907 376-2020
Fax: 907 357-3937
4505 E Greenstreet Cir
Wasilla AK 99654

Austin Anderson, OD
Lauren Evans, OD
Amber Mayberry, OD
Joseph Shetler, 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 ☐ Female ☐	Date of Birth	Marital Status (circle) S M W D

Race:	Ethnicity: ☐ Hispanic or Latin ☐ Unknown ☐ Non-Hispanic or Latin	Primary Language:	Email:

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	Social Security #

Subscriber Name	Subscriber birth date	Policy #	Group #

Is this insurance through your employer? Yes ☐ No ☐	Patient's relationship to insured Self ☐ Spouse ☐ Child ☐ Other ☐

Secondary Insurance Coverage

Secondary Insurance Company	Address	Social Security #

Subscriber Name	Subscriber birth date	Policy #	Group #

Is this insurance through your employer? Yes ☐ No ☐	Patient's relationship to insured Self ☐ Spouse ☐ Child ☐ Other ☐

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 including Refractions (measurements for your prescription) and I will be responsible in full for any routine vision services.

_____ _____

Patient Signature **Date**

****PLEASE SEE REVERSE SIDE FOR BILLING POLICY AND SIGNATURE****

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

You'll See The Difference!

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BILLING POLICY & PROCEDURE

Patient Name:_____ Date:_____

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

Billing

- You authorize payment of medical benefits to Wolf Eye Center for any/all services provided to you by the physician. You understand that you are financially responsible for any amount not covered by your insurance plan. You authorize Wolf Eye Center to release information concerning your health care, advice, treatment, and/or supplies to your insurance company and/or it's agents for the purpose of evaluating and administering claims. _____
- It is your responsibility to provide all of your insurance information. Without complete insurance information, Wolf Eye Center cannot bill for services and you will be responsible for your balance. _____
- Insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your coverage, etc. except to supply factual information as needed. _____
- Wolf Eye Center is a "preferred provider" for the following insurances: Medicare, Medicaid, Blue Cross, EBMS/PEHT, Tricare, VA and VSP. If your insurance is not one of these, please be aware that your claim will likely be processed as "out of network". _____
- Your co-pay and any unmet deductible will be collected at time of service. If we cannot verify what your co-pay is, we will collect 20% of your balance. _____
- If proof of insurance cannot be provided, payment will be due in full. For payment in full at time of service, we do offer a discount. If you are unable to pay in full at time of service, you must establish an approved payment plan with the 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

- Please be advised, if you are here for a complete eye exam and have health problems that you want to discuss with your doctor during your visit, this could result in additional charges, or testing. This may or may not be covered by your insurance. You must discuss and clarify the reason for your visit with the technicians and doctor. Please verify if you are here for your routine annual vision exam, as it is our policy to NOT change the diagnosis after your visit – regardless of any medical condition you may have. _____
- Refraction is a test that is performed to measure your best vision possible. This test is performed for several different reasons including (but not limited to): determining the correct prescription for glasses or contact lenses, screening and monitoring of medical conditions, pre-operative care and 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 this is $48.00. _____

Delinquent Accounts

- A statement of your account will be mailed to you at the beginning of each month if an outstanding balance of greater than $5.00 exists. Please watch your insurance EOB's to see if you owe a balance. _____
- Payment in full is expected within 30 days after the insurance company has made a determination of payment, or 90 days from the date of service, whether or not insurance has responded. If circumstances prevent you from paying your account in a timely manner, please contact our billing department to set up payment arrangements. Delinquent accounts are subject to collection processes which may include the account being transferred to Cornerstone Credit Services (CCS). You will be responsible for any fees and/or commission charged by CCS. Patients whose accounts have been sent to CCS will be reviewed for possible discharge from the clinic. _____
- Balances on your account need to be paid in full before you will be seen again, unless a payment arrangement has been made with our billing department. Please contact our billing department in a timely manner, as any claim over 90 days will be due in full. _____
- Wolf Eye Center will charge a $25.00 fee for any returned checks for non-sufficient funds (NSF). _____

I, the undersigned, authorize payment of medical benefits to Wolf Eye Center 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

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WOLF EYE CENTER
PATIENT HISTORY FORM

Austin Anderson, OD
Lauren Evans, OD
Amber Mayberry, OD
Joseph Shetler, OD
Evan Wolf, MD PhD

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

PERSONAL MEDICAL HISTORY/REVIEW OF SYMPTOMS:

Do you have any problems in the following areas? Or are you taking any medication? (*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. **GENITAL / 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, high cholesterol, 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, Macular Degeneration, 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 □ soft □ 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**

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WOLF EYE CENTER
CHILDREN'S HISTORY FORM

Austin Anderson, OD
Lauren Evans, OD
Amber Mayberry, OD
Joseph Shetler, OD
Evan Wolf, MD PhD

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	□	□
Have excess tearing	□	□
Have red eyes or lids	□	□
Have swelling around the eyes	□	□
Have white appearance in the pupil	□	□

DOES YOUR PRE-SCHOOLER (AGE 3-5):	**Yes**	**No**
Have an eye that ever appears to be out of proper alignment	□	□
Tend to bump into objects	□	□
Have red eyes or lids	□	□
Rub eyes frequently	□	□
Have excess tearing	□	□
Turn or tilt head to use one eye only	□	□
Have encrusted eyelids	□	□
Have frequent styes	□	□
Avoid coloring, puzzles or detailed activities	□	□
Experience difficulty with eye-hand body coordination	□	□

DOES YOUR SCHOOL-AGE CHILD (AGE 6-12):	**Yes**	**No**
Lose place while reading	□	□
Avoid close work	□	□
Hold reading material closer than normal or shift the reading distance	□	□
Tend to rub eyes	□	□
Have headaches	□	□
Turn or tilt head to use one eye only	□	□
Make frequent reversals when reading or writing	□	□
Use finger to maintain place when reading	□	□
Omit or confuse small words when reading	□	□
Consistently perform below potential	□	□
Struggle to complete homework	□	□

FAMILY HISTORY:	**Yes**	**No**
Do any family members have Lazy eye (ambloypia)	□	□
Eye turn (strabismus)	□	□
Eye Tumor	□	□
Other eye or medical problems	□	□

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

Rev06192014rw

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WOLF EYE CENTER
YOU'LL SEE THE DIFFERENCE! INC

Austin Anderson, OD
Lauren Evans, OD
Amber Mayberry, OD
Joseph Shetler, OD
Evan Wolf, MD, PhD

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 your 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. At four months a final prescription will be written based on the trial lenses dispensed if you fail to return for follow up care.

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. At four months a final prescription will be written based on the trial lenses dispensed if you fail to return for follow up care.

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, undamaged,** with **a non-expired expiration date and within 6 months of signed Contact Lens Fitting Agreement** 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