Retinal Health Screening Tests

Both offices have the OPTOMAP (OPTOS):

We started requiring retinal photos at the start of COVID for social distancing and the Doctors were better able to diagnose more eye conditions. The Doctors have now made the **retinal photography a requirement** to fully evaluate everyone's ocular health. The cost of the photography is $39.00, and cannot be opted out of.

Retinal Photo *Computerized imaging of the retina and optic nerve*	*$39 co-pay*	***Required***	✓

OR, we encourage you to combine the retinal photography with a Macular Pigment Density Test (normally a $25 co-pay on its own).

Retinal Photo and Macular Pigment Density Test *(age 30 and above only)* *Retinal photo and measurement of macular degeneration risk*	*$50 co-pay*	*Optional*	

Additionally, if you are 65 or older and/or diabetic, you **WILL BE DILATED** to meet insurance requirements.

By signing, I also understand that Piedmont Eyecare Associates, O.D. is required by law to protect my privacy and health information, as stated in the *Notice of Privacy Practices*. A copy of this is available at the front desk.

Patient name (Print) ______________________________

Patient/Guardian Signature ______________________________ Date: ______________

Please Read:
In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.
Your signature will allow Piedmont EyeCare to file the insurance you provided for your exam today. Payment from my insurance is to be paid directly to Piedmont EyeCare. I understand that my insurance will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quote to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

______________________________ ______________________________
Signature **Date**

Patient/Guardian Signature ______________________________ Date: ______________

Piedmont EyeCare
Associates, OD, PLLC

Patient Name or ID # ______________________

CONTACT LENS EVALUATION CONSENT

☐ Yes, I confirm I would like a contact lens evaluation to renew or get an initial contact lens prescription. I am aware my vision plan may not cover the cost nor offer any discounts.

☐ No, I decline to have a contact lens evaluation to renew my contact lens prescription. Measurements necessary for a contact lens prescription will not be performed.

____
Signature Date

Contact lens pricing ranges from $85.00 – 125.00. Specialty evaluation prices start at $250.00.

Please Note: some of the evaluation cost may be covered by your vision plan.

Piedmont EyeCare Patient Portal

Via Revolution PHR Personal Health Record

We're live! You now have access to easily view and print your prescription, connect with your provider, check on status of orders, and view healthcare information through your mobile device or computer.

To complete enrollment:

Please provide your full name:

Your email address:

(Your email address will be your user name)

Your cell/mobile phone number:

Signature:

We will send you a temporary passcode. (You'll need to enter the temporary passcode twice)

A MEMBER OF

Piedmont EyeCare Associates
Welcome To Our Office

Welcome to Piedmont EyeCare Associates. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. If you have any questions, please do not hesitate to ask.

HEALTH HISTORY

What is the main reason for today's exam? ______________________________

When was your last exam? ______________

When was your last health exam? ____________

Past Illnesses or Injuries: ______________________________

Past Surgeries: ______________________________

Current Medications: ______________________________

____

Current Eye Drops: ______________________________

____

Medicines that cause reactions or sensitivities: ______________________________

Specific Allergies: ______________________________

Patient name (Print) ______________________

Piedmont EyeCare
Associates, OD, PLLC

MEDICAL INFORMATION RELEASE FORM

LIST ANYONE YOU AUTHORIZE TO HAVE ACCESS TO YOUR MEDICAL RECORDS FROM OUR OFFICE. THIS CAN INCLUDE OTHER MEDICAL OFFICES AS WELL AS FAMILY MEMBERS.

NAME: ______________________________

PHONE: ______________________________

RELATIONSHIP: ______________________________

NAME: ______________________________

PHONE: ______________________________

RELATIONSHIP: ______________________________

PATIENTS NAME: ______________________________

PATIENTS DOB: ______________________________

PATIENT/GUARDIANS SIGNATURE: ______________________________

PIEDMONT EYECARE ASSOCIATES
8811 BLAKENEY PROFESSIONAL DRIVE, STE 100
CHARLOTTE NC 28277
PHONE # 704-926-EYES (3937)
FAX # 704-926-3938

DR. SCOTT L. PHILIPPE **DR. MICHAEL J. JOHNSON** **DR. PRIYA SHETH**

DR. REBECCA MAJOR **DR. ANDREW BARROWS** **DR. SHALINI PATEL**

DR. KALENE FIX-MASTENBROOK

DATE: ____________

MEDICAL RECORDS RELEASE FORM

MEDICAL RECORDS ARE BEING REQUESTED FROM:

____

____

____

PATIENTS NAME: ______________________________

PATIENTS DOB: ______________________________

PATIENT/GUARDIANS SIGNATURE: ______________________

PLEASE RELEASE MY RECORDS TO:

PIEDMONT EYECARE ASSOCIATES
8811 BLAKENEY PROFESSIONAL DRIVE, STE 100
CHARLOTTE NC 28277
PHONE # 704-926-EYES (3937)
FAX # 704-926-3938

___ DR. SCOTT L. PHILIPPE, OD

___ DR. REBECCA MAJOR, OD

___ DR. SHALINI PATEL, OD

___ DR. KALENE FIX-MASTENBROOK, OD

___ DR. MICHAEL J. JOHNSON, OD

___ DR. ANDREW BARROWS, OD

___ DR. PRIYA SHETH, OD

How did you hear about our practice?

- ☐ Friend ______________________
- ☐ Relative ______________________
- ☐ Doctor ______________________
- ☐ Next Door App.
- ☐ School Email/Newsletter
- ☐ Facebook
- ☐ Piedmont Eye Care Mailer
- ☐ Internet Search
- ☐ Insurance Website
- ☐ Our Website
- ☐ Google
- ☐ YMCA
- ☐ Drive by
- ☐ Church Bulletin
- ☐ Truck Advertisement
- ☐ Piedmont Eyecare Employee ________________________________
- ☐ Other (please explain) ______________________________________

Do you suffer from Migraines?

If so, please answer the following six questions about your experience with migraines by telling us your best answer for each.

1. How many days a month do you suffer from migraine attacks?

<1	1-4	5-8	9-12	13+

2. Do you experience light sensitivity or spend time in a dark room during migraine attacks?

YES	NO

3. Are bright overhead lights, LED's, computer or TV screens a known migraine trigger for you?

YES	NO

4. How would you rate the impact of migraine on your ability to function during an attack?

I CAN FUNCTION NORMALLY	I CAN DO MOST ACTIVITIES	I CAN DO SOME ACTIVITIES	I CAN DO VERY FEW ACTIVITIES	I AM UNABLE TO FUNCTION

5. How often does your migraine impact your productivity or ability to work?

Never	Rarely	Sometimes	Often	Very Often

6. How often does migraine impact personal plans; your ability to spend time with children, family or friends; or ability to complete daily tasks?

Never	Rarely	Sometimes	Often	Very Often

SPEED™ QUESTIONNAIRE

Name: ______________________ **Date:** ___/___/___ **Sex:** M F (Circle) **DOB:** ___/___/___

For the Standardized Patient Evaluation of Eye Dryness (SPEED) Questionnaire, please answer the following questions by checking the box that best represents your answer. Select only one answer per question.

1. Report the type of SYMPTOMS you experience and when they occur:

	At this visit		Within past 72 hours		Within past 3 months	
Symptoms	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Dryness, Grittiness or Scratchiness						
Soreness or Irritation						
Burning or Watering						
Eye Fatigue						

2. Report the FREQUENCY of your symptoms using the rating list below:

Symptoms	**0**	**1**	**2**	**3**
Dryness, Grittiness or Scratchiness				
Soreness or Irritation				
Burning or Watering				
Eye Fatigue				

0 = Never **1** = Sometimes **2** = Often **3** = Constant

3. Report the SEVERITY of your symptoms using the rating list below:

Symptoms	**0**	**1**	**2**	**3**	**4**
Dryness, Grittiness or Scratchiness					
Soreness or Irritation					
Burning or Watering					
Eye Fatigue					

0 = No Problems
1 = Tolerable - not perfect, but not uncomfortable
2 = Uncomfortable - irritating, but does not interfere with my day
3 = Bothersome - irritating and interferes with my day
4 = Intolerable - unable to perform my daily tasks

4. Do you use eye drops for lubrication? ☐ YES ☐ NO **If yes, how often?** ______________

Cornea. 2013 Sep;32(9):1204-10
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13-ADV-123 A

For office use only
Total SPEED score (Frequency + Severity) = ____/28

Lifestyle Index

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 ○

	Symptom	1 Never	2 Rarely	3 Sometimes	4 Very Often	5 Always
	Headaches of any severity each week, usually getting worse later in the day	○	○	○	○	○
	Stiffness / pain in neck / shoulders when you work at a computer or read	○	○	○	○	○
	Discomfort with Computer Use in your eyes (redness, burning) after long hours looking at the screen	○	○	○	○	○
	Tired Eyes with increasing feeling of eye fatigue throughout the day	○	○	○	○	○
	Dry Eye Sensation feeling progressively more gritty/sandy while working at computer or reading	○	○	○	○	○
	Light Sensitivity especially with brighter, stronger lights like fluorescents or headlights	○	○	○	○	○
	Dizziness or an experience like motion sickness or vertigo	○	○	○	○	○

FOR OFFICE USE

Neurolens Value	Prism Split for Order Entry	Misalignment	Mono PD	MQI	AC/A Ratio
	OD:	Near:	OD:	Near:	
	OS:	Distance:	OS:	Distance:	