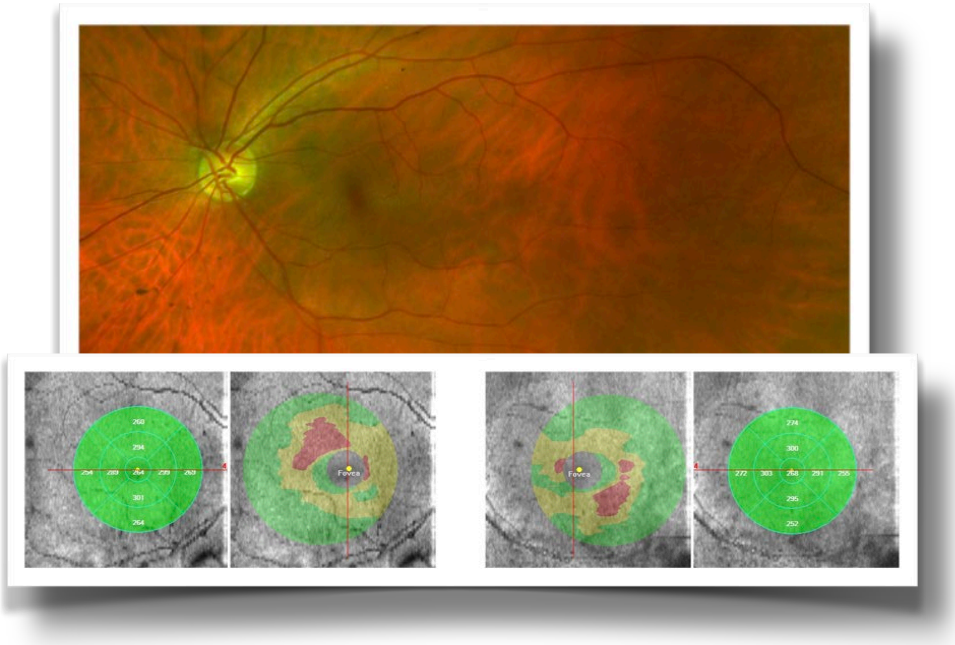
EyeWellness Consent Form

Due to COVID-19 and our personal responsibility to provide the best care to every patient, EyeWellness screening procedures will now be performed annually for all patients at the time of their comprehensive eye health exam. This helps us achieve a TOUCHLESS eye exam.



The EyeWellness imaging is a quick, non-invasive image that:

- DOES NOT REQUIRE DILATING DROPS. You may NOT need to be dilated today, potentially eliminating a 30-minute wait and avoiding side effects such as blurry vision and light sensitivity.
- Provides the doctor with an in depth view of the retina and optic nerve to confirm the health of your eyes.
- Allows your doctor to detect the presence of diseases in their earliest stages, when they are most treatable.
- Will be part of your permanent record and will serve as an initial point from which important comparisons can be made, as we follow your eye health in subsequent years.

The copay for this part of your eye exam is $35. As a screening test, this procedure is not covered under most vision/medical insurances or Medicare.

☐ **I understand that the EyeWellness imaging will be performed during my eye exam and do not have any questions.**

Signature_____**Date** _____

La Paz Optometric Center
25260 La Paz Road Ste G
Laguna Hills, CA 92653
949-586-8200

CONTACT LENS EVALUATION AGREEMENT

A contact lens evaluation is in addition to the standard comprehensive eye exam. It involves identifying the best contact lens for your eyes which will give you the vision and comfort to meet all of your visual needs in the safest manner possible. The evaluation always involves more doctor decision making and often additional follow up visits. A contact lens evaluation is required in order to update the contact lens prescription and order contact lenses.
Contact lens prescriptions are valid for 12 months.

Evaluation Fees:

NEW CONTACT LENS PATIENT TO OUR OFFICE

Soft Spherical Lens	$125
Soft Toric Lens (Astigmatism) / Bifocal / Rigid Gas Permeable	$125 - $150
Specialty / Keratoconus lens	$350 -$1000
Platinum Care Fitting (year round soft contact lens care)	$395
CRT	$1400

EXISTING (WITHIN 24 MONTHS) CONTACT LENS WEARER IN OUR OFFICE

Soft Spherical Lens	$79
Soft Toric Lens (Astigmatism) / Bifocal / Rigid Gas Permeable/CRT	$95 - $155
Platinum Care Fitting (year round soft contact lens care)	$395
Specialty / Keratoconus Lens	$295 - $500

*** Additional $25 for New or Existing Patients to our office requiring training to insert/remove/clean contact lenses for all lenses except Specialty Lenses.

The contact lens evaluation entitles you to the following benefits:

1. Immediate 20% Discount on non-prescription sunglasses. Discount is valid anytime during the year.
2. Contact lens related check-ups for one month at no charge. *Unlimted visits for Platinum care fitting
   Exceptions - complications resulting in medical diagnoses.
   i.e. Red Eye, Pink Eye, Conjunctivitis, Ulcer, Abrasion, etc.
3. Exchange of lenses when there is a change in prescription.
   When buying contact lenses with us, we will exchange any unmarked, undamaged, non-expired boxes of contacts for credit or for the new prescription.
4. Complimentary lenses. Emergencies occur where you are out of lenses, or have lost/torn a lens; we will give you an extra pair of lenses when this occurs.
5. Complimentary delivery of contact lenses to your home or workplace with year supply purchase.

☐ **Yes, I understand the Contact Lens Service Agreement and would like to proceed with a contact lens evaluation. I acknowledge that a copy of my contact lens prescription will be provided at the completion of my contact lens fitting via the Patient Portal.**

☐ **No, I do not want contacts and will not proceed with a contact lens evaluation at this time.**

Signature_____ **Date** _____

25260 La Paz Road Ste G
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FINANCIAL AGREEMENT

Thank you for choosing our practice for your vision care. We are committed to providing the highest quality of vision care in a patient focused environment. The following is a statement of our financial agreement, please read and sign.

- Payment is due in full at the time of service for any in-office services.
- Payment is due in full **prior** to any tele-health service
- We accept Cash, Bank Debit, Visa, Mastercard, Discover and American Express.

VISION and MEDICAL INSURANCE

- If you are using insurance coverage for today's visit, this is a contract between you and your insurance company and not with La Paz Optometric Center. Your vision policy is an agreement between you and your insurance company.
- If we have received all your insurance information on the day of the appointment, we will submit the claim as a courtesy to you. If the information is not available, you will be responsible for fees that day of service.
- You must be familiar with your insurance benefits, as any amount not covered by your insurance company will be forwarded as a balance to you. These fees include deductibles, co-payments, or certain procedures not covered or partially covered by your insurance policy and its specific plan. Once your insurance has responded to your claim, any balance is now your financial responsibility. This will be forwarded to you and payment is due within 30 days.
- If your insurance company does not pay for your services within 45 days of your visit, you are responsible for full payment.

☐ I understand the information above and authorize La Paz Optometric Center to file a claim with my insurance.

PAST DUE ACCOUNTS

- Accounts are considered past due after 30 days from your statement date. Past due accounts will be charged a finance charge of 1.5% per month. Account balances exceeding 90 days in age from time of service may be forwarded to a third party collection agency. All costs incurred in collecting unpaid fees will be charged to your account.

Signature_____**Date** _____

25260 La Paz Road Ste G
Laguna Hills, CA 92653
949-586-8200

NOTICE OF PRIVACY PRACTICES

Effective date of notice: January 1, 2005.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). “Health care operations” mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies

- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS

We may call, write, email or text to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call, write, email or text to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will email or text you an appointment reminder and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

GENERAL EMAIL CORRESPONDENCES -Including SPECTACLE AND CONTACT LENS PRESCRIPTION REQUEST/ RETINAL PHOTOS/ SURGICAL CONSENT FORMS AND THERAPY CORRESPONDENCES.

Patients may request a copy of their spectacle and/or contact lens prescriptions to be delivered in written or electronic format. Patients may also elect to communicate with our team via their non-secure personal email address. This document discloses that when information is sent over a public email server and not via a secure patient portal, it is not deemed a secure method of delivering protected health information.

Delivery via fax transmission or via a secure electronic patient portal is considered the most secure method of electronic transmission of protected health information. By signing this document and at the request of the patient or legal guardian, said individual understands that they are waiving their right for such information to be protected if an email transmission request occurs using a public email server.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, provide us a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using email to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or email shown at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or email shown at the

beginning of this Notice.

- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our website.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or email shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

☐ **I acknowledge that I have received La Paz Optometric Center's Notice of Privacy Practices.**

Signature_____Date _____

Patient Name: _____

Legal Guardian Name (IF APPLICABLE): _____

La Paz Optometric Center

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Help Prevent the Spread of Coronavirus (COVID-19)
Consent Form

In our ongoing effort to keep our patients and staff safe from COVID-19 while in our office, we have implemented the following safety protocols:

- Upon arrival, we request that patients to remain their car to check-in by calling or texting (949)586-8200
- All patients and staff are required to wear masks
- Temperature screening and hand sanitizing will be performed upon arrival
- We encourage patients to come alone or with their caretaker when possible

Please review the below questions and acknowledge that your answers are all **NO**. Thank you for helping us maintain a clean and safe environment for all patients and employees.

1. Do you have a cough?	Yes ☐	No ☐
2. Do you have a fever now or have you in the past 3 days?	Yes ☐	No ☐
3. Are you experiencing shortness of breath?	Yes ☐	No ☐
4. Have you traveled outside of the country in the past 2 weeks?	Yes ☐	No ☐
5. Have you come in contact with someone experiencing symptoms of COVID-19 in the past 2 weeks?	Yes ☐	No ☐

As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. Be assured that we have always followed state and federal guidelines and recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so. Thank you for your continued trust in our practice.

****If you have any questions or concerns about our new protocols, please give our office a call at (949) 586-8200 prior to your appointment****

☐ **Although exposure is unlikely, I will accept consent to treatment.**

Signature_____ **Date**_____

FOR PATIENT USE

Lifestyle Index

FOR OFFICE USE

PT INITIALS / ID _____

DATE _____

This questionnaire is meant to help your doctor understand what you're experiencing on a regular basis — whether it's caused by your eyes, posture, stress, etc. Your responses will help make sure you receive the best care possible.

How often do you experience any of these symptoms? Fill in applicable circle. For example: 1 2 3 4 5 (3 selected)

Headaches

- You get headaches of any severity each week (even just a dull ache counts).
- Your headaches tend to get worse later in the day.

1 Never ○ 2 Rarely ○ 3 Sometimes ○ 4 Very Often ○ 5 Always ○

Stiffness / pain in neck / shoulders

You experience stiffness/tension in your neck/shoulders when you work at a computer or read (this might even be from your posture).

1 Never ○ 2 Rarely ○ 3 Sometimes ○ 4 Very Often ○ 5 Always ○

Discomfort with Computer Use

Your eyes get tired, burn, or get red easily when you work at a computer for long hours.

1 Never ○ 2 Rarely ○ 3 Sometimes ○ 4 Very Often ○ 5 Always ○

Tired Eyes

Your eyes feel increasingly fatigued/tired as the day goes on.

1 Never ○ 2 Rarely ○ 3 Sometimes ○ 4 Very Often ○ 5 Always ○

Dry Eye Sensation

Your eyes progressively feel more dry/sandy/gritty while working at the computer or reading.

1 Never ○ 2 Rarely ○ 3 Sometimes ○ 4 Very Often ○ 5 Always ○

Light Sensitivity

Bright / Strong lights (vehicle headlights, fluorescent lights etc.) bother you.

1 Never ○ 2 Rarely ○ 3 Sometimes ○ 4 Very Often ○ 5 Always ○

Dizziness

You experience dizziness, motion sickness, or vertigo.

1 Never ○ 2 Rarely ○ 3 Sometimes ○ 4 Very Often ○ 5 Always ○

Additional Notes

Any additional notes you'd like to add: _____