

## Welcome to Alva S. Pack III OD & Associates

We are pleased that you have chosen to come to our office for your eye care needs. Each patient's needs remain the primary focus of our team. The mission of our practice is to meet your comprehensive visual and ocular health needs and to exceed your expectations in a friendly, compassionate, educational atmosphere, nurturing a lasting relationship with you.

Although we do our best to stay on schedule, sometimes delays cannot be avoided due to the complexity of our patient's cases or emergencies that the doctor has to work into his schedule. We apologize for any wait time that you may experience, but please understand that your time is very important to us and the doctor will spend as much time with you as needed to answer all your questions and provide a thorough diagnosis and plan for you.

Many people are misled into thinking eye care is the same from one place to another, but it's not. Seeing the eye chart is one thing...but vision and medical eye health care varies dramatically. We see it as total vision and medical eye health. We want you to know that we are not only concerned about your current vision, but maintaining good vision for many years to come. In order to adequately assess the overall health of your eyes, we often need to dilate your eyes. The dilating drops may cause blurry vision up close and light sensitivity. These side effects may last 3-6 hours depending on your eye color and age. You may want to bring along a driver to be present when your eyes are dilated. You may come in at a later date for the dilated portion of your exam if it is not convenient for you the same day of your exam.

### What To Bring To Your Appointment

#### All Patients

1. Picture ID, Vision and Medical Insurance Card
2. Current glasses
3. List of medications
4. Completed health and history form

#### Contact Lens Patients

5. Current contact lens prescription and the brand of lenses

**Please fill out the enclosed paperwork and bring it along with the above items in order to expedite the check-in process on the day of your appointment.**

**All professional fees are due at time of service. Please be prepared to pay your copay on the day care is received.** \_\_\_\_\_

#### Alva S Pack III OD & Associates

Alva S. Pack III OD    Louis Martin OD    Janell Martin OD

399 E. Henry Street, Spartanburg, SC 29302

Phone: 864-585-0208

Fax: 864-594-6783

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## SUMMARY OF NOTICE OF PRIVACY PRACTICES

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In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office. You may request a copy of the Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document.

As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes includes

6. Care and services provided here
7. Disclosure of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional
8. Disclosure of your health information for purpose of payment to:
  - to a billing agent or vendor for processing claims or obtaining payment.
  - to third-party payers or insurers for claims review, determination of benefits and payment.
  - to auditors hired by third-party payers and insurers. .

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

By signing this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You also signify that you have received this summary and have been offered a full copy of our Notice of Privacy Practices.

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Patient or Personal Representative of Patient

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Print Name

## Authorization Form to Disclose Protected Health Information to Family Members

Federal privacy law limits our ability to disclose your health information to others, including to your family members. The privacy law now requires that every adult must give a written authorization before we may disclose your information to another person. If an authorization is not on file, we can only disclose information to the covered adult whom the information relates.

I authorize you to disclose my health information to the following individual(s):

\_\_\_\_\_  
Name and Relationship

\_\_\_\_\_  
Name and Relationship

\_\_\_\_\_  
Name and Relationship

\_\_\_\_\_  
Name and Relationship

\_\_\_\_\_  
Name and Relationship

\_\_\_\_\_  
Name and Relationship

**Signature** \_\_\_\_\_

**Date Signed** \_\_\_\_\_

Right to Revoke: I understand that I have the right to revoke this authorization at any time by notifying our office.

**ALVA S. PACK III OD PA & ASSOCIATES**  
**Pediatric Questionnaire**

Patient Information	Insurance Information		
<p><b>Today's Date</b> _____</p> <p>Child's Last Name _____</p> <p>First _____ MI _____</p> <p>Preferred Name _____</p> <p>Street _____</p> <p>City _____ State _____</p> <p>Zip Code _____</p> <p>Home Phone _____</p> <p>Mother's Name _____</p> <p>Work Phone _____ Cell Phone _____</p> <p>Email: _____</p> <p>Father's Name _____</p> <p>Work Phone _____ Cell Phone _____</p> <p>Email: _____</p> <p>May we send you info about eye appointments and our practice by email: <input type="checkbox"/> Yes    <input type="checkbox"/> No  by text:    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Child's SSN _____</p> <p>Date of Birth _____ Age _____</p> <p>Sex    M    F</p> <p>School: _____ Grade: _____</p> <p>What is the major purpose of this visit?  _____</p> <p><b>VERY IMPORTANT! NEW PATIENTS ONLY:</b>  Who may we thank for referring you to our office?  Name of friend or relative _____</p> <p>If not referred, how did you choose our office?  <input type="checkbox"/> Another Dr.                      <input type="checkbox"/> Insurance List  <input type="checkbox"/> Saw Sign/Building              <input type="checkbox"/> Newspaper/Radio/TV  <input type="checkbox"/> Yellow Pages: Which directory? _____</p> <p><input type="checkbox"/> Other _____</p>	<p>Vision Insurance _____</p> <p>Policy/ID Number _____</p> <p>Group Number _____</p> <p>Subscriber's Name _____</p> <p>Subscriber's SSN _____</p> <p>Subscriber's Birth Date _____</p> <p>Subscriber's Employer _____</p> <p>Primary Medical Insurance _____</p> <p>Policy/ID Number _____</p> <p>Group Number _____</p> <p>Subscriber's Name _____</p> <p>Subscriber's SSN _____</p> <p>Subscriber's Birth Date _____</p>		
<b>Lifestyle Questions</b>			
<p><b>Does your child...(check box if your answer is yes)</b></p> <p><input type="checkbox"/> ..spend time on the computer? How many hrs/day? ____</p> <p><input type="checkbox"/> ..find him/herself bothered by glare or reflection? ____</p> <p><input type="checkbox"/> ..spend time outdoors? How many hrs/week? ____</p> <p><input type="checkbox"/> ..have sun wear (prescription and/or non-prescription)?</p> <p><input type="checkbox"/> ..have a spare pair of glasses in your current Rx?</p> <p><input type="checkbox"/> ..have family members or friends in need of eye care?</p> <p><b>Has your child ever experienced, been diagnosed or treated for any of the following?</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; vertical-align: top;"> <input type="checkbox"/> Blurry Vision  <input type="checkbox"/> Sunlight Sensitivity  <input type="checkbox"/> Eye Injury  <input type="checkbox"/> Itchiness  <input type="checkbox"/> Burning  <input type="checkbox"/> Tearing  <input type="checkbox"/> Other eye disorders _____ </td> <td style="width:50%; vertical-align: top;"> <input type="checkbox"/> Flashes of Lights  <input type="checkbox"/> Eye Infections  <input type="checkbox"/> Eye Surgery  <input type="checkbox"/> Crossed eye/Eye Turn  <input type="checkbox"/> Lazy Eye  <input type="checkbox"/> Dry Eyes </td> </tr> </table>		<input type="checkbox"/> Blurry Vision <input type="checkbox"/> Sunlight Sensitivity <input type="checkbox"/> Eye Injury <input type="checkbox"/> Itchiness <input type="checkbox"/> Burning <input type="checkbox"/> Tearing <input type="checkbox"/> Other eye disorders _____	<input type="checkbox"/> Flashes of Lights <input type="checkbox"/> Eye Infections <input type="checkbox"/> Eye Surgery <input type="checkbox"/> Crossed eye/Eye Turn <input type="checkbox"/> Lazy Eye <input type="checkbox"/> Dry Eyes
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Patient Medical History	
Name of Pediatrician _____	
Town _____	
Date of Last Physical Check-up _____	
<b>CURRENT MEDICATIONS (Rx or Over the Counter)</b> (List name of medications including eye drops & vitamins)	
_____	
_____	
_____	
Allergic to any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, what medications? _____	
_____	
Has your child had any major surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please list _____	
_____	
<b>Has your child ever been diagnosed or treated for any of the following health problems?</b>	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Blood/Lymph
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Cancer
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Digestive
<input type="checkbox"/> Ears/Nose/Throat	<input type="checkbox"/> Eczema/Rashes
<input type="checkbox"/> Fevers	<input type="checkbox"/> Genitourinary
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Skin
<input type="checkbox"/> Kidney	<input type="checkbox"/> Muscle/Bone
<input type="checkbox"/> Neurological	<input type="checkbox"/> Psychological
<input type="checkbox"/> Respiratory	<input type="checkbox"/> Sinus

Patient Eye History	
Date of Last Eye Exam _____	
By Whom? _____	
Does your child currently wear contact lenses?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
What kind? _____	
If he/she doesn't, would you be interested in your child being fit for contact lenses?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your child currently wear glasses?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Family Medical/Eye History (Check all that apply)	
Is there a family medical history of any of the following?	
	Relationship to Your Child
Blindness	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Mother's Pregnancy History (did any of the following occur?)	
<input type="checkbox"/> Infection	<input type="checkbox"/> Alcohol use
<input type="checkbox"/> Drug Use	
<input type="checkbox"/> Other _____	
_____	

Please be advised if you are using insurance coverage for today's visit, we require a valid copy of your insurance card to ensure that your claims are filed properly. We will file your insurance for you as a courtesy, however if your insurance does not cover a particular service, you will be responsible for the balance, any copays, contact lens fitting fees and/or deductibles. Payment of these fees is due at the time of the service.

I authorize my insurance company to pay by check made out to: **Alva S. Pack III OD PA**. If my current policy prohibits direct payment to the doctor, I authorize my insurance company to make the check in my name and mail it as follows:  
**Alva S. Pack III OD PA/ 399 East Henry Street/ Spartanburg, SC 29302.**

I authorize the practice to deposit these checks received on my account when made out to me, the patient.  
 I authorize the practice to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_