Date ___________________________

NAME___________________________________Date of Birth_______________Age _______

(Mr., Mrs., Ms., Miss, Dr., other)

If Child, Name of Parent/Guardian______________________________School Grade ________

Street Address____

City/State/Zip____

Home Phone (___)____________Work Phone (___)______________Soc. Sec. # ____________

Cell Phone (___)_____________

Fax # (___)__________________E-mail ____

Occupation________________________________ Employer ____________________________

Referred by ___________________________

Reason for this Examination: ____

Do you have, or is there any family history of: (S = Self; F = Family)

___ Glaucoma
___ Headaches
___ Double Vision
___ Cataracts
___ Flashes, Floaters
___ Reading Difficulty
___ Sudden Vision Loss

___ Eye Surgery
___ Eye Head Injury
___ Blindness
___ Eye Exercises / Vision Training
___ Arthritis
___ Heart/Vascular Problems
___ Eye Discomfort/Irritation

___ Hypertension
___ Diabetes
___ Allergies (list)

____

____

Are there any other general health or eye problems that you wish to discuss:

____

Do you use cigarettes/tobacco?__________Alcohol?__________Other Substance(s)?________

List any medications, vitamins, shots, etc. that you presently take:

____

Date of last eye examination__________________ Doctor__________________ City_________

Name of regular physician________________________ City _____________________________

Do you presently wear glasses?_____________ If Yes, age of present prescription ___________

Do you wear contact lenses?__________ If Yes, how old are they? (R)_________(L)_________

Did you ever try contact lenses?_______ If Yes, why did you stop? ______________________

____

If you have questions about any of the following, please circle:

Contact Lenses
Soft
Gas Permeable
Disposable
Bifocal
Tinted
Astigmatic
Extended Wear

Eyeglasses
No-Line Bifocals
Ultra-thin Lenses
Prescription Sunglasses
Photochromic Lenses
Tints, Coatings
U.V. Protection
Sports Glasses

Computer Eyewear
Children's Vision
Swimming with Contact Lenses
Protective Eyewear

Other:___________

Laser Vision Correction

So that we may better meet your visual needs, please complete this lifestyles questionnaire. Please circle the activities that you ***MOST OFTEN*** participate in.

Name: ___________________________________ Age___________ M F

Sports

basketball	softball/baseball	tennis	gymnastics
golf	racquetball	hockey	volleyball
skiing	soccer	swimming	hunting
football	fishing	bowling	water-skiing

Other____

Physical Fitness

aerobics	martial arts	biking	jogging
walking	rollerblading	dancing	hiking

Other ____

Social/Hobby

gardening	musical instrument	crafts	evening out
travel	movies	sewing	computers
boating	snowmobile	jet ski	

Other____

Business

presentations	interviews	travel computer

Other____

Does the glare from headlights or indoor lighting affect your vision or comfort? Y N

Have you ever experienced skin irritation caused by corrosion of your spectacle frame? Y N

Do you normally wear sunglasses? Y N

Are there times you would like to see clearly, but your glasses are inappropriate? Y N

Are you interested in Laser Vision Correction? Y N

- Professional fees are due when service is rendered.
- Eyewear must be paid for in full when ordered.
- There is a $15.00 fee for all returned checks.
- A collection fee equal to 35% of the balance due will be added to all accounts referred for collection services.
- Patients are responsible for all charges not paid by their insurance carriers.

Signature__________________________

PATIENT AGREEMENT

I, the undersigned, realize that I am financially responsible for all services rendered to me by Klessman & Rosenblatt, O.D., P.C., (the Practice).

For those insurances for which the Practice accepts assignment, I realize that I am personally responsible for all co-payments, deductibles and non-covered services, as dictated by my insurance coverage.

I, the undersigned, hereby authorize Klessman & Rosenblatt, O.D., P.C. to apply for benefits for covered services rendered by the Practice, and request that the payments from Medicare Part B, Vision Service Plan and/ or my insurance carrier be paid directly to the Practice. I certify that the information that I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to my insurance carrier(s) (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration). I permit a copy of this authorization to be used in place of the original.

________________________________ ___________

Signature of Patient or Guardian Date

Klessman and Rosenblatt, O.D., P.C.
1800 K Street, N.W., Suite 921
Washington, DC 20006
Tel. 202-331-7566
Fax. 202-331-8533

Public Information Officer: Carol Gaskin

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal "healthcare operations" such as internal quality assessments and financial or billing audits.

I have received, read and understand Klessman and Rosenblatt, OD, PC's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Klessman and Rosenblatt, OD, PC has the right to change its *Notice of Privacy Practices* from time to time and that I may contact Klessman and Rosenblatt, OD, PC at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient name ____

Signature ____

Date ____________________

Relationship to patient (If signed by personal representative of Patient) ________________

Print Name____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

_____________ _____________ _________________________________

Date Initials Reason

Drs. Klessman, Rosenblatt and McCarthy

OPTOMAP™

IMPORTANT ANNOUNCEMENT AND INFORMED CONSENT

Our primary goal during your vision examination is to provide a thorough evaluation of your eye health as well as to give you the best vision possible. We are pleased to announce that our office was the first in the metropolitan area to offer the Optomap™ Retinal Imaging System to its patients. A complete view of the internal eye can be achieved one of two ways – dilation with drops or with the Optomap™. The Optomap™ is a revolutionary technology that provides a complete view of nearly the entire retina – WITHOUT DILATING DROPS. Therefore, NO BLURRED VISION!!!

Did you know that by looking inside your eyes, your eye doctor can identify eye health problems such as macular degeneration, cataracts and retinal detachments, and also general health conditions such as diabetes and high blood pressure?

Until now, dilation was the only way for a doctor to view most of the retina. The Optomap™ allows us to quickly and accurately detect most retinal problems in just a couple of minutes. The nearly instant digital image becomes a permanent part of your medical record that the doctor can review with you at the time of your exam. This may completely eliminate the inconvenience of dilation: the additional hour needed beyond the normal exam time, the extreme light sensitivity, and the inability to focus on ordinary reading and the computer for at least 3 hours.

The fee for the procedure is $44.00. Although many patients have basic vision examination coverage, most insurance plans do not cover advanced diagnostic testing at this time. If you decline to have this procedure, your doctor will want to dilate your eyes for a complete view of the retina. If you also decline dilation, our ability to detect retinal conditions is severely limited. In our continued efforts to provide our patients with the highest level of care available, our doctors strongly recommend the Optomap™.

____ I would like to have the Optomap and agree to the $44 fee.

____ I would like to have my eyes dilated.

____ I do not want an Optomap or dilation.

________________________________ ____________

Patient Signature Date