**WELCOME TO OUR PRACTICE**

**Please fill out the following information completely:**

KERRY SOLOMON, MD

## 1. Patient Information:

Social Security No: _____ E-Mail Address: _____

Name: (Last) _____ (First) _____ (M.I.) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Sex: M F Marital Status: S M D W

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Race: ☐ American Indian ☐ Alaska Native ☐ Asian ☐ African American ☐ Caucasian
☐ Native Hawaiian or other Pacific Islander ☐ Unknown ☐ Decline to answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to answer

Employed: ☐ No ☐ Full Time ☐ Part Time ☐ Retired Business Phone: _____

Name of Employment or School: _____

## 2. Guarantor Information: Same as Above: ☐ Yes If patient is a minor please fill out.

Social Security No: _____ E-Mail Address: _____

Name: (Last) _____ (First) _____ (M.I.) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Sex: M F Marital Status: S M D W

Employed: ☐ No ☐ Full Time ☐ Part Time ☐ Retired Business Phone: _____

Name of Employment or School: _____

## 3. Insurance Information:

Primary Insurance: _____ Policy #: _____

Insured's Name: _____ DOB: _____ Insured's SS# _____

Insured's Employment: _____ Work Phone: _____

Secondary Insurance: _____ Policy #: _____

Insured's Name: _____ DOB: _____ Insured's SS# _____

Insured's Employment: _____ Work Phone: _____

## 4. Appointment Information:

Family Doctor: _____ Referring Doctor's Name: _____

Who is your eye doctor? _____

How did you hear about us? _____

**List any family members who are patients:** _____

_____

**Emergency Contact:**

Name: _____ Relationship: _____ Phone No: _____

**Pharmacy:**

Pharmacy Name: _____ Pharmacy Location: _____

Pharmacy Phone: _____

KERRY SOLOMON, MD

Patient Name: _____ DOB: _____

## Eye History:

Have you experienced or been diagnosed with any of the following:

- ☐ Cataract
- ☐ Glaucoma
- ☐ Amblyopia
- ☐ Retinal Detachment
- ☐ Dry Eyes
- ☐ Macular Degeneration
- ☐ Diabetes
- ☐ Migraines
- ☐ Other _____

Please describe the reason for your visit:_____

_____

What activity would you look forward to most with improved vision? _____

Have you ever experienced a serious eye injury or had eye surgery? _____

Explain: _____

Date of your last exam: _____

Please list any eye drops or eye medications you are currently using: _____

_____

## Medical History:

Do you have any medication allergies? _____

If so, please list: _____

Have you ever been diagnosed with any of the following?

- ☐ Asthma
- ☐ Stroke
- ☐ Thyroid
- ☐ Cancer
- ☐ Arthritis
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Bleeding Disorder
- ☐ Diabetes

Please list your current medications and dosages:

_____ _____ _____

_____ _____ _____

Please list prior major surgeries: _____

Have you ever had a flu shot? ☐ Yes ☐ No

Have you ever had a pneumonia shot? ☐ Yes ☐ No

## Family History:

Has anyone in your immediate family been diagnosed with any of the following?

- ☐ Glaucoma
- ☐ Cataract
- ☐ Blindness
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Other _____
- ☐ Macular Degeneration
- ☐ Crossed or Lazy Eye

## Social History:

Do you smoke? Yes / No If so, how many packs per day? _____

Has there been any change in your weight in the past 6 months? Yes / No Gain / Loss

Do you drink alcoholic beverages? Yes / No

If so, how much? Socially / With Meals / 2-3 Per Week / More _____

Are you pregnant or planning? Yes / No

Your Occupation: _____ Hobbies: _____

Reviewed with patient by:_____ On: _____

KERRY SOLOMON, MD

# PATIENT VISUAL ASSESSMENT QUESTIONNAIRE

Patient Name: _____ DOB: _____ MRN #: _____

| **Please complete this form to assist us in better understanding your current visual state. Do your wear glasses or contact lenses?** | **Yes** ☐ | **No** ☐ |
|---|---|---|

If yes, please answer each question as if you are wearing your glasses or contact lenses.

1. **Does your distance vision seem impaired?** ☐ ☐
   If yes, for what activities is your distance vision most bothersome (check all that apply)
   ❑ Driving/traffic signs ❑ Watching TV/sports scores
   ❑ Store signs/menu boards ❑ Golf ❑ Tennis
2. **Does your near vision seem impaired?** ☐ ☐
   If yes, what activities is your near vision most bothersome (check all that apply)
   ❑ Reading books/newspaper ❑ Writing checks/completing forms
   ❑ Food labels/recipes ❑ Sewing/knitting ❑ Carpentry
3. **Are you bothered by glare and or halos when driving?** ☐ ☐
   If yes, when do you notice it the most?
   ❑ During the day due to sunlight ❑ At night due to bright lights ❑ Both
4. **Have you ever had refractive surgery?** ☐ ☐
   *Refractive eye surgery is any eye surgery used to improve the refractive state of the eye and decrease or eliminate dependency on glasses or contact lenses.* If yes, select which procedure you had:
   ❑ LASIK or PRK - hyperopic ❑ LASIK or PRK - myopic
   ❑ RK ❑ unknown type
5. **Have you worn monovision contacts in the past?** ☐ ☐
   *Monovision is one option for presbyopia. Monovision means one eye is corrected for distance vision and the fellow eye is corrected for near vision.* If yes, how did you fair?
   ❑ Tried and did not tolerate ❑ Tried and did fairly well
   ❑ Enjoyed and/or currently wearing monovision contacts successfully
6. **Do you prefer to be less dependent on glasses?** ☐ ☐
7. **Would you be willing to pay out of pocket to reduce your need for glasses?** ☐ ☐
8. **Would you prefer to be less dependent on glasses for distance only, or distance and near?** ❑ Distance only ❑ Distance and near
9. **If you had to wear glasses after surgery, what activities do you prefer to wear them for?**
   ❑ Near (reading) ❑ Intermediate (computer) ❑ Distance (driving)

**By signing below you understand that cataract surgery is performed to alleviate visual impairments attributable to lens opacity. If your vision is unsatisfactory (even with glasses) and cataract surgery is medically indicated, are you interested in pursuing cataract surgery?** ☐ ☐

Patient Signature: _____ Date: _____

KERRY SOLOMON, MD

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

I understand your *Notice to Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

Patient name: _____ DOB: _____

Signature (of Patient or Legal Guardian): _____

Date: _____

*****I authorize the following to have access to my complete health records:**

_____

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**PRACTICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgment of the Notice of Privacy Practices Acknowledgment but was unable to do so as documented below:

| Date: | Initials: | Reason: |
|---|---|---|
| | | |

KERRY SOLOMON, MD

# FINANCIAL RESPONSIBILITY AND WAIVER/RELEASE

I understand that it is the patient's responsibility to supply CAROLINA EYECARE PHYSICIANS, LLC with any current insurance information and/or any referral authorization forms that may be necessary for my insurance. I am aware that if I have a routine diagnosis my Insurance may not cover this appointment. If this account results in collection agency involvement, the undersigned guarantor agrees to pay all legally allowed interest and associated fees. I authorize CAROLINE EYECARE PHYSICIANS, LLC to receive all payments for medical services rendered to my dependents or myself. These authorizations will remain on file for all future treatment. I AM AWARE THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCES.

I understand that Medicare and most Insurance companies do not cover standard care or eye refraction (eyeglass prescriptions) and that I will be fully responsible for these charges. I understand that insurance companies require beneficiaries to pay deductibles, company insurance, co-payments, and any non-covered services at the time services are rendered.

Most insurance companies do not cover the contact lens fitting or contact lens modification. The contact lens modification is a yearly charge that is separate from the eye exam charge. I understand that I am responsible for this additional charge.

I understand that a comprehensive eye exam involves dilation of the pupil, which may temporarily blur my vision for several hours. I recognize that operation of a motor vehicle after dilation may be hazardous and I have made appropriate arrangements.

IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. WE GLADLY ACCEPT CASH, CHECK, MC, VISA, AMERICAN EXPRESS, AND DISCOVER.

1) Date: _____ Signature _____

I authorize CAROLINA EYECARE PHYSICIANS, LLC to obtain information from other physicians that they may feel is beneficial in their evaluation or treatment. I authorize the physicians of CAROLINA EYECARE PHYSICIANS, LLC to furnish information to insurance carriers or other doctors concerning my illness and treatment. They may also obtain pre-certification and prior authorization when necessary.

2) Date: _____ Signature _____

Reviewed by: _____

KERRY SOLOMON, MD

# WHAT IS A *REFRACTION*?

***Refraction*** refers to the testing used to determine your best possible vision in each eye. Your doctor recommends refraction at the time of your annual exam or anytime you present with a visual complaint.

**A visual complaint cannot be addressed without this service, and we cannot prescribe glasses or contacts if refraction is not performed.**

**If you are considering cataract surgery, a refraction must be performed within 90 days of surgery.**

The fee for refraction is **$60.00** and **is not** covered by most insurance carriers.

I hereby acknowledge that I have read the above. I understand that if I elect to have a refraction performed, I will be responsible for a fee of $60.00 at the time of the service. I also understand that if I decline this service, I will not receive a prescription for glasses and/or contacts nor will I be able to proceed with cataract surgery.

❒ Accept

❒ Decline

Signature of Patient

Date

KERRY SOLOMON, MD

Dear Valued Patient,

Before your visit, we would like to inform you about your options for Advanced Vision Testing and Advanced Surgery Options.

**Why does Dr. Solomon recommend Advanced Vision Testing?**

- It is required in order to be eligible for any Advanced Surgery Options.
- This testing can detect early signs of eye conditions, such as Macular Degeneration, that standard tests cannot.
- This additional testing will give you a complete look at the health of your vision and help you make better, more informed decisions about your care.

**What are Advanced Surgery Options?**

- Advanced Surgery Options may include Laser-Assisted Cataract Sugery and Premium Lens Implants.
- These advanced technologies can provide added benefits, such as astigmatism correction and more independence from glasses.
- Options may be available to help you achieve freedom from glasses for distance and/or reading.
- Not all options are an ideal fit for every patient. Advanced Vision Testing allows Dr. Solomon to recommend the options that will work best for your individual case.
- Because these options are considered elective, they do entail out of pocket expenses not covered by insurance. This cost varies based on the specific options selected.

**How much does Advanced Vision Testing Cost?**

- The cost for this additional testing is $225. It is not covered by insurance.

*Please check one of the below and sign:*

☐ **Yes, I want to learn more about Advanced Surgery Options that can help me reduce my dependence on glasses and contacts.** I understand that if I elect any of these options, I will be responsible for out-of-pocket expenses, and that I will have to undergo Advanced Vision Testing. I am aware that there is a fee of $225 due at the time of this testing, which is not covered by insurance.

☐ **No, I am not interested in any elective options for reducing my dependence on glasses and contacts.** I do not wish to undergo Advanced Vision Testing, and I will only be pursuing traditional cataract surgery, which is billable to most medical insurance providers.

_____ _____

**Signed** **Date**

KERRY SOLOMON, MD

# Cataract Surgery Eye Drop Options/Instructions

We offer three options of surgery drops for use before and after your Cataract Surgery. We understand these drops can become costly therefore our goal is to provide you an option that is most affordable for you. **Please review all three options and indicate your choice of drops by checking the box next to the option you prefer.** If you have any questions, we will discuss them with you at the time of your appointment.

## ❑ Option 1: BRANDED EYE DROPS

**VIGAMOX (Antibiotic)**

- Start 3 days before surgery.
- Use one (1) drop in operative eye four (4) times per day.
- Continue for two (2) weeks after surgery then stop.

**ILEVRO (Non-Steroidal Anti-Inflammatory)**

- Start 3 days before surgery.
- Use one (1) drop in operative eye one (1) times per day.
- Continue for four (4) weeks after surgery then stop.

**DUREZOL (Steroid Anti-Inflammatory)**

- Start using one (1) hour prior to surgery arrival.
- Use one (1) drop in operative eye every fifteen minutes.
- After surgery continue four (4) times per day for two (2) weeks
- Beginning the third (3) week after surgery use one (1) drop two (2) times per day for two (2) weeks then stop.

*SHAKE ALL BOTTLES BEFORE USING – USE 3 MINUTES APART*

*** The cost will vary based on your insurance coverage. Many of our patients have reported these drops cost in excess of $400.00. These drops are available at your local pharmacy.**

## ❑ Option 2: GENERIC EYE DROP SUBSTITUTIONS

**OFLOXACIN (Antibiotic)**

- Start 3 days before surgery.
- Use one (1) drop in operative eye four (4) times per day.
- Continue for two (2) weeks after surgery then stop.

**KETOROLAC 0.5% (Nonsteroidal Anti-Inflammatory)**

- Start 3 days before surgery.
- Use one (1) drop in operative eye four (4) times per day.
- Continue for two (2) weeks after surgery.
- Beginning the third (3) week after surgery use one (1) drop two (2) times per day for two (2) weeks then stop.

**PREDNISOLONE ACETATE (Steroid Anti-Inflammatory)**

- Start using after surgery
- Use one (1) drop to operative eye four (4) times per day for two (2) weeks.
- Beginning the third (3) week after surgery use one (1) drop two (2) times per day for two (2) weeks then stop.

*SHAKE ALL BOTTLES BEFORE USING – USE 3 MINUTES APART*

*** The cost will vary based on your insurance coverage. Many of our patients have reported these drops cost in excess of $300.00. These drops are available at your local pharmacy.**

## ❑ Option 3: COMPOUNDED EYE DROP

**PRED-GATI-BROM (Antibiotic, Non-Steroidal Anti-Inflammatory, Steroid Anti-Inflammatory)**

- Start one day before surgery.
- Use One (1) drop three (3) times a day in the operative eye.
- Use until gone.

***The cost is $75.00 per bottle plus $10.00 shipping and handling. This drop is not covered by most insurance plans. If you choose this option Imprimis pharmacy will contact you within 24 hours to take payment and confirm mailing address. These drops are delivered to your home and are not available at your local pharmacy.**

**Imprimis Pharmacy: (858) 704-4644**

**You are not able to take advantage of this option if you have an allergy to Levaquin or Vigamox antibiotics.*

*** If you have agreed to participate in a research study, this option may not be available.*