



Dr. Monika Spokas
Developmental Optometrist
Dr. Amber Cumings, FAAO
Developmental/Pediatric/
Neuro-Optometrist

First Name: _____ Last Name: _____ Date: _____

What is your main reason for your visit today? _____

HEALTH HISTORY: Circle any conditions that apply to you or that run in your family.

- | | | | | | |
|---------------------|-------------------------------|---------------------------------|----------------------|-------------------------------|---------------------------------|
| Allergies | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Lazy eye | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Respiratory disease | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Turned eye | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Cancer | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Color "blind" | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Diabetes | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Light sensitive | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Heart problem | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Eyestrain | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| High blood pressure | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Dry eyes | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Thyroid | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Floaters/spots | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Migraines/headaches | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Flashing lights | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Blindness | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Retinal detachment | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Head trauma | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Macular degeneration | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| Eye surgery/injury | <input type="checkbox"/> Self | <input type="checkbox"/> Family | Cataracts | <input type="checkbox"/> Self | <input type="checkbox"/> Family |
| | | | Glaucoma | <input type="checkbox"/> Self | <input type="checkbox"/> Family |

Other medical problems _____

What medications do you currently take?	And for what condition?
_____	_____
_____	_____
_____	_____
_____	_____

RETINAL IMAGING

We are pleased to provide our patients with an advanced digital retinal exam. It is great for documenting a baseline image for our charts, screen for eye diseases, and improve our ability to view your internal retinal health. A dilated exam may still be recommended by the doctor if a more peripheral view of the retina is indicated. Since insurance only covers retinal photos after eye disease is discovered, the Retinal Imaging Exam is an out-of-pocket expense. **The fee is \$35.00.**

- I want to have my retinal health evaluated with Retinal Imaging.
- I do not wish to have Retinal Imaging Exam. I understand that I will still have a thorough eye exam with dilation.

Signature _____ Date _____



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PAYMENT POLICY/HIPAA

Examination and procedure fees are due at the time of service and may be submitted to your major medical insurance carrier. Any applicable co-payments are due at the time of service. If you have insurance coverage for these services or materials, we will submit claims for you. However, we are not liable for collecting your claim. After 30 days, we will expect payment in full if your insurance company has not paid. Any balance 90 days after the date of service will incur a monthly billing service charge of \$2.00 or 1.3% (15.6% APR) whichever is greater until the balance is paid in full. Returned NSF checks will be charged a service fee of \$35.00.

I HEREBY AUTHORIZE MY INSURANCE CARRIER TO MAKE PAYMENT DIRECTLY TO CLARENDON VISION DEVELOPMENT CENTER FOR ANY AND ALL SERVICES RENDERED TO ME BY CLARENDON VISION DEVELOPMENT CENTER. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.

- I HAVE READ AND AGREE TO THE PAYMENT POLICY STATED ABOVE.

THE OFFICE’S COMPLETE HIPAA POLICY STATEMENT IS AVAILABLE FOR REVIEW UPON REQUEST.

- I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW THE OFFICE’S HIPAA POLICY STATEMENT.

Signature of Responsible Party _____ Date _____

APPOINTMENT CANCELLATION / NO SHOW POLICY

Thank you for trusting your medical care to Clarendon Vision Development Center. When you schedule an appointment with Clarendon Vision Development Center, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

- Please provide our office a 24-hour notice if you need to reschedule or cancel your appointment.
- A “No-Show”, “No-Call” or missed appointment, without proper 24-hour notification, will be charged a \$150 fee. In the event of an emergency where prior notice could not be given, consideration will be given, and a one-time exception may be granted.
- If you are more than 10 minutes late for your appointment, the appointment may be cancelled and rescheduled.
- If a reminder call or message from our office is not received by the patient, the cancellation policy still remains in effect.
- The cancellation/no show fees are the sole responsibility of the patient and must be paid in prior to the patient’s next appointment.
- This fee is not billable to your insurance.

If you have any questions regarding this policy, please let our staff know and we will be glad to answer them.

I have read and understand the Appointment Cancellation/No Show Policy and agree to its terms.

Signature of Responsible Party _____ Date _____

Thank you for carefully completing this questionnaire. The information you supplied will allow us to provide a more comprehensive evaluation and better meet your child’s specific visual needs.

If you have any questions, please contact our office at (630) 323-7300 prior to your appointment.