Corneal Consultants of Indiana d/b/a Price Vision Group

Acknowledgment

I hereby acknowledge that Corneal Consultants of Indiana made available to me a copy of their Notice of Privacy Practices.

_____ _____

Patient or Patient's Representative **Date**

_____

Representative's Relationship to Patient

Patient refused to sign:

_____ _____

Employee **Date**

Price Vision Group

9002 N. Meridian Street, Suite 106A
Indianapolis, IN 46260-5349
(317) 814-2933
www.pricevisiongroup.com

Patient Information Record

Name of Patient: _____ Date: _____

Address: _____City: _____ State: _____ ZIP: _____

Home #: _____ Work #: _____ Alternate #: _____

Personal E-Mail Address: _____

Business E-Mail Address: _____

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

Social Security #: _____ Marital Status: ☐ Single ☐ Married

Occupation (if retired, previous occupation): _____

Employer: _____

Employer Address: _____

_____

Emergency Contact

Name: _____ Telephone #: _____

Name of Family Physician: _____

You, as the patient, will be expected to pay our stated fees. In all cases, the patient will have to pay our fees in full prior to examinations and surgery and file the claim themselves to recover whatever the insurance company will pay, if anything.

I have read the above and understand that I will be responsible for payment of any part of my VISION CORRECTION examinations and surgery and that such balance is due at the time of service.

_____

Signed by Printed Name Date

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Patient History

Name of Patient: _____

Why are you interested in refractive surgery? (Check all that apply)

- ☐ Decrease dependency on glasses or contacts
- ☐ Unable to wear contact lenses
- ☐ Appearance or fashion
- ☐ Work related reasons
- ☐ Improved self-image
- ☐ Undecided

How did you hear about us? (Check all that apply)

- ☐ Friend (Name?)
- ☐ Family (Name?)
- ☐ Patient (Name?)
- ☐ Eye Doctor (Name?)
- ☐ Other Doctor (Name?)
- ☐ Internet Search
- ☐ Social Media
- ☐ Event/Fair (Name?)
- ☐ Newspaper
- ☐ Radio
- ☐ Seminar
- ☐ Television

Write name here: _____

Other: _____

Check the box for YES to each of the following if you currently have:

- ☐ AIDS or HIV exposure
- ☐ Cataracts
- ☐ Epilepsy
- ☐ Retinal Detachment History
- ☐ History of Herpes Simplex Eye Disease
- ☐ Taking Aspirin, Blood Thinners, Cortisone
- ☐ Exposed, infected or in close contact with MRSA (Methacillin Resistant Staph Aureus) or MRSE (Methacillin Resistant Staph Epidermidus)
- ☐ Pregnant or Nursing
- ☐ Diabetes or Hypoglycemia
- ☐ Glaucoma
- ☐ Stroke or Vascular Disease
- ☐ Autoimmune Disease
- ☐ Dry Eyes
- ☐ Rheumatoid Arthritis
- ☐ Cigarette Smoker
- ☐ Drink Alcohol
- ☐ Family History of Keratoconus or Corneal Transplant

Please explain any YES answers above or any information we should be aware of prior to your surgery:

_____

_____

_____

List all allergies	**List all medications**	**Strength**	**Dosage**
_____	_____		
_____	_____		
_____	_____		

Have you previously had any problems taking the following:

Valium (diazepam) - mild sedation medication

☐ No ☐ Never taken ☐ Yes (explain) _____

Last eye exam (date and location) _____

Did they refer you here? ☐ Yes ☐ No

How long since you've last worn your contact lenses? _____

☐ Soft ☐ Hard ☐ Gas-permeable

Have you been out of the country in the last year? ☐ **YES** ☐ **NO**

If yes, please list location: _____

Check the box for YES to each of the following:

SKIN
- ☐ Eczema
- ☐ Rashes in last 6 months
  Location: _____
- ☐ Ulcers (legs)

EYES
- ☐ Eye disease
- ☐ Glaucoma

RESPIRATORY
- ☐ Allergies
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Tuberculosis

CARDIOVASCULAR
- ☐ Heart disease
- ☐ Stroke
- ☐ High blood pressure

PSYCHIATRIC
- ☐ Nervous breakdown

GASTROINTESTINAL
- ☐ Hernia
- ☐ Stomach trouble
- ☐ Ulcers (stomach)
- ☐ Ulcers (duodenal)

GENITOURINARY
- ☐ Hemorrhoids
- ☐ Kidney disease
- ☐ Venereal disease

MUSCULOSKELETAL
- ☐ Lupus
- ☐ Rheumatoid arthritis
- ☐ Swollen/red joints

NEUROLOGICAL
- ☐ Chronic headaches
- ☐ Epilepsy
- ☐ Neuritis

LIST OTHER ILLNESSES

_____
_____
_____
_____

ENDOCRINE
- ☐ Autoimmune disease
- ☐ Cancer-tumors
- ☐ Diabetes
- ☐ Diverticulosis
- ☐ Gout
- ☐ Liver disease
- ☐ Pancreatitis
- ☐ Thyroid disease
- ☐ Unexplained weight loss/gain

HEMATO-IMMUNOLOGIC
- ☐ Exposure to AIDS
- ☐ Positive HIV
- ☐ Chicken pox
- ☐ Hepatitis
- ☐ Malaria
- ☐ Measles
- ☐ Mumps
- ☐ Mononucleosis
- ☐ Rheumatic fever
- ☐ Bleeding tendencies
- ☐ Exposure to MRSA
- ☐ Exposure to MRSE

EYE SURGERY/OPERATIONS	MONTH-YEAR	NAME OF HOSPITAL
_____	_____	_____
_____	_____	_____
_____	_____	_____

OTHER OPERATIONS	MONTH-YEAR	NAME OF HOSPITAL
_____	_____	_____
_____	_____	_____
_____	_____	_____

		IF LIVING HEALTH STATUS				IF DECEASED	
Family	**Age**	**Good**	**Fair**	**Poor**	**Known illnesses**	**Age at death**	**Eye Diseases**
Father	____	☐	☐	☐	_____	____	_____
Mother	____	☐	☐	☐	_____	____	_____
Siblings	____	☐	☐	☐	_____	____	_____
_____	____	☐	☐	☐	_____	____	_____
_____	____	☐	☐	☐	_____	____	_____
_____	____	☐	☐	☐	_____	____	_____
_____	____	☐	☐	☐	_____	____	_____

Patient Signature _____ **Date** _____

Corneal Consultants of Indiana, P.C., d/b/a Price Vision Group
9002 N. Meridian St, #100 · Indianapolis, IN 46260
Phone: (317) 844-5530 · Fax: (317) 844-5590

EMAIL COMMUNICATION CONSENT FORM

PATIENT:

_____ _____
Name of Patient/Previous Names Birth Date

_____ _____
Street Address City, State, Zip Code Current Email Address

For the ease of our patients, our office would like to offer the opportunity to communicate by email. Transmitting patient information poses several risks and the patient should not agree to communicate with the practice via email without understanding and accepting these risks. This consent authorizes Price Vision Group and its affiliated health care providers (all referenced here as "PVG") to communicate with me using open internet email channels. The specific email address that I am currently using is noted above. However, this consent allows PVG to communicate with me using any email address that I provide to PVG, and/or any email address that I send communications to PVG.

I authorize PVG to notify me of appointments by email appointment reminders. In addition, I authorize PVG to share information about its programs and services offered in the community, including programs or services specific to me, using email communications. I may also receive patient surveys, promotional offers or information about PVG charities and fundraising programs.

I understand that I can "opt out" of the use of email as a means of communication by sending an email to PVG at pvgclinic@pricevisiongroup.net or by calling (800)317-3937. I understand that some messages already scheduled for delivery may be sent after I opt out, and I authorize PVG up to ten business days to fully process my opt-out request.

The risks include, but are not limited to, the following:
- The privacy and security of email communication cannot be guaranteed.
- Email senders can misaddress, resulting in it being sent to many unintended recipients.
- Employers/online services may have a legal right to inspect and keep emails that pass through their system.
- Even after deletion of the email, back-up copies may exist on a computer.
- Email is easier to falsify than signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient read the email.
- Emails can introduce viruses, generally damage, or disrupt the computer.
- Email can be used as evidence in court.

Conditions of using email
Our office will use reasonable means to protect the security and confidentiality of email information sent and received—however; we cannot guarantee the security of email communication. Thus, patients must consent to the use of email for patient information, billing, and communication. Consent to use email includes agreement with the following conditions:
- Emails to or from the patient concerning treatment may be printed in full and made part of the patient's medical record. Because they are part of the medical record, authorized individuals will have access the medical record/email (e.g. billing staff).
- Our office may forward emails internally to those involved, as necessary, for healthcare operations and other handling. Our employees will not forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
- Although our office will endeavor to read and respond promptly to all emails from the patient, it is not guarantee that any particular email will be read and responded to within any particular period of time. The patient should not use email for medical emergencies or other time- sensitive matters.
- If the patient's email invites a response from the provider and a response is not received within a reasonable time period, it is the patient's responsibility to follow up.

I have read and understand the risks of using email and agree that email messages may include protected health information about me or the patient named below (if I am signing as the patient's representative).

PATIENT SIGNATURE: _____ DATE: _____
(If signed by other than patient, state relationship and authority to do so.)

PVGEMAILRELEASE Rev 8.12.2024

Price Vision Group

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Insurance Coverage For Laser Vision Correction

At the present time very few health insurance plans cover refractive surgery (LASIK) due to the fact that this is an **elective** procedure. This means that your refractive error is able to be corrected non-surgically. Therefore, you will be expected to pay for your surgery in full at the stated fees.

If you have LASIK coverage with your insurance carrier, we will supply the necessary information for you to submit to your insurance carrier, upon request.

Our normal fees include post-operative care and free enhancement within the one-year period upon completion of post-operative care (unless otherwise directly stated).

No insurance will be filed for exams, testing, procedures, or any other services provided by Price Vision Group Refractive Clinic.

Your cooperation is appreciated.

The Doctors and Staff of Price Vision Group

☐ **I have read the above and understand that I will be responsible for payment of all fees from my elective refractive surgery.**

☐ **I have read the above and declare that I am responsible for payment of all exam and testing fees in full at the time of service. If a medical diagnosis is found, a referral will be made to an appropriate provider.**

Patient Signature **Patient Name Printed** **Date**