2595 Tampa Rd., Suite R
Palm Harbor, FL 34684

Lighthouse for the Visually Impaired and Blind
9130 Ridge Road
New Port Richey, FL 34654

P: 727-463-2579 F: 727-934-4409

Your appointment is at one of the following locations:

Please write your appointment date and time here: _____

□ 2595 Tampa Rd., Suite R, Palm Harbor, FL 34684
(Located behind Mobile Gas Station on northeast corner of US Hwy 19 and Tampa Rd. in Oaklake Medical & Professional Centre)

□ Lighthouse for Visually Impaired and Blind, 9130 Ridge Road, New Port Richey, FL 34654

IMPORTANT: PLEASE COMPLETE ALL FORMS PRIOR TO YOUR LOW VISION EXAMINATION.

NOTE: you do not have to mail anything back to us, just bring in your paperwork with you to the exam.

Date: _____ Full name of patient: _____

If patient is a minor:
Full name of parent or guardian and how related:
_____

Mailing address: Street: _____

City: _____

State/Zip code: _____

Telephone number with area code: _____

Email address: _____
For use in sending out information and communication. By providing the email address you accept that we may use it for communicating with you.

Patients date of birth: _____ Patient's Age: _____

Gender (circle): Male Female

SSN of patient: _____ -_____- _____

If patient is a minor: SSN of <u>parent or guardian</u>: _____ -_____- _____
<u>New Patient's Only</u>

Who may we thank for referring you to our office?

_____

If not referred, how did you choose our office for your needs?

_____

What is the main reason for the eye/vision examination today?

_____
_____
_____

Check if you have had any of the following conditions and mark how long you have had them:

- □ **High Blood Pressure: _____**
- □ **Diabetes: _____**
- □ **Heart Trouble: _____**
- □ **Stroke: _____**
- □ **Migraine: _____**
- □ **Cataracts: _____**
- □ **Macular Degeneration: _____**
- □ **Diabetic Retinopathy: _____**
- □ **Cancer: _____**
- □ **Emphysema/Asthma: _____**
- □ **Arthritis: _____**
- □ **Thyroid Problems: _____**
- □ **Kidney Disease: _____**
- □ **Liver Disease: _____**
- □ **Stomach Ulcer: _____**
- □ **Glaucoma: _____**

Any other medical problems not listed above?

_____
_____

List any family members who have any of the above diseases:

_____
_____

<u>Patient General Health</u>

Who is your primary care physician?

_____

City and state of your primary care physician?

_____

Please list any allergies you have (include medication allergies):

_____
_____
_____

Please list any injuries you have had in past five years:

_____

_____

Please list any hospitalizations you have had in the past five years:

_____

_____

Patient Social History

Please indicate with a checkmark your current living conditions:

□ Lives alone **□ Lives in retirement center**
□ Lives with family **□ Lives with caretaker**
□ Lives in assisted living facility **□ Lives in nursing home**

	Yes	No	
Do you drive?	___	___	
Tobacco Use?	___	___	**If yes, type and frequency: _____**

Over the past two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself – or that you're a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

___ Not difficult at all ___ Somewhat difficult ___ Very difficult ___ Extremely difficult

Have you fallen in the past twelve months?

☐ not at all ☐ several days ☐ more than half the days ☐ nearly every day

Do you have problems with balance or difficulty walking?

☐ yes ☐ no

Did you have a fall that has resulted in an injury?

☐ yes ☐ no

During the past four weeks, was someone available to help you if you needed and wanted help? For example, if you felt very nervous, lonely, or blue, became sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself.

☐ yes, as much as needed ☐ yes, some ☐ yes, a little ☐ no, not at all

● Please answer Yes or No as it pertains to the following questions:

Can you get to places not within walking distance without help?

☐ Yes ☐ No

Can you shop for groceries or clothes without help?

☐ Yes ☐ No

Can you prepare your own meals?

☐ Yes ☐ No

Can you do your own housework without help?

☐ Yes ☐ No

Can you handle your own money without help?

☐ Yes ☐ No

Do you need help eating, bathing, dressing, or getting around your home?

☐ Yes ☐ No

During the past four weeks, how would you rate your health in general?

☐ excellent ☐ very good ☐ good ☐ fair ☐ poor

Are you having difficulties driving your car?

☐ yes, often ☐ sometimes ☐ no ☐ not applicable, I do not drive.

During the past four weeks, how much bodily pain have you generally had?

□ no pain □ mild pain □ moderate pain □ severe pain

How often during the past four weeks have you been bothered by any of the following problems?

Fall or dizzy when standing up?

☐ never ☐ seldom ☐ sometimes ☐ often ☐ always

Trouble eating well?

☐ never ☐ seldom ☐ sometimes ☐ often ☐ always

Problems using the telephone?

☐ never ☐ seldom ☐ sometimes ☐ often ☐ always

Tired or fatigued?

☐ never ☐ seldom ☐ sometimes ☐ often ☐ always

**** Signature of patient (or parent/guardian): _____ Date: _____**

Reviewed by E. Huggett, O.D.: _____

Note to my future Low Vision Patient: This low vision examination will be different than any standard eye examination you have had in the past. I am not treating your medical condition; you have a doctor that provides treatment. I am specifically examining your functional vision and determining what can specifically be done to improve it.

Although your vision cannot be made perfect again, in almost every case, if you have vision, we can make it better than it is using special high-powered eyeglasses or other optical devices for distance such as TV, faces, etc. and near such as reading and computer.

You will be taught how to use your remaining vision more efficiently than you do now. There are eye exercises (vision rehabilitation) I may prescribe that may help you a great deal and we can recommend alternate devices to you perform better with improved lighting, contrast, enlarged print, etc.

Sincerely,

Ed Huggett, O.D.

Before your appointment, please complete this form.

"Wish List," this is a list of the things you wish you could see better. Anything you think of that is important for you to see better goes here (e.g., see faces, watch TV, drive, read, knit). Even if you think it cannot be done – please write it down. Dr. Huggett will be directing his work to help you achieve these wish items.

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

Does sunlight bother your eyes? **YES** **NO**

Do you wear eyeglasses? **YES** **NO**
(If yes, please bring your newest glasses with you.)

Are you using any magnifying devices? **YES** **NO**
(If yes, please bring them with you.)

Please bring to your appointment the following:

- **Any device that you are using to help you see better such as eyeglasses, magnifier, or other optical device, flashlight, etc.**
- **Example of what you wish to read but are struggling with to read (e.g., book, magazine, newspaper, etc.).**
- **Example of project or hobby that you have trouble seeing.**
- **Current eyeglasses.**
- **Photo ID and insurance card(s).**
- **Optimism, if you have any usable vision, we can almost always make it better than it is!**

Authorization for Release of Medical Records and Protected Health Information (PHI)

Please print, complete and send to your eye doctor

Records requested: most recent two eye exams and the last visual field (even if from years ago).

Person whose information is requested (Please Print):

Name of Patient: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Telephone Number: _____

Send my medical records from provider (please print):

Name: _____

Street Address: _____

City: _____

State: _____ ZIP Code: _____

Release my records to:
Edward Huggett, O.D.
NuEyes Low Vision Solutions
2595 Tampa Rd., Ste R
Palm Harbor, FL 34684

FAX: 727-221-9462

By signature I authorize the release of all records. This release is valid for one year from the date of signature.

Patient or authorized person (signature): _____

Date: _____

FINANCIAL POLICY

Release of Information and Assignment of Benefits

Please print, sign and bring to your appointment

Edward J. Huggett, Jr., O.D., P.A. is a provider for Medicare B and accepts assignment for that insurance plan only.

1) It is agreed by the Insured or Responsible Party: "Edward J. Huggett, Jr., O.D., P.A., d.b.a., *NuEyes Low Vision Solutions*, extends the courtesy of filing a claim to your insurance company. However, insurance coverage is a contract between the Insured and the insurance company, the Insured is ultimately responsible for the payment of services whether an authorization was obtained or not. I agree that all co-payments, deductible amounts, or non-covered service fees are due to be paid within 30 (thirty) calendar days as invoiced."
2) I agree as the Insured/Responsible Party I will be required to pay for services as invoiced.
3) I agree that should my account become delinquent, I will be responsible for all collection costs, including but not limited to the outstanding balance, interest fees, attorney fees, court costs and agency fees.
4) We will collect $95.00 if you are using medical insurance such as Medicare B, United, Humana, Aetna, etc., (except Medicaid, or Medicaid related plans such as Optimum) (note, we do not accept vision insurance plans) by credit card, check, or cash. We will submit a claim for you to your insurance company. Your payment collected today will be applied toward the refraction, office visit, eye examination, and other services or testing if required.
5) We will collect $295 for the visit today if you do not have medical insurance or insurance coverage. This may not be the full amount billed if additional services are provided as medically indicated necessary.

I hereby authorize my insurance company to make payment directly to Edward J. Huggett, Jr., O.D., P.A. for any services rendered to me. I authorize Edward J. Huggett, Jr., O.D., P.A. to release any information required by my insurance company and their agents needed to determine these benefits for related services. A photocopy of this assignment shall be considered as effective and valid as the original.

A full listing of our fees is posted and available for review as needed, please ask.

Signature of responsible party: _____

Date: _____**/**_____**/**_____