VISION COVERAGE OF COLORADO

Record # _____

Medical History Questionnaire

Patient's Name: _____ Date: _____

Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Guardian: _____ phone:_____

Patient address: _____

Responsible party name:_____ phone: _____

Billing address: _____

Insurance Information

Medical Insurance: _____ Member: _____

Reason for Today's Visit: _____

Allergies: _____

Current Medications (Rx and over the counter, including eye drops): *Or Attach List*

_____

_____

Review of Systems	**Yes**	**No**
Seasonal Allergies	☐	☐
Rheumatoid Arthritis	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Diabetes	☐	☐
Gastrointestinal	☐	☐
Cancer	☐	☐
Endocrine/Thyroid	☐	☐
Ear/Nose/Throat	☐	☐
Seizures	☐	☐
Urinary	☐	☐
Blood/Lymph Nodes	☐	☐
Psychiatric	☐	☐
Respiratory	☐	☐

Family History	**Yes**	**No**
Retinal Detachment	☐	☐
Macular Degeneration	☐	☐
Diabetes	☐	☐
Glaucoma	☐	☐

Ocular History	**Yes**	**No**
Blurred Vision	☐	☐
Cataracts	☐	☐
Strabismus (eye turn)	☐	☐
Amblyopia (lazy eye)	☐	☐
Double Vision	☐	☐
Eye Injury/Trauma	☐	☐
Flashes/Floaters	☐	☐
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Retinal Disease	☐	☐
Retinal Detachment	☐	☐
Optic Nerve Disease	☐	☐
Dry Eyes	☐	☐
Iritis	☐	☐
Keratoconus	☐	☐
Diabetic Retinopathy	☐	☐

Previous Eye Surgeries	**Yes**	**No**
Cataracts	☐	☐
Retinal Detachment	☐	☐
Muscle Surgery	☐	☐
LASIK/PRK	☐	☐

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

VISION COVERAGE
OF COLORADO

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I, _____ give consent to Vision Coverage of Colorado, LCC to perform all diagnostic procedures, tests and/or treatments when indicated to provide the most efficient eye care, including:

External photos document the progress or deterioration of certain conditions to include the: eyelids, eyelashes, sclera, conjunctiva and cornea, anterior chamber, iris and filtration angle.

Retinal photos document the appearance of the retina. It inspects anomalies associated to diseases that affect the eye, including macular degeneration, retinal neoplasm's, choroidal disturbances, diabetic retinopathy, glaucoma, multiple sclerosis and other central nervous system abnormalities.

Medications will be prescribed for the treatment of eye conditions as necessary.

Glasses: I am aware that services related to glasses, as well as glasses themselves are not generally covered by insurance must be paid in full before glasses will be made.

All patients receiving a glasses prescription will be billed a **$50 refraction (CPT code 92015)**. A refraction is the procedure of determining which lenses are most appropriate for optional vision. The CPT code for a refraction is not considered a medical procedure, and therefore **is not billed or paid by medical insurances. I understand I am responsible for payment of this fee.**

Dilation: Dilation is needed for proper examination of the retinal-vitrious status. Macular degeneration, glaucoma and diabetes, among other diseases, can adversely affect vision. Early detection gives the best chance to prevent vision loss or at least minimize the threats.

This medical consent will be in effect continuously while receiving care from Vision Coverage of Colorado, LLC. I am aware that I may be billed for certain insurance co-payments and Medicare deductibles.

Signature_____

Printed Name _____

Date _____

P.O.A Signature _____

Printed Name _____

Date _____

Form updated 8/2023 by A Benson

VISION COVERAGE
OF COLORADO

SUMMARY NOTICE OF PRIVACY PRACTICES

Revised October 18, 2017

THIS IS A SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains Patient rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. You may obtain a copy by asking the front desk or Privacy Officer. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

Our pledge to protect your privacy:

Vision Coverage of Colorado, LLC is committed to protecting the privacy of your medical information. Your care and treatment is recorded in a medical record. So that we can best meet your medical needs, we share your medical record with the providers involved in your care. We share your information only to the extent necessary to collect payment for the services we provide, to conduct our business operations, and to comply with the laws that govern health care. We will not use or disclose your information for any other purpose without your permission.

Patient Rights - You have the following rights regarding your medical information:

- to request to inspect and obtain a copy of your medical records, subject to certain limited exceptions;
- to request to add an addendum to or correct your medical record;
- to request an accounting of Vision Coverage of Colorado, LLC disclosures of your medical information;
- to request restrictions on certain uses or disclosures of your medical information; to request that we communicate with you in a certain way or at a certain location; and to receive a copy of the full version of our Notice of Privacy Practices.

We may use and disclose medical information about you for the following purposes:

- to provide you with medical treatment and services;
- to bill and receive payment for the treatment and services you receive;
- for functions necessary to run Vision Coverage of Colorado, LLC and assure that our Patients receive quality care;
- to provide basic contact information (no medical information is provided) to our development office for purposes of fundraising for Vision Coverage of Colorado, LLC; to support our standing as a federally qualified health center; and as required or permitted by law.

VISION COVERAGE
OF COLORADO

ACKNOWLEDGEMENT OF RECEIPT
OF SUMMARY NOTICE OF PRIVACY PRACTICES

Revised October 18, 2017

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke the Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Vision Coverage of Colorado, LLC provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____	_____	_____
Name of Patient (print)	Signature of Patient	Date

_____	_____	_____
Signature of Patient Representative	Relationship to Patient	Date

□Parent of Minor Child □Legal Guardian □Power of Attorney □Executor □Other _____

Vision Coverage of Colorado, LLC may disclose medical care and prescription information to the following people:

_____			_____		
Name	Relationship	Phone Number	Name	Relationship	Phone Number
_____			_____		
Name	Relationship	Phone Number	Name	Relationship	Phone Number