Appointment Guidelines

[illegible]

- If you feel unwell on the day of your appointment or up to 7 days before your appointment, please re-schedule
- You must wear a mask or a face covering to enter the building
- Patients should come to the office alone, unless they are a minor or if they are in need of a true caregiver
- We are operating a curbside waiting area. Please call the office at 330-348-0269 when you arrive in the parking lot. You will be given the okay to enter the building once we can maintain proper social distancing inside

Please bring:

- Completed Forms
- Driver's License
- MEDICAL Insurance Card
- Medication List
- Prescription Eyeglasses
- Contact Lenses (please wear to exam)
- Any Eye Drops or Ointments

Dilation Explained:

Dr. Smargiasso may need to used drops to dilate your eyes to fully evaluate the internal health. This will temporarily increase sensitivity to light and cause fuzzy vision at a near and distance. These effects should disappear within two to three hours

AURORA **EYECARE**

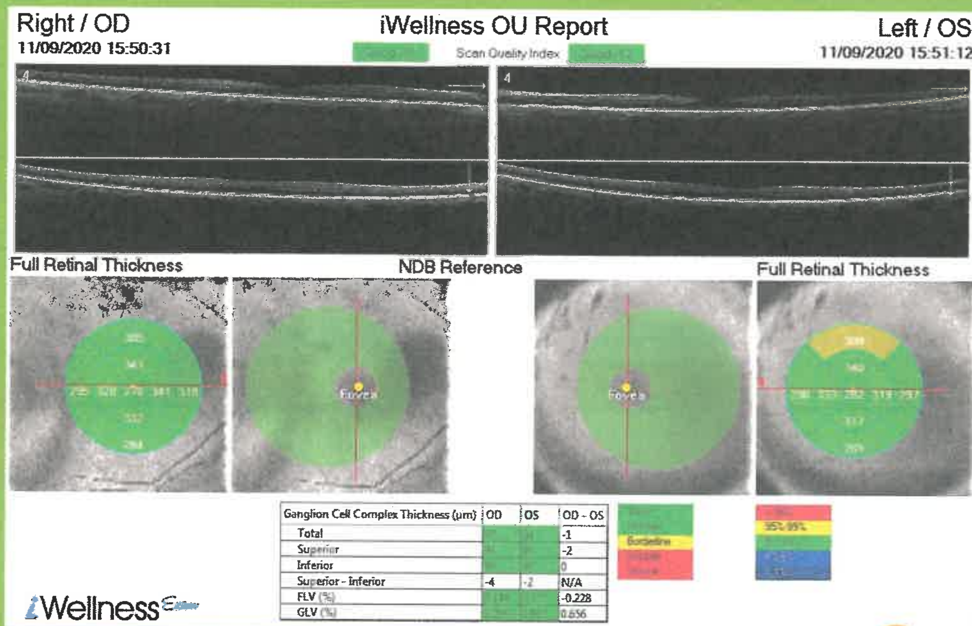
HEALTH · VISION · STYLE

WHAT IS YOUR EYE EXAM MISSING?

Aurora Eye Care proudly offers Optical Coherence Tomography (OCT) technology in-office. iWellness is a scan that gives the doctor a better look at the back of your eye and all of the layers of your retina. For more mature patients, this scan can also detect early stages of eye disease, including glaucoma and macular degeneration.

WHO NEEDS iWELLNESS?

iWellness is encouraged for all patients, regardless of age.



Patient Information

Last Name________________ First Name________________ MI____ Sex M F Date of Birth____________

Preferred Name________________ Preferred Phone________________ ❑Cell Phone ❑Land Line

Address________________ City________________ State_____ Zip__________

Social Security Number________________ Email Address________________

Occupation________________ What is the purpose of this visit?________________

New Patients Only**:** **Who may we thank for referring you to our office?**________________

If not referred, how did you choose our office? ❑Another Doctor ❑Newspaper/Radio/TV ❑Insurance List ❑Website ❑Saw Sign/Building ❑Google

Patient Medical History

Name of Family Physician________________ City________________ Date of Last Check Up__________

Current Medications (List names of all medications, eye drops, vitamins, supplements, birth control pills or ***you may provide a separate list***):

Prescription Medications:	Vitamins/Supplements:	Over the Counter:

Allergies to Medications(s)? ❑Yes ❑No If yes, what medication(s)________________

Have you had any eye surgeries? ❑Yes ❑No If yes, what procedure?________________

Do you use cigarettes/tobacco, alcohol or other substances? ❑Yes ❑No

Have you ever been diagnosed or treated for the following health problems?

❑Allergies ❑Arthritis ❑Blood/Lymph ❑Bronchitis ❑Cancer ❑Cardiovascular (Heart) ❑Cholesterol
❑Diabetes ❑Digestive ❑Endocrine ❑Ear/Nose/Throat ❑Eczema/Rashes ❑Fatigue ❑Fevers
❑Genitourinary ❑ Thyroid ❑Skin ❑Kidney ❑Muscle/Bone ❑Neurological ❑Psychological
❑Respiratory ❑Sinus ❑Throat Infections ❑High Blood Pressure ❑Unusual Weight Loss/Gain

Patient Eye History – Have you experienced, been diagnosed or treated for the following health problems?

❑Blurry Vision ❑Cataracts ❑Dryness ❑Eye Infections ❑Tearing ❑Flash of Light ❑Glaucoma
❑Headaches ❑Itchiness ❑Burning ❑Lazy Eye ❑Uncomfortable Glasses ❑Double Vision ❑Eye Injury
❑Macular Degeneration ❑Floaters/Spots ❑Grittiness ❑Iritis/Uveitis ❑Retinal Detachment ❑Corneal Abrasions
❑Crossed Eye/Eye Turn ❑Sunlight Sensitivity ❑Trouble Seeing at Night
❑Other Eye Disorders________________

Date of Last Eye Exam?____________ **By Whom?**________________

Do you currently wear Prescription Glasses? ❑ Yes ❑ No **Do you wear Contact Lenses?** ❑ Yes ❑ No
If Contacts, what brand?________________

Any problems with your current prescription glasses or contact lenses?________________

Family Eye History – Is there a *family* medical history of any of the following?

	Relationship (Mother or Father's Side)		Relationship (Mother or Father's Side)
❑Blindness		❑Glaucoma	
❑Cataracts		❑Lazy Eye	
❑Corneal Problems		❑Macular Degeneration	
❑Diabetes		❑Retinal Problems	

Insurance Information

Vision Insurance Name____________________

Subscriber Name____________________

Subscriber SSN____________________ Subscriber D.O.B.____________________

Subscriber Employer____________________

Primary Medical Insurance Name____________________

Subscriber Name____________________

Subscriber SSN____________________ Subscriber D.O.B.____________________

Subscriber Employer____________________

Signature

- **Please be advised if you use insurance coverage for any visits to Aurora Eye Care, this is a contract between you and your insurance company, not Aurora Eye Care.**
- **If your insurance company has not reimbursed our office in full within 90 days, you are responsible for providing payment in full to Aurora Eye Care.**

How will you settle your account today? ☐Cash ☐Check ☐Credit/Debit Card

I have read and understand the Consent Form and consent to the use and disclosure of my health information for the purpose of treatment, payment, and health care operations.

____________________ ____________________

Patient Signature (Parent or Guardian if Patient is a Minor) Date

Consent to Use or Disclose Health Information for Treatment, Payment and Health Care Operations

While 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 to treat you, obtain payment for our services and to conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services 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 our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers and insurers, among 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 the office or from our website.

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 health care operations. You can revoke this consent in writing at any time unless we have already treated you, sought payment for our services or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to service you if you elect not to sign this consent form.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our Notice of Privacy Practices, we are not obligated 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 CONSENT FORM AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS (PLEASE SIGN AT THE BOTTOM OF THE INTAKE FORM, NOT THIS FORM)

220 S. Chillicothe Rd.
Aurora, OH 44202

P: 330.348.0269
F: 330.348.0794
info@aurora-eyecare.com
www.aurora-eyecare.com

Contact Lens Evaluation Informed Consent and Compliance Agreement

Patient eye health is Dr. Smargiasso's top priority. Contact lenses are medical devices and wearers need to be evaluated annually to assure that the eyes are healthy and can support these devices. ***Even if you are a current contact lens wearer, the health of your eyes must be evaluated annually.***

The charge for evaluating and determining your suitability for contact lens wear is not included in the comprehensive examination fee or refraction fee. A comprehensive eye examination must be performed prior to the contact lens evaluation. Your vision plan may or may not cover the cost of the contact lens evaluation (also called a fitting fee). This fitting fee is for professional services and does not include the cost of lenses.

The Following Products And Services ARE Included In The Contact Lens Evaluation Fee:

- Professional examination of contact lens fit and power
- Contact lens follow-up care for 90 days
- Trial pair of contact lenses
- Professional insertion and removal training (if necessary)
- New contact lens case and trial sized solution (if necessary)
- Manufacturer rebates for contacts purchased through Aurora Eye Care (if applicable)

Professional fees for examination and contact lens evaluation fees are NOT REFUNDABLE. Failure to return within 90 days to complete the contact lens evaluation process WILL result in additional office visit fees.

Risk of Contact Lens Wear:

The use of contact lenses is not without risk. A small, but significant percentage of individuals wearing contact lenses develop potentially serious complications which can lead to permanent eye damage and vision loss. Specifically, extended wear contact lenses pose the risk of complication greater than that of daily wear. Presbyopic contact lens corrections (monovision or bifocal contact lenses) can create vision compromises that may reduce visual acuity and depth perception for distance and near tasks. For extended wear patients, extra care is necessary to help prevent eye-health complications and for presbyopic (monovision or bifocal contact lenses) patients, supplemental or alternative vision correction during hazardous activities is advised.

Aurora Eye Care reserves the right to terminate the agreement upon non-compliance of prescribed wearing times or follow-up visits. By signing below, I acknowledge that I have read and understand this agreement. I am aware of potential risks, side effects and adverse reactions due to contact lens wear. I agree to wear my contacts no longer than prescribed by the doctor, agree to properly care for my contact lenses as instructed, and agree to return for recommended follow-up visits

Date	Patient's Name	Patient's Signature (guardian, if a minor)

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