If You Are A Contact Lens Wearer: or N/A

Which solution do you use? Renu / Optifree / Complete /Other ______

Average amount of time wearing (hours/day)? 8 / 10 / 12 /14 / 16 / Other ______

Do you rub your contacts when you clean them? Yes / No

How often do you dispose of your contacts? 2 weeks /1 month / 3 months / Yearly / Other ______

Do wear contacts while sleeping? Yes / No If yes, how many days a week? ______

If you wear contact lenses, are you satisfied with the vision and comfort? Yes / No

What type and brand of contacts do you wear? ______

What power and base curve do you wear? ______

HIPAA Privacy

Acknowledgement of Receipt of Privacy Notice

By signing this acknowledgement of Receipt of Notice of Privacy Practices (the "Notice"); I acknowledge that I have been provided with a copy of the Notice of Privacy for review and to keep for my records on the date signed below.

I understand that the Location may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/or types of products provided) to another party to permit the Location to perform its administrative duties, provide me with eye care services (including referral to another provider/specialist as needed for my treatment) and products, process my benefit claims and communicate with me regarding vision care services provided by the Location (for example, mailings of exam reminders or information about vision services/products provided by the Location).

I can be assured that this Location does not sell my personal health information of any kind to the third party for such party's own use. I authorize the Location to submit my vision benefit claims to my plan sponsor or health plan to receive reimbursement directly for the vision services and products that I have received from this Location.

______ ______

Patient Signature or Patient's Legal Representative **Date**

The Optomap allows the doctor to have a wide view of the health of the inside of the eye, particularly the retina and optic nerve.

Important reasons to have the test done:

- Floaters/spots in vision, or/and flashes of light, curtains over your vision
- Loss of vision/reduced best corrected vision/blurred vision
- Headaches
- Higher eyeglass prescriptions, thinner retina
- Ocular conditions/ systemic/ or family history: macular degeneration, diabetic retinopathy, glaucorna, narrow anterior chamber angles, high blood pressure, cholesterol, multiple sclerosis, on plaquenil

______ I elect to have the Optomap Retinal Imaging of my retina for $39

______ I decline the Optomap Retinal Imaging

______ I would like to schedule the Optomap Retinal Imaging

Print Name: ______ **Signature:** ______ **Date:** ______