

907 376-2020

Fax: 907 357-3937
4505 E Greenstreet Cir
Wasilla AK 99654



Lauren Evans, OD
Amber Mayberry, OD
Evan Wolf, MD PhD

PATIENT REGISTRATION

Welcome to our office. In order to serve you properly, we will need the following information.
(Please Print)

Patient First Name	Middle Initial	Last Name	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth	Marital Status (circle) S M W D
Mailing Address	City	State	Zip	Home Phone:	Social Security #
Name of employer	Address			Business Phone	Occupation
Name of Spouse/Parent	Date of Birth		Social Security #	Business Phone	
Reason for visit	How were you referred to this office?				
Person to contact in case of emergency	Relationship to patient			Phone	

Primary Insurance Coverage

Primary Insurance Company	Address				
Subscriber Name	Subscriber birth date	Policy #	Group #		
Is this insurance through your employer? Yes <input type="checkbox"/> No <input type="checkbox"/>	Patient's relationship to insured Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				

Secondary Insurance Coverage

Secondary Insurance Company	Address				
Subscriber Name	Subscriber birth date	Policy #	Group #		
Is this insurance through your employer? Yes <input type="checkbox"/> No <input type="checkbox"/>	Patient's relationship to insured Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				

Medicare Patients Only, Read and Sign

Medicare Lifetime Signature

I request payment of authorized Medicare benefits to Wolf Eye Center for any service provided to me by the physician. I authorize any holder of medical information about me, to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that Medicare does not cover routine vision exams.

Patient Signature

Date

Please see reverse side for billing policy and signature.

Thank you for choosing Wolf Eye Center, Inc. as your eye care provider.

You'll See The Difference!

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BILLING POLICY & PROCEDURE

This document was prepared to assist patients with the financial policies of Wolf Eye Center, Inc. Please read and then sign in the space provided. Should you have further questions our staff will gladly assist.

Patients with Insurance

It is your responsibility to provide your insurance information. Without complete insurance information Wolf Eye Center, Inc cannot bill for services. Proof of insurance is required at the time of service. Insurance is a contract between you and your insurance company. We are NOT a party to this in most cases. We ARE a party to the following insurance companies and will handle claims according to our agreement with them; Blue Cross, Medicare, Medicaid, Tricare and VSP. As a courtesy to you we will file your claim but you are ultimately responsible for all charges regardless of what your insurance does or does not pay. Your co-pay and any unmet deductible will be collected at the time of service. If you do not know what your co-pay is, we will collect 20% of the balance.

Patients without Insurance

All charges incurred at the time of service must be paid in full at the end of each appointment. For payment in full at time of service, we offer a discount. If you are unable to pay in full at the time of service you must establish an approved payment plan with Wolf Eye Center billing department. All payment plans must be paid in full within 120 days. A minimum of 20% of the balance is due at the time of service.

All Patients – Refractions

Refraction is a test that is performed to measure your best vision possible. Refraction is performed for several different reasons including (but not limited to):

1. Determining the correct prescription for glasses or contact lenses
2. Screening and monitoring of medical conditions such as diabetes, cataracts, glaucoma, and macular degeneration
3. During pre-operative care
4. During post-operative care

Federal guidelines require that the eye examination and the refraction are billed separately, but some insurance companies (i.e.: Medicare) do not pay for the refraction. Depending on your insurance benefits, you may be responsible for payment of this service. The current charge for the refraction is \$45.00.

Delinquent Accounts

A statement of your account will be mailed to you at the beginning of each month if an outstanding balance exists. Payment in full is expected within 30 days after the insurance company has made its determination of payment or 90 days from the date of service whether or not insurance has responded. Failure to pay your account within 90 days from the date of service will result in collection proceedings. Should circumstances prevent you from paying your account in a timely manner prior to commencement of collection activity please contact our billing department to make other arrangements for payment. Patients with delinquent accounts may be permanently discharged from our practice.

Returned checks for non-sufficient funds (NSF) will incur a \$25.00 NSF fee.

I, the undersigned, authorize payment of medical benefits to Wolf Eye Center, Inc for any/all service provided to me by the physician. I understand that I am financially responsible for any amount not covered by my insurance plan. I authorize Wolf Eye center to release information concerning my health care, advice, treatment, and/or supplies to my insurance company and/or it's agents for the purpose of evaluating and administering claims. I understand that if I do not have insurance coverage payment is due in full at time of service unless an approved payment plan has been established.

Patient, Parent or Guardian Signature (if child is under 18)

Date

**WOLF EYE CENTER
PATIENT HISTORY FORM**

Name _____ DOB _____ Chart # _____ Date _____
Daytime Phone: _____ Primary Care Physician: _____

PERSONAL MEDICAL HISTORY/REVIEW OF SYMPTOMS:

Do you <i>CURRENTLY</i> have any problems in the following areas? (CIRCLE ALL THAT APPLY)	YES	NO
1. EYES (poor vision, dry eyes, eye pain, tearing, redness, etc.)		
2. GENERAL (fever, weight loss or gain, fatigue, other)		
3. EAR / NOSE / MOUTH / THROAT (hearing loss, stuffy nose, dry mouth, other)		
4. HEART (chest pain, high blood pressure, irregular heartbeat, other)		
5. RESPIRATORY (asthma, shortness of breath, wheezing, coughing, TB, other)		
6. STOMACH (stomach upset, diarrhea, constipation, hernia, ulcers, other)		
7. GENTAL / KIDNEYS / BLADDER (painful or frequent urination, impotence, other)		
8. SKIN (pimples, warts, growths, rashes, other)		
9. MUSCLE / BONE / JOINTS (joint pain, stiffness, swelling, cramps, arthritis, other)		
10. NEUROLOGICAL (numbness, headaches, seizures, paralysis, other)		
11. BLOOD / LYMPH (bleeding, cholesterolemia, anemia, blood clot disorder, other)		
12. FEMALES (Are you pregnant? Nursing?)		
13. HORMONE (thyroid problems, other)		
14. DIABETES (If YES, how is it controlled? Circle all that apply: Insulin / Diet / Medications / None)		
15. PSYCHIATRIC (depression, anxiety, insomnia, other)		
16. IMMUNOLOGIC (sarcoidosis, lupus, iritis, rheumatoid arthritis, Crohn's, Graves, MS)		
17. INFECTION / VIRUS (HIV/AIDS, Hepatitis, TB, Shingles, Herpes Simplex, MRSA, other)		

ALLERGIES/CURRENT MEDICATIONS:

Are you allergic to LATEX? YES NO

Please list all allergies to medications:

Please list all medications you are taking, including eye drops:

EYE HISTORY:

Have you ever had eye surgery? YES NO
 Have you ever had an eye infection? YES NO
 Have you ever had an eye trauma? YES NO
 If yes to any of the above, please explain: _____

FAMILY HISTORY – Has any member of your family had these diseases (CIRCLE ALL THAT APPLY):

	Yes	No	UNKNOWN
Blindness, Cataracts, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis, Other heritable disease:			

SOCIAL HISTORY –(CIRCLE ALL THAT APPLY):

	Yes	No
Does your vision limit any activities of daily living (driving, reading, sports, work, etc)?		
Have you ever had a blood transfusion?		
Do you drink alcohol? If YES, how much? _____		
Do you smoke? If YES, how much? _____ How many years? _____		

CONTACT LENSES	Yes	No
Do you wear contact lenses?		
I sleep in my contact lenses		
My lenses are <input type="checkbox"/> soft <input type="checkbox"/> rigid gas permeable		
I have worn contact lenses for _____ years		
My cleaning solution is:		
I dispose of contacts every _____ weeks/days		

The information above is complete and accurate to the best of my knowledge.

PATIENT or PARENT/GUARDIAN SIGNATURE

Date

Physician Signature

Date

Technician Signature

Date

**WOLF EYE CENTER
CHILDREN'S HISTORY FORM**

Name _____ DOB _____ Chart # _____ Date _____
Daytime Phone: _____
Child's Doctor: _____ Last Exam Date: _____

DOES YOUR INFANT/TODDLER (AGE 0-2):

Yes No

- | | | |
|------------------------------------|--------------------------|--------------------------|
| Have an eye that turns in or out | <input type="checkbox"/> | <input type="checkbox"/> |
| Have excess tearing | <input type="checkbox"/> | <input type="checkbox"/> |
| Have red eyes or lids | <input type="checkbox"/> | <input type="checkbox"/> |
| Have swelling around the eyes | <input type="checkbox"/> | <input type="checkbox"/> |
| Have white appearance in the pupil | <input type="checkbox"/> | <input type="checkbox"/> |

DOES YOUR PRE-SCHOOLER (AGE 3-5):

Yes No

- | | | |
|---|--------------------------|--------------------------|
| Have an eye that ever appears to be out of proper alignment | <input type="checkbox"/> | <input type="checkbox"/> |
| Tend to bump into objects | <input type="checkbox"/> | <input type="checkbox"/> |
| Have red eyes or lids | <input type="checkbox"/> | <input type="checkbox"/> |
| Rub eyes frequently | <input type="checkbox"/> | <input type="checkbox"/> |
| Have excess tearing | <input type="checkbox"/> | <input type="checkbox"/> |
| Turn or tilt head to use one eye only | <input type="checkbox"/> | <input type="checkbox"/> |
| Have encrusted eyelids | <input type="checkbox"/> | <input type="checkbox"/> |
| Have frequent styes | <input type="checkbox"/> | <input type="checkbox"/> |
| Avoid coloring, puzzles or detailed activities | <input type="checkbox"/> | <input type="checkbox"/> |
| Experience difficulty with eye-hand body coordination | <input type="checkbox"/> | <input type="checkbox"/> |

DOES YOUR SCHOOL-AGE CHILD (AGE 6-12):

Yes No

- | | | |
|--|--------------------------|--------------------------|
| Lose place while reading | <input type="checkbox"/> | <input type="checkbox"/> |
| Avoid close work | <input type="checkbox"/> | <input type="checkbox"/> |
| Hold reading material closer than normal or shift the reading distance | <input type="checkbox"/> | <input type="checkbox"/> |
| Tend to rub eyes | <input type="checkbox"/> | <input type="checkbox"/> |
| Have headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| Turn or tilt head to use one eye only | <input type="checkbox"/> | <input type="checkbox"/> |
| Make frequent reversals when reading or writing | <input type="checkbox"/> | <input type="checkbox"/> |
| Use finger to maintain place when reading | <input type="checkbox"/> | <input type="checkbox"/> |
| Omit or confuse small words when reading | <input type="checkbox"/> | <input type="checkbox"/> |
| Consistently perform below potential | <input type="checkbox"/> | <input type="checkbox"/> |
| Struggle to complete homework | <input type="checkbox"/> | <input type="checkbox"/> |

FAMILY HISTORY:

Yes No

- | | | |
|---|--------------------------|--------------------------|
| Do any family members have Lazy eye (amblyopia) | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye turn (strabismus) | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye Tumor | <input type="checkbox"/> | <input type="checkbox"/> |
| Other eye or medical problems | <input type="checkbox"/> | <input type="checkbox"/> |
- If yes please explain: _____

The information above is complete and accurate to the best of my knowledge.

PARENT/GUARDIAN SIGNATURE

Date

Physician Signature

Date

Technician Signature

Date

WOLF EYE CENTER, INC.

NOTICE OF PRIVACY PRACTICES

Patient Name: _____ **Chart #:** _____

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, except in certain limited instances, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of Protected Health Information about you for non-subsidized treatment, payment and health care operations, and for other purposes as permitted or required by law. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected Health Information may be disclosed or used for treatment, payment or health care operations, or for other purposes permitted or required by law. However, we will obtain from you a separate written authorization for “subsidized” disclosures, meaning disclosures involving product or service with respect to which the Practice receives remuneration from a third party.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions, except in certain limited instances.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: _____
Patient or Representative

Relationship to Patient (if other than patient): _____

Date: _____

In front of _____
Printed name – Practice representative

WOLF EYE CENTER, INC.

PATIENT COMMUNICATION FORM

Patient Name: _____

Chart #: _____

A. Family and Friends. It is the office policy of Wolf Eye Center not to release confidential medical information regarding your treatment to family members or friends, except for (1.) parent/legal guardian, (2.) other persons authorized by the patient, (3.) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (4.) in emergency situations, or (5.) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check (✓) the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse: _____	_____ yes	_____ no
Parent: _____	_____ yes	_____ no
Other: _____	_____ yes	_____ no
_____	_____ yes	_____ no
_____	_____ yes	_____ no

B. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way. We currently contact patients by phone, text and email.

I hereby request Wolf Eye Center does NOT contact me by: _____

PRINTED NAME _____

Patient/Parent/Guardian Signature: _____

Date: _____

FOR OFFICE USE

Changes to above authorized by patient over phone:

Change	Date	Staff Initials
_____	_____	_____
_____	_____	_____
_____	_____	_____



YOU'LL SEE THE DIFFERENCE!

Patient Name: _____ Date: _____ Chart# _____

WE WOULD LIKE TO KNOW HOW YOU USE YOUR EYES! Along with your eye exam, this information will help us recommend the best options for your eyes and your lifestyle.

1. **Do you wear glasses now?** Yes No **If yes how often?** All the time Sometimes
 Only for distance Only for reading Only for computer Other
2. **Do you mind wearing glasses?** Yes No
3. **What do you like about your current glasses?** Style Comfort Tinting Clarity
 Glare reduction Scratch resistance Other _____
4. **What do you dislike about you current glasses?** _____
5. **Do you own prescription sunglasses?** Yes No
6. **Do you own prescription computer/reading glasses?** Yes No
7. **Do you wear or have you ever worn contact lenses?** Yes No **If yes, what type?**
 Single vision Multifocal Monovision Other **If you no longer wear contacts, why did you stop?** _____
8. **How many hours per day do you:** Read _____ Use computer _____ Drive _____
9. **Where do you hold a book when reading?** Close to face Chest level In lap
10. **What type of computer do you use?** Desktop Laptop Tablet Smartphone
11. **Do you have eyewear to protect your eyes from injury while working and playing?** Yes No
12. **Please check any of the following items that are giving you trouble with your vision:**
 Bright lighting/glare Failed DMV test Night driving Tolerating glasses
 Using eyes together Double vision Close work Depth perception
13. **What activities, sports, and hobbies do you enjoy doing most?** _____

Please place an "X" on the following scale to best describe your personality

Easy going _____ Perfectionist

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CONTACT LENS FITTING FEE AGREEMENT

Patient Name: _____ Chart #: _____

In order to make your contact lens experience with our office as pleasant and informed as possible we would like to explain our contact lens fitting procedure.

A contact lens (CL) prescription is different from a glasses prescription. A CL is a medical device that rests on the cornea of your eye and requires proper fitting on the eye to create a healthy environment. If you are having an eye examination and wear CL's, our professional staff will be evaluating your current CL's to determine the present appropriateness of your lenses. This fitting and assessment are above and beyond your eye examination and will require an additional fee.

NEW FIT:

If this will be the first time that you have been fit with CL's then this is considered a new fit and you will be charged a CL fee in the amount of **\$100.00 - \$200.00**. (The fitting fee will be determined by the doctor according to the type of CL's and the difficulty of the fit.) This fee covers the CL fit and any follow-ups required for four (4) months.

All CL fitting fees are due before any trial CL's or trial CL prescriptions will be released. This fitting fee will cover four (4) months of contact lens follow up care with the doctor to insure the proper contact lens fit and health of your eyes. If the CL are lost or damaged, another pair may be obtained for a small handling charge at our optical shop. After your four months of fittings you may be charged additional follow up fees should the doctor feel more follow up care is necessary.

The initial CL fitting appointment will require measurements to determine the proper power and fit of the CL's. If you have never worn a contact lens, you will need a contact lens training session with one of our technicians. After your training is complete you will be given a follow-up appointment with the doctor and they will either order another trial lens or give you your final contact lens prescription.

REFIT:

Patients will be responsible for a CL refit fee if they currently wear CL's and either request or require a change in the brand of CL's, or who do not know their CL prescription information or who wear CL's and are new to the practice. The CL refit fee in the amount of **\$80.00 - \$150.00** covers the new measurements, selection of new CL's, and any follow-ups required for up to four (4) months with follow-up care starting on the dispense date. If we do not have your trial pair in stock you will be notified for a follow-up appointment with our doctor. At that time the doctor will give you your final CL prescription.

ASSESSMENT:

Patients who currently wear CL's and are existing patients who do not require any changes will be charged a small fitting fee of **\$45.00**. This fee is required in order for the doctor to assess that the patient's eyes are still healthy enough to wear contacts and that the CL's they are wearing are performing the way they should.

Alaska Statute, Article 4 section 08.71.200 states "contact lenses shall be fit in conjunction with and under the supervision of a licensed physician or optometrist and with a written contact lens prescription showing that the prescription may be filled for contact lenses and requiring that the patient return to see their prescribing physician or optometrist."

I have read the contact lens fitting fee agreement and I understand the fitting procedure. I understand that it is my responsibility to return for contact lens dispensing and follow up evaluations of my contact lenses at the intervals recommended by this office. I agree to pay the contact lens fitting fee listed above and I understand that the cost of my exam today and my final contact lenses are not included in this contact lens fitting agreement.

Date

Patient Signature

PATIENT CL AGREEMENT

Virtually all types of contact lenses will be available for fitting and we will make every attempt to conform to your wishes. However, we will recommend the contact lenses that give you the best vision possible and fit your individual lifestyle. In order to provide our patients with the highest standard of care, all patients are **REQUIRED** to have a comprehensive vision and medical examination by our doctors prior to contact lens fitting. Contact lens fitting fees vary depending on the type of contact lens with which you are fit.

Professional fees are paid for contact lens fittings and are nonrefundable. Contact lenses are purchased separately and in the case of soft contact lenses any boxes purchased must be returned **unopened** and with a **non-expired expiration date** to receive credit. Gas permeable contacts must be returned in good condition, lost or damaged gas permeable contact lenses are non refundable.

I am aware of other alternatives for the correction of my vision other than contact lenses. Even with proper care there are risks to wearing contact lenses, which include: **Soft lenses** - irritation from solutions or protein build-up, conjunctivitis, dry eyes, corneal vascularization and severe and potentially blinding corneal infections and loss of eye. **Rigid lenses** - intolerance, corneal swelling and ulceration, corneal warping, change in shape of the cornea causing problems seeing well with glasses and irritation from chipped or broken lenses. **Extended wear contact lenses** - we do not recommend overnight wear of any contact lenses. Risks include, but are not limited to, significantly increased risk of corneal ulcer and infection, severe and potentially blinding corneal infections, and possible loss of eye(s). "Extended wear" does not imply "continuous wear".

I acknowledge that I have been properly instructed in the care of my contact lenses. I also understand that if I do not follow the instructions given for the care of my lenses, I put myself at risk to develop infections that can lead to the loss of vision or even the loss of an eye.

I understand that poor care of my lenses may make them uncomfortable and not wearable and may increase the cost of my contact lens wear. I understand the fragility of contact lenses and that there is no warranty against damage of the lenses. Also, I have been instructed and have practiced insertion and removal of my lenses. (If applicable)

I understand that this contact lens prescription is valid for replacement lenses for **one year** and that an annual eye and contact lens examination will be required to update this prescription for replacement lenses after one year. I understand that if I do not have an exam after one year, than my risk of infection, discomfort, or ruined lenses becomes greater as time passes. No trial contact lenses and/or contact lens refills will be given if the prescription is expired.

There are many variables to contact lenses and I understand there is no guarantee that I will become a successful contact lens wearer.

I understand that it is normal if at first:

- My lenses itch or feel unusual.
- I feel one lens more at times.
- My vision seems fuzzier than with glasses.
- One eye sees better than the other.

I will remove my lenses and call the office if:

- I develop unusual pain or redness.
- I experience decreased vision that does not get better.
- I suspect something is wrong.

I understand that full payment is expected at the time a contact lens fitting is performed.

Date

Patient Signature