155 Borthwick Avenue, Suite 200 East
Portsmouth, NH 03801
603-501-5000 or 1-866-302-5327
www.ClearAdvantageLaser.com

We look forward to meeting you during your evaluation!

During your evaluation our doctors and staff will educate you on the vision correction procedures available, the procedure that is recommended for you based on your prescription, and your specific vision concerns. Please complete the attached paperwork in preparation for your appointment so we can dedicate more time in understanding your expectations and answering your questions.

PLEASE COMPLETE THIS FORM AND BRING IT WITH YOU TO YOUR EVALUATION. We will collect it upon arrival.

COMING FROM MANCHESTER / CONCORD – ROUTE 101 EAST

- Follow Route 101 East towards Portsmouth / Seacoast / Maine
- Take Route 95 Exit (this exit does not have an exit number, but is AFTER exit 12)
- Proceed through Toll Booth ($.75) and remain in left lane towards 95 North – Maine / Portsmouth NH
- Take Exit 3 - Greenland

** At the end of exit you will come to a set of lights, take right

- Immediately get into left lane and take left at lights onto Borthwick Ave. (You'll see the blue hospital "H" sign)
- Bear right at stop sign to continue on Borthwick Avenue
- 155 Borthwick is the 2nd building on the left (Highliner Foods will be the first building on your left)
- The elevator is located half way down the hall when entering the building, and stairs are just past the elevator. We are located on the 2nd floor of the East building. Take a left out of the elevator to access our office.

COMING FROM 95 SOUTH (MASSACHUSETTS POINTS)

- Take 95 North.
- Take Exit 3 - Greenland

** Follow directions at this point above from Manchester / Concord

NOTES:
Please wear glasses only prior to your evaluation and surgery:

Soft lenses: 5 days
Toric lenses: 14 days
Hard lenses: 8 weeks

You will be dilated at the evaluation. Dilation does not effect distance vision, but does make near vision somewhat blurry and you will be light sensitive. This will last about 4-5 hours.

COMING FROM 95 NORTH (MAINE POINTS)

- Follow 95 South to New Hampshire
- Take Exit 5 Portsmouth/Newington / Portsmouth Traffic Circle.
- Stay in the right lane and exit immediately (Portsmouth).
- Move all the way over to the left lane and enter the Portsmouth Traffic Circle.

*** Exit directly across from where you entered- Route 1 South.

- Go straight through the first light.
- At the second light take a right onto Borthwick Ave.
- 155 Borthwick Ave is the 2nd building after Portsmouth Regional Hospital. We are located between Liberty Mutual and Highliner Foods.
- The elevator is located half way down the hall when entering the building, and stairs are just past the elevator. We are located on the 2nd floor of the East building. Take a left out of the elevator to access our office.

COMING FROM THE SPAULDING TURNPIKE (ROUTE 16)

- Take 16 South until the highway forks.
- Take the left branch 95N, Route 1, Portsmouth
- Stay in the left lane and enter the Portsmouth Traffic Circle.

*** Follow from this point above coming from 95 North (Maine points)

COMING FROM ROUTE 1 SOUTH

- Take Route 1 North passing Water Country and Yoken's (formerly).
- Bear left heading towards the Portsmouth traffic circle after passing Lafayette Plaza on the right (you will see Fresh Market, Planet Fitness & Margaritas). You will travel beneath an over-pass.
- At the second light (after passing Lafayette Plaza) turn left onto Borthwick Ave heading in the direction of Portsmouth Regional Hospital (you will see a blue "H" hospital sign). If you end up in the traffic circle, you've gone too far.
- 155 Borthwick Ave is the 2nd building after Portsmouth Regional Hospital. We are located between Liberty Mutual and Highliner Foods
- The elevator is located half way down the hall when entering the building, and stairs are just past the elevator. We are located on the 2nd floor of the East building. Take a left out of the elevator to access our office.

PLEASE COMPLETE ALL PAPERWORK IN BLACK OR BLUE INK

PATIENT INFORMATION

NAME:_____DOB_____AGE_____
First *MI* *Last*

_____
Address *City* *St* *Zip*

NOTE: If you would like to receive appointment reminders via text, please check the appropriate box. Text messaging rates may apply. We would appreciate having at least 2 phone numbers on file in case of emergency.

HOME # _____ CELL # _____ WORK #_____

☐ *OK to text* ☐ *Calls ONLY*

EMAIL_____ MARITAL STATUS:_____

EMPLOYER:_____OCCUPATION_____

HOW DID YOU HEAR ABOUT US?_____

WHO IS YOUR OPTOMETRIST?_____YEAR OF LAST EYE EXAM?_____

DEMOGRAPHIC

Ethnicity: ____Hispanic or Latino ____Not Hispanic or Latino

Race: ___American Indian or Alaska Native ____Asian ____Black or African American ____Native Hawaiian or Other Pacific Islander ___White ___Unknown ____Other

Language: ____English ____Spanish ____Other

PATIENT RELEASE FORM

The doctors / staff of Clear Advantage Vision Correction Center may release my medical information or answer questions about my care, either verbally or in writing, to the following: **(Please initial each appropriate answer and complete)**

_____ **Myself / Patient** *(Required in case you call our office requesting records or to verify / change appointments)*
(initials)

_____ **Family member(s)** – Name(s)_____
(initials)

_____ **Optometrist** or Name or Practice _____
(initials)

Address_____

Phone_____ **If the service was offered at no additional charge, would you be interested in seeing your optometrist for your follow up care after LASIK?* ____Yes ____No ____Not sure

_____ **Other** _____
(initials)

**** Please understand: Due to HIPAA regulations, without your consent, we can't discuss <u>anything</u> about you with <u>anyone</u>, including confirming appointment times.***

<u>ABOUT YOUR EVALUATION:</u> Your appointment is to determine your candidacy for LASIK procedures. Although the comprehensive evaluation will determine your prescription as well as your overall ocular health, this evaluation cannot be billed through your insurance company (unless it is an evaluation for cataracts), nor can we assist you with a prescription for glasses or contact lenses.

FOR OFFICE USE ONLY Counselor: KS AB HV KQ SB

Treatment: LASIK ZEISS MIXED MONO PRK BLADELESS VISIAN ICL RAINDROP STUDY
OD/OS/OU OD/OS/OU OD/OS/OU OD/OS OD/OS/OU OD/OS/OU OD / OS

SX Scheduled? Y N _____ Eye(s) OD OS OU LCA 15 20 1 _____

Call in RX / Given RX Pharm:_____

Follow up with regular OD? ___Yes ___No OD office_____
Co-managing packet sent? Y N _____ O.D. agrees to comanage? Y N

MEDICAL HISTORY

What type of glasses do you wear? □ Distance ONLY □ Reading ONLY □ Bi-Focals □ Tri-Focal / Progressive □ None

Do you wear contact lenses? Yes*_____ No**_____

*** If YES:** What type? ____Soft ____Soft Toric ____Hard / Gas Permeable

Number of years you have worn contact lenses? Years: _____

Were they mono-vision (one eye near, one eye far) or bi-focal lenses? Yes_____ No_____

In preparation for your exam today, what is the date you took out your contact lenses? Date:_____

*(**Note**: if you are having a <u>full</u> exam, you should be out of contact lenses prior to your evaluation: Soft=5 days / Toric=2 wks / Hard=8wks)*

****If NO:** Have you ever tried contact lenses? Yes_____ No _____

When you tried the lenses, how long did you wear them? _____years / months / days

What type were the lenses? ___Soft ____Soft Toric ____Hard / Gas Permeable

Have you ever had any prior eye surgery? If yes, please describe:

_____ □ None

Have you ever had an eye trauma (i.e. scratched cornea, something lodged in eye, etc.)? If yes, please describe:

_____ □ None

Have you ever been diagnosed with an eye condition / disease? (glaucoma, strabismus, keratoconus, lazy eye as a child, etc.)?
If yes, please describe:

_____ □ None

Any family history of eye problems (i.e. cataracts, macular degeneration, retinal detachment, etc.)? If yes, please describe and note your relationship to the individual (i.e. cataracts-grandmother, glaucoma-father, etc.)

_____ □ None

_____

Do you have any of the following? (Please check all that apply)

□ Diabetes (Type I)	□ Rheumatic disorders	□ Auto-immune deficiencies (Lupus, HIV, colitis, etc.)
□ Diabetes (Type II)	□ Stomach ulcers	□ Pregnant or actively trying to become pregnant**
□ Pacemaker	□ Keloid scarring	□ Breastfeeding**
□ Bleeding Disorders	□ Herpes Simplex / Zoster	** If pregnant or nursing please call the office prior to your appointment

□ Other:_____ □ None

Do you smoke? ___Yes ___No If yes, how many cigarettes per day?_____
Do you drink alcohol? ___Yes ___No If yes, how many drinks per week?_____

MEDICATIONS

Are you taking any of the following (please indicate with a √):

___ Prescription migraine medication (i.e. Imitrex or Accutane). If yes, date last taken:_____

___ Blood thinners (i.e. Coumadin, Plavix, Warfarin) □ None

Please list any medications and the condition you are treating:

_____ □ None

_____

Any allergies to medications (i.e. latex, iodine, valium, antibiotics, steroids, etc.) If yes, please list:

_____ □ None

_____

HIPAA CONSENT FORM

Our Notice of Privacy Practices provides information about our use of a patient's protected health information. The Notice contains a Patient Rights section describing your rights under the law. Patients have the right to access, inspect and copy protected health care information used to make decisions about them.

The Practice will only include information used to make decisions about the patient. This includes medical records, but does not include psychotherapy notes. Under some circumstances, such as increased risk of harm or injury, the Practice may withhold the requested information. The Privacy Officer of this Practice will evaluate this Request and notify the patient of our decision within fifteen (15) days of this Request. If the Request is approved, the Practice will provide the information within thirty (30) days or within sixty (60) days if such an extension is necessary. Reasonable costs will be charged for the Request. Costs will be submitted to the patient upon approval of the Request. The Practice may provide a summary of the requested information if you are agreeable. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), including subsequent modifications to the HIPPA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Omnibus Final Rule.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full-length Notice is available in our office.

Date of last revision: September 23, 2013 **Effective Date: Immediately**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information? Here are a few examples:

- For medical treatment
- To obtain payment for services
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and ensure all our patients receive quality care
- For research
- To avert a serious threat to health or safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain request arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our Office Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy your records
- The right to amend
- The right to an accounting of disclosures
- The right to an electronic copy of electronic medical records
- The right to restrict the disclosure to a health plan for those services for which you have paid out of pocket
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications
- The right to get a notice of a breach

I acknowledge that I have been given access to, and/or received a copy of the Providers Notice of Privacy Practices with the effective date of September 23, 2013.

The information contained in this document is accurate to the best of my knowledge. Signing this also serves as your authorization for your patient release form on page 2.

Today's Date:_____/_____/_____ **Patient Date of Birth:_____/_____/_____**

_____ _____

Printed name of person completing this form **Signature / Patient Signature**

_____

Witness Signature *(must be over 18 years old)*