_____ ☐Trouble Breathing ☐Nausea/Vomiting ☐Rash/Hives ☐Swelling ☐Other_____

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DILATION CONSENT

Dilation eye drops are used to relax a muscle that controls the pupil size. This allows the doctor to examine the peripheral retina. For young children, infants and non-verbal patients there is an additional benefit of obtaining the most accurate glasses prescription by relaxing their ability to over-focus.

Side effects include

- Light sensitivity
- Blurred near vision
- Blurred distance vision in some cases

Patients reserve the right to decline any test or diagnostic procedure recommended. If a patient declines, however, he/she assumes all of the risk for potentially not detecting, and thereby treating in a timely manner, any serious eye conditions.

- **I consent to dilate**

- **I wish to discuss with the doctor and decide in the exam room**

- **I decline dilation**
  - **Returning to work**
  - **Returning to school**
  - **I did not bring a driver**
  - **other**

  By signing below, I agree to the following:

  I understand that I am assuming all risks associated with the failure to diagnose eye conditions, due to lack of information, which may have been provided by dilation. Acting under my own will and judgment, I fully understand the circumstances associated with declining to have my eyes dilated.

- I wish to have retinal photos taken during my exam. Retinal photos can be stored in your chart for comparison of year to year stability and/or changes. Retinal photos can detect some conditions in the central portion of the retina but are not a substitute for a full dilated exam.

Patient/Parent/Guardian Print Name _____ **Date** _____

Patient/Parent/Guardian Signature _____

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GENERAL CONSENT AND INSURANCE INFORMATION

Patient Name: _____ **Patient Name:** _____

Patient Name: _____ **Patient Name:** _____

You may complete 1 form per family by listing family members above.
Yellow boxes MUST be completed by the patient or patient's responsible party.

PRIMARY MAJOR MEDICAL INSURANCE	VISION INSURANCE
Company	Company
Primary Holder	Primary Holder
Primary Holder Birth Date	Primary Holder Birth Date
Primary Holder SSN#	Primary Holder SSN#
Member ID#	Member ID#
Group#	
SECONDARY MAJOR MEDICAL INSURANCE	We file most insurances as a courtesy to our patients. Verifying eligibility of insurance is not a guarantee of insurance payment. You are responsible for knowing your insurance coverage. In the event the insurance is not active at the time of service, billing goes towards your deductible, claim is denied or you are unable to provide active insurance information before/on the date of your exam, you are responsible for the balance.
Company	
Primary Holder	
Primary Holder Birth Date	
Primary Holder SSN#	
Member ID#	
Group#	

INSURED PATIENTS ASSIGNMENT OF BENEFITS AUTHORIZATION

I, the undersigned, certify that I (or my dependent) have insurance coverage with those listed above and assign directly to Full Spectrum Optometry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Full Spectrum Optometry to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party's Signature: _____Date:_____

Relationship to Patient: _____

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General Consent and Acknowledgement of Financial Responsibility

PROMPT PAY PATIENTS / UNINSURED PATIENTS

Initial all that apply.

_____ (Initial) I have NO insurance. I am responsible for today's fees at the time of service.

_____ (Initial) I have insurance; however, I do NOT wish to file an insurance claim on today's visit. I choose to pay the prompt -pay discount fee. I am aware that not filing a claim means that the fees I pay today will not be filed towards my insurance deductible.

_____ (Initial) I am aware that Dr. Motley is an **out of network open access provider** with my vision insurance. I am responsible for payment at the time of service. Full Spectrum Optometry will file the claim on my behalf and my insurance will send payment directly to me. An insurance eligibility form, benefits form and an insurance authorized service form are not a guarantee of an insurance payment.

_____ (Initial) I understand that Dr. Motley is out of network with my Medical insurance.. I am responsible for today's fees at the time of service.

_____ (Initial) I understand that Full Spectrum Optometry is not responsible for filing insurance that was not presented at the time of service. We will provide patients with itemized receipts to self file as the need arises.

Responsible Party's Signature: _____Date:_____

Relationship to Patient: _____

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Receipt of Notice of Privacy Policies and Consent Form

Patient Name: _____ Date of Birth: _____

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 Notice of Privacy Practices you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described 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 at www.fullspectrumoptometry.com if needed.

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 a 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.

_____ (Initial) I consent to text and/or email communications for appointment verification, appointment reminders, glasses order completion notification, contact lens order notification. At any time I wish to discontinue this line of communication, I will notify the office.

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 Full Spectrum Optometry.

Patient / Guardian Signature_____ Date: _____

Print Name:_____ Relationship to Patient:_____

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