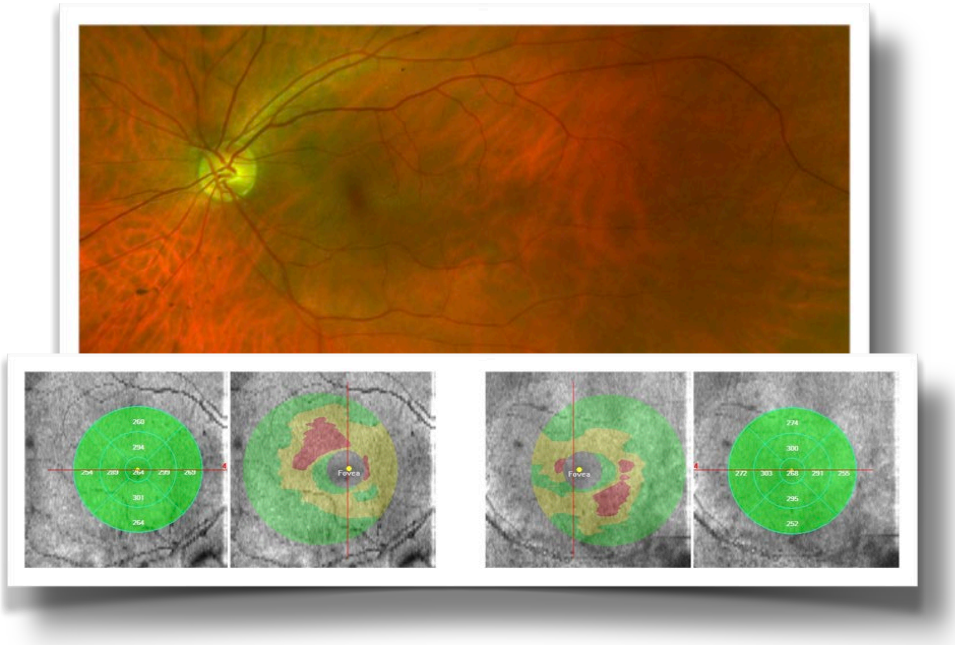
EyeWellness Consent Form

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** _____

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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: _____