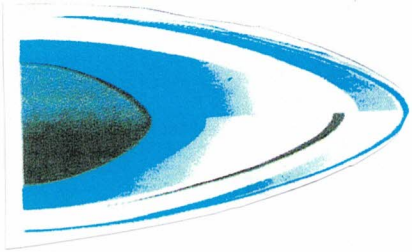

ALABAMA COAST EYE CLINIC
FELBER AND ASSOCIATES LLC
DR DAVID R FELBER

TODAY'S DATE: _____

LAST NAME: _____ FIRST NAME: _____ M.I._____

PREFERRED NAME: _____ BIRTHDATE: _____ MALE_____ FEMALE_____

SSN: _____ EMPLOYER: _____

MARITAL STATUS: SINGLE _____ MARRIED _____ DIVORCED _____ WIDOWED _____

MAILING ADDRESS: _____

CITY/STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____

EMERGENCY CONTACT: NAME: _____ RELATIONSHIP: _____

PHONE NUMBER: _____

RESPONSIBLE PARTY INFORMATION (if different)

NAME: _____ RELATIONSHIP: _____ DOB: _____

ADDRESS: _____

PHONE NUMBER: _____ EMPLOYER: _____

SSN: _____

INSURANCE INFORMATION

HEALTH Insurance Carrier: _____

Secondary or Supplemental HEALTH Insurance Carrier: _____

VISION Insurance Carrier: _____

Information Below is only needed if you have not provided your insurance cards to the front desk

Policy/Contract/SS Number: _____

Policy Holders LEGAL Name: _____

Policy Holders Date of Birth: _____

Policy Holders Address: _____

PLEASE TURN PAGE OVER

HEALTH INFORMATION: CHECK IF YOU HAVE A HISTORY OF:

____ High Blood Pressure
____ Heart Disease
____ Heart Attack
____ High Cholesterol

____ Diabetes
____ Thyroid Disease

____ Stroke
____ Seizures
____ Epilepsy

____ Kidney Disease
____ Prostate Problems

____ Stomach Problems
____ Ulcers
____ Weight Loss/Gain

____ Ear Problems
____ Sinus/Allergy Problems
____ Headaches
____ Migraines

____ Anemia
____ Hepatitis/Jaundice
____ Sickle Cell or Trait
____ Cancer

____ Arthritis
____ Back Problems
____ Neck Problems

____ ADHD
____ Alcoholism
____ Drug Addiction
____ HIV

____ Asthma
____ Emphysema

____ Skin Cancer
____ Rosacea

WHEN WAS YOUR LAST EYE EXAM? _____

DO YOU WEAR GLASSES NOW? Y or N

DO YOU WEAR CONTACT LENSES? Y or N

DO YOU WANT AN EXAM FOR CONTACTS TODAY? Y or N

WHAT KIND/BRAND DO YOU WEAR? _____

PHARMACY NAME/LOCATION: _____

MEDICATIONS ALLERGIC TO: _____

ARE YOU PREGNANT / NURSING? _____

SOCIAL HISTORY: Do you use: Tobacco: Y___ N___ How much/often? _____

Alcohol: Y___ N___ How much/often? _____

PLEASE LIST ANY MEDICAL CONDITIONS THAT RUN IN YOUR FAMILY:

_____

_____

The above information is true to the best of my knowledge.

_____ DATE: _____

SIGNATURE OF PATIENT OR GUARDIAN

ALABAMA COAST EYE CLINIC
FELBER AND ASSOCIATES LLC
DR DAVID R FELBER

HIPAA/CONSENT/OFFICE POLICIES

$50 CANCELLATION/NO SHOW FEE

If you are unable to keep your scheduled appointment, we do require 24-hour notice (1-full business day) so that we may accommodate the needs of another patient. All appointments are reserved exclusively for you. In the event of a failed doctor's appointment or same day cancellation, the patient is charged a $50 fee and will not be permitted to reschedule until that fee is paid. Patient Initials_____

AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION (HIPPA CONSENT)

Privacy regulations require us to have a release form signed by our patients so we may speak with family members, friends, and others regarding your medical treatment and financial information. Each person you would like to have access to your information must be listed below.
Please print the name and relationship for each person you are authorizing access to your medical information and account balances.
Please choose and initial an option below.
The person(s) listed below have access to my private information. Patient Initials_____

Name_____Relationship _____Phone _____

Name_____Relationship _____Phone_____

I choose not to authorize anyone to have any of my private information. Patient Initials_____

NOTICE OF PRIVACY PRACTICES

I have the right to review the "Notice of Practices", prior to signing this consent and agree with these privacy policies. Patient Initials_____

FINANCIAL POLICY

Fees for professional services and materials are due at the time of service or when materials are ordered. I hereby authorize Felber and Associates LLC to release any medical information required to my insurance company, and I permit payment to Felber and Associates LLC from my insurance for any benefits due for services rendered. I understand that all benefits quoted to me are not guarantee of payment by my insurance company. Final determination can only be made after the claim is processed. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes but is not limited to coinsurance, copayment, deductible and non-covered services. I also understand that I am ultimately responsible for any charges incurred today, including those charges that my insurance company may deny.

I agree to pay my bill in full for services rendered by Felber and Associates LLC.
I understand that a 10% finance charge will be added to my account if my bill is not paid within 30 days of my statement. Patient Initials_____

Signature of Patient or Legal Guardian: _____Date: _____

RETINAL SCANNING

We have a state-of-the-art device in our office that will scan the eye and the structures underneath. This is a non-invasive scan (OCT scan) that allows our doctor to see below the surface of the retina. This technology can allow us to see problems in the eye up to 10 years earlier than can be seen with a normal eye exam and dilation. In most cases this scan will replace the need for dilation. This procedure provides a permanent scan and image that can be reviewed and compared from year to year and track any changes in health.

The doctor strongly recommends that all patients have this procedure performed.
If you choose not to have the scan, then you must be dilated.

This scan is **NOT** covered by your health or vision insurance.

_____ I choose the scan and agree to pay $25.00 to have this procedure done.

_____ I do not want to have this procedure performed. I prefer to be dilated.

_____ _____

Signature Date

VISION ASSESMENT:

Do you drive after dark? (circle)

Often Sometimes Rarely

Do you use a computer? (circle)

Often Sometimes Rarely

Do you do a lot of close detail work, like sewing or building models? (circle)

Often Sometimes Rarely

Screen Time:
How many hours per day do you spend looking at digital screens?
How often do you take breaks from screens?

Symptoms:
Do you experience eye strain, dryness, redness, or irritation when using digital devices?

Do you have headaches or neck pain associated with screen time?

Do you notice blurred vision or difficulty focusing on screens?

Viewing Habits:
How far away do you typically hold your digital device from your eyes?

What is the position of your screen relative to your eye level?

Do you adjust the brightness and contrast settings on your devices?

Environmental factors:
What is the lighting like in your workspace when using digital devices?

Do you experience glare from your screen?

Corrective vision:
Do you currently wear glasses or contact lenses?

Have you considered getting computer glasses specifically designed for digital screens?

Other factors:
Do you blink frequently when using digital devices?

Do you have any pre-existing conditions like dry eye syndrome?

Please answer the questions below to help us give an assessment to how we can best service your vision needs

VISION SCREENING QUESTIONS

1. Does your vision problems make it difficult for you to do the things you like doing?
2. Can you see the large print headlines in the newspaper?
3. Can you see the regular print in magazines and books?
4. When you are walking outside can you see the street name signs?
5. Does trouble with your vision make it difficult for you to watch tv and other activities?
6. Does trouble with your vision make it difficult to see labels on medicine bottles?
7. Does trouble with your vision make it difficult to read prices when you shop?
8. Does trouble with your vision make it difficult to read your own mail?
9. Does trouble with your vision make it difficult for you to read your own handwriting?
10. Can you recognize the faces of family or friends when they are across a room?
11. Do you have any difficulty seeing in dim light?
12. Do you tend to sit very close to the television?
13. Has a doctor ever told you that nothing more can be dome for your vision?

Please answer the questions below to help us give an assessment whether a demo with Nuance Audio device would be beneficial to your needs.
Nuance is the newest technology with an all-in-one solution to address vision and hearing needs in one device.

NUANCE AUDIO SCREENING QUESTIONS

1. On a scale of 1 to 10, how would you rate your hearing? (10 being excellent)
2. Do family members ever mention that you have difficulty hearing what they say?
3. Do you have trouble hearing in noisy environments such as restaurants?
4. Have others ever commented that you turn the volume on your devices up too high?
5. Do you find yourself straining to understand what others are saying?