Clemson Eye

Toll-free: 855-654-2020
Web: clemsoneye.com

Dear Patient,

Your eye health and satisfaction are our primary concerns. For over 40 years, our highly trained team of doctors and staff have offered the most advanced examinations, procedures and technology available. My colleagues and I work closely with local referring doctors to deliver the best, precision-driven results for our patients.

Please complete the enclosed forms and give them to the receptionist when you arrive:

- Patient Information and Patient Privacy Practices
- Medical History (list your current medications)
- Financial Policy & Non-Covered Services
- Dry Eye Questionnaire

Also, bring with you:

- Eye glasses and/or contact lenses you currently use
- Medical &/or Vision Plan Insurance cards (including primary policy holder information),
- Referral letter, if required by your insurance
- Photo identification and a Form of Payment

A comprehensive eye exam takes about 1 to 1 ½ hours. If you have time restrictions, please let us know upon your arrival. Your eyes will be thoroughly examined by the doctor, additional tests may be performed and, in some cases, treatment may be initiated. If your pupils are dilated, it will cause temporary minor blurriness and light sensitivity that can last for several hours. Please exercise caution if you are driving and wear sunglasses or have someone transport you.

Upon completion of your exam, covered charges for our services will be billed directly to your insurance provider and you will be responsible for paying for any co-pays, co-insurance, deductibles, and non-covered services. If you have both a Vision Care Plan (such as VSP and EyeMed) and Medical Insurance, then tell us which you type of coverage you wish to use. Vision Care plans only cover routine exams plus eyeglasses and contact lenses. However, your Medical Insurance must be used if you have any eye or systemic health problem that requires care. Your doctor will determine if these conditions apply to you, but some are determined by your case history. Clemson Eye accepts cash, check and credit cards and payment plans are available for higher balances. We look forward to serving you soon!

Sincerely

Sherri Mann
Patient Service Specialist

Anderson
2011 E Greenville St
Anderson, SC 29621
Office: 864-622-5000
Fax: 864-622-5020

Clemson
931 Tiger Blvd
Clemson, SC 29631
Office: 864-654-6706
Fax: 864-654-3275

Easley
15 Southern Center Ct
Easley, SC 29642
Office: 864-855-6800
Fax: 864-855-6850

Greenville
360 Pelham Rd
Greenville, SC 29615
Office: 864-268-1000
LASIK: 864-297-8777
Fax: 864-292-2020

Simpsonville
877 NE Main St
Simpsonville, SC 29681
Office: 864-967-8582
Fax: 864-963-3232

Clemson Eye

Patient Information and Privacy Practices

Patient Information

Name: _____
First Middle Last

Address: _____

City: _____ State: _____ Zip: _____

Tel: _____ Cell: _____ Email: _____

Birth Date (Mo/Day/Yr): _____ Age: _____ Sex: _____ Social Security #: _____

Name of Insurance: _____ Policy Holder Name: _____

Birth Date (Mo/Day/Yr): _____ Social Security #: _____
Policy Holder Policy Holder

Family Physician: _____

Optometrist: _____ Tel: _____

Referring Physician: _____ Tel: _____

Emergency Contact (Relationship): _____ Tel: _____

Employer: _____ Tel: _____

How Did You Hear About Us?

Friend ☐ Referring Doctor ☐ E-blast ☐ Website ☐ Billboard ☐ Radio ☐ Print ☐ Other ☐

Patient Electronic Information Disclosure

Patients in our practice may be contacted via email or text messaging for appointment reminders, eyewear ready notifications, and other communications related to Clemson Eye services, health care news, new technology, special offers, etc. If, at any time, you do not wish to receive these communications, you can revoke permission by following the "unsubscribe" information at the bottom of any email or by replying "STOP" to any text message you receive from us.

Notice of Privacy Practices:

I authorize the following person(s) to have access to my health information

Name / Relationship to Patient: _____

Name / Relationship to Patient: _____

By signing this form, I acknowledge receipt of the Notice of Provider Privacy Practices of Clemson Eye, which outlines how they may use and disclose my protected health information. I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in the document by sending a written notification to Clemson Eye P.A. I understand that their Notice of Provider Privacy Practices is subject to change and that I may obtain a copy of the revised notice or ask any questions by contacting Clemson Eye at 855-654-2020. I hereby authorize Clemson Eye to release my health information for purposes of treatment, payment and healthcare operations as described in Clemson Eye Visual Health and Surgery's Notice of Provider Privacy Practices.

Name: _____ Date: _____
Patient / Guardian / Guarantor

Signature: _____

Please Turn Over

This Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Clemson Eye, PA must maintain the privacy of your personal health information and give you this notice that describes our legal duties and privacy practices concerning your personal health information. In general, when we release your health information, we must release only the information we need to achieve the purpose of the use or disclosure. However, all of your personal health information that you designate will be available for release if you sign an authorization form, if you request the information for yourself, to a provider regarding your treatment, or due to a legal requirement. We must follow the privacy practices described in this notice.

We reserve the right to change the privacy practices described in this notice, in accordance with the law. Changes to our privacy practices would apply to all health information we maintain. If we change our privacy practices, you will receive a revised copy.

Without your written authorization, we can use your health information for the following purposes:

1. Treatment: For example, a doctor may use the information in your medical record to determine which treatment option, such as a drug or surgery, best addresses your health needs. The treatment selected will be documented in your medical record, so that other health care professionals can make informed decisions about your care.

2. Payment: In order for an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis, and the treatment provided to you. As a result, we will pass such health information onto an insurer in order to help receive payment for your medical bills.

3. Health Care Operations: We may need your diagnosis, treatment, and outcome information in order to improve the quality or cost of care we deliver. These quality and cost improvement activities may include evaluating the performance of your doctors, nurses and other health care professionals, or examining the effectiveness of the treatment provided to you when compared to patients in similar situations.

In addition, we may want to use your health information for appointment reminders or to re-schedule appointments. For example, we may look at your medical record to determine the date, time and type of your next appointment with us, and then send you a reminder or re-scheduling letter or have our automatic telephone appointment reminder system call to help you remember the appointment. Or, we may look at your medical information and decide that another treatment or a new service we offer may interest you. For example, we may contact patients who are potential candidates for Laser Refractive Surgery (LASIK), BOTOX, or certain Plastic Treatments or Procedures. Furthermore, we may want to use information found in your medical record, such as your name, address, phone number and treatment dates, to contact you for our fund-raising purposes. For example, in order to provide more charity care or otherwise improve the health of your community, we may want to raise additional money and therefore may contact you for a donation.

4. As required or permitted by law: Sometimes we must report some of your health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries, or to respond to a court order.

5. For public health activities: We may be required to report your health information to authorities to help prevent or control disease, injury, or disability.

This may include using your medical record to report certain diseases, injuries, birth or death information, information of concern to the Food and Drug Administration, or information related to child abuse or neglect. We may also have to report to your employer certain work-related illnesses and injuries so that your workplace can be monitored for safety.

6. For health oversight activities: We may disclose your health information to authorities so they can monitor, investigate, inspect, discipline or license those who work in the health care system or for government benefit programs.

7. For activities related to death: We may disclose your health information to coroners, medical examiners and funeral directors so they can carry out their duties related to your death, such as identifying the body, determining cause of death, or in the case of funeral directors, to carry out funeral preparation activities.

8. For organ, eye or tissue donation: We may disclose your health information to people involved with obtaining, storing or transplanting organs, eyes or tissue of cadavers for donation purposes.

9. For research: Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research. Such research might try to find out whether a certain treatment is effective in curing an illness.

10. To avoid a serious threat to health or safety: As required by law and standards of ethical conduct, we may release your health information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to your or the public's health or safety.

11. For military, national security, or incarceration/law enforcement custody: If you are involved with the military, national security or intelligence activities, or you are in the custody of law enforcement officials or an inmate in a correctional institution, we may release your health information to the proper authorities so they may carry out their duties under the law.

12. For workers' compensation: We may disclose your health information to the appropriate persons in order to comply with the laws related to workers' compensation or other similar programs. These programs may provide benefits for work-related injuries or illness.

13. For Clemson Eye, PA's directory (should one exist): Unless you object, we may use your health information, such as your name, location in our facility, and your general health condition (e.g., "stable," or "unstable") for our directory. It is our duty to give you enough information so you can decide whether or not to object to release of this information for our directory. The information about you contained in our directory will be released to people who ask for you by name. We may allow you to agree or disagree orally regarding the use of your health information for directory purposes.

14. To those involved with your care or payment of your care: If people such as family members, relatives, close personal friends or other persons or organizations are helping care for you or helping you pay your medical bills, we may release important health information about you to those people in person, by letter, by telephone, by facsimile (fax), or by electronic mail (e-mail). The information released to these people may include your location within our facility, your general condition, or death. You have the right to object to such disclosure, unless you are unable to function or there is an emergency. In addition, we may release your health information to organizations authorized to handle disaster relief efforts so those who care for you can receive information about your location or health status. We may allow you to agree or disagree orally to such release, unless there is an emergency. It is our duty to give you enough information so you can decide whether or not to object to release of your health information to others involved with your care.

Note: Except for the situations listed above, we must obtain your specific written authorization for any other release of your health information.

If you sign an authorization form, you may withdraw your authorization at any time, as long as your withdrawal is in writing. If you wish to withdraw your authorization, please submit your written withdrawal to the Privacy Officer at Clemson Eye, PA.

Your Health Information Rights

You have several rights with regard to your health information. If you wish to exercise any of the following rights, please contact the Privacy Officer at Clemson Eye, PA. Specifically, you have the right to:

1. Inspect and copy your health information: With a few exceptions, you have the right to inspect and obtain a copy of your health information. However, this right does not apply to psychotherapy notes or information gathered for judicial proceedings, for example. In addition, we may charge you a reasonable fee if you want a copy of your health information.

2. Request to correct your health information: If you believe your health information is incorrect, you may ask us to correct the information. You will be asked to make such requests in writing and to give a reason as to why your health information should be changed. However, if we did not create the health information that you believe is incorrect, or if we disagree with you and believe your health information is correct, we may deny your request.

3. Request restrictions on certain uses and disclosures: You have the right to ask for restrictions on how your health information is used or to whom your information is disclosed, even if the restriction affects your treatment or our payment or health care operation activities. Or, you may want to limit the health information provided to family or friends involved in your care or payment of medical bills. You may also want to limit the health information provided to authorities involved with disaster relief efforts. However, we are not required to agree in all circumstances to your requested restriction. If you receive certain medical devices, (for example, life-supporting devices used outside our facility), you may refuse to release your name, address, telephone number, social security number or other identifying information for purpose of tracking the medical device.

4. As applicable, receive confidential communication of health information: You have the right to ask that we communicate your health information to you in different ways or places. For example, you may wish to receive information about your health status in a special, private room or through a written letter sent to a private address. We must accommodate reasonable requests.

5. Receive a record of disclosures of your health information: In some limited instances, you have the right to ask for a list of the disclosures of your health information we have made during the previous six years, but the request cannot include dates before April 14, 2003. This list must include the date of each disclosure, who received the disclosed health information, a brief description of the health information disclosed, and why the disclosure was made. We must comply with your request for a list within 60 days, unless you agree to a 30-day extension, and we may not charge you for the list, unless you request such list more than once per year. In addition, we will not include in the list disclosures made to you, or for purposes of treatment, payment, health care operations, our directory, national security, law enforcement/corrections, and certain health oversight activities.

6. Obtain a paper copy of this notice: Upon your request, you may at any time receive a paper copy of this notice, even if you earlier agreed to receive this notice electronically. The Notice of Provider Privacy Practices may be found on the web site of Clemson Eye, PA, www.clemsoneye.com, and is available electronically.

7. Complain: If you believe your privacy rights have been violated, you may file a complaint with us and with the federal Department of Health and Human Services. We will not retaliate against you for filing such a complaint. To file a complaint with either entity, please contact the Privacy Officer of Clemson Eye, PA, who will provide you with the necessary assistance and paperwork.

Again, if you have any questions or concerns regarding your privacy rights or the information in this notice, please contact the Privacy Officer of Clemson Eye, PA. Effective Date: January 1, 2010.

Clemson Eye

Financial Policy

Clemson Eye, PA is committed to being a leader in visual health and surgery, offering our patients the best results using the most advanced technology. Please assist us in achieving these goals by complying with our financial policy and verifying your health plan coverage (co-pay, deductible, shared costs) prior to your visit.

Forms of Payment	Cash, check, debit, major credit card, or payment plan.
Co-Pays, Deductibles, Shared costs	All Medicare, Medicaid, and other health plan co-pays, deductibles, and shared costs are payable on the date of service, otherwise a fee of $20 will be added to your bill as a fee for late payment. We verify your benefits, to the best of our ability. However, it is ultimately your responsibility to know your coverage.
Medicare	We are contracted providers and will file all Medicare claims. At the time of service, you are responsible for 20% of the Medicare allowable fee, plus the deductible and any other service charges not covered by Medicare. Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862(a)(I) of the Medicare law. If Medicare denies payment, by signing below you agree to be personally and fully responsible for payment. You also agree that payment of authorized Medicare / Medigap benefits be made payable to Clemson Eye, PA for services rendered by Clemson Eye. Your signature will also authorize any holder of medical information about you to release to the Heath Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.
Medicaid	A current copy of the Medicaid card is required prior to treatment or the patient will be rescheduled.
Private Health & Vision Plans	If we are a contracted provider for your health or vision plan, then we will file your health or vision claims. Your plan will directly pay Clemson Eye, PA for services rendered, but if they fail to do so, you are responsible for payment.
Self-Pay	If you do not have health or vision plan coverage, we are happy to provide an estimate of our professional fees. Generally, an eye exam costs between $70-$200. Your balance due will be calculated and payable at the completion of our services. We offer payment plans or you may reschedule your appointment until you have sufficient funds.
WC	Workers Compensation authorization is required prior to the appointment.
Non-Covered Services	Payment for all non-covered services is due at the time the service is provided. Please see the reverse side for more details about our most common Non-Covered Services.
Forms & Records	Nominal fees apply for all requested forms and letters. Most commonly, we are asked to complete the DMW DL-63 Eye Exam Form along with other insurance forms, dictated letters from our doctors, copies of medical records, etc. Documents will be ready in 1-3 business days.
Service Charges	Any check returned to our office for non-payment will generate an additional processing fee. We can assist you with setting up a payment plan to pay any outstanding balance. If your account is sent to a collection agency, you will also incur an administrative fee for that effort, including any court costs.
No-Show Charge	Due to the negative impact of missed appointments on our staff, doctors and other patients, a fee of $50 will be charged for a no-show or missed appointment if you have not provided us with at least 24 hour notice.
Refunds	Credit balances of under $50 will remain as a credit on your account to be applied to your next visit, or you may request a refund.

I have read and accept the terms of Clemson Eye, PA's Financial Policy. I agree that I am ultimately responsible for the balance of my account for any professional services and items provided to me by Clemson Eye, PA. not paid by my health plan, including Medicare and Medicaid.

Name (print): _____ Date: _____

Patient / Guardian / Guarantor

Signature: _____

Non-Covered Services

Financial Policy

Medicare, Medicaid, and private health and vision plans contract with Clemson Eye, PA to cover many common items and services. However, technology often progresses faster than insurers and as a result, several new tests and services are non-covered. Clemson Eye, PA will obtain your plan benefits and authorizations, and inform you of any non-covered services prior to your treatment. Examples of non-covered services include, but are not limited to, services, treatments or tests not specified as being covered in the patient's health care plan (or benefit summary). Any non-covered fees are payable at the time of service or prior to a treatment. Non-covered services are optional, so you may decline to receive them. However, when you opt to proceed with them, you accept full financial responsibility for any non-covered items or services. Examples of non-covered services include, but are not limited to:

Refraction: An essential part of a complete eye exam, this test determines the eye's prescription and need for corrective lenses. Most health care plans, including Medicare, DO NOT COVER refractions, but some vision plans do cover them. If a patient is experiencing blurred or decreased vision, refraction determines if this is due to a need for corrective lenses or a medical problem. For patients anticipating cataract surgery, a refraction is required to prove that vision cannot be corrected with glasses and eye surgery is medically necessary. Patients who have a refraction will receive a new prescription valid for one year. Federal law requires that we bill for refractions and if we are a contract provider with a health or vision plan that covers refractions, we will bill them for the coverage. Otherwise, **our fee for a refraction is payable on the date of service**. Patients who pay may request we bill their plan and may receive a refund if their insurance ultimately does cover the charge for this test.

Enhanced Vision Package for Cataract Patients: ONLY ONE TEST for your new intraocular lens implant power is covered by Medicare and most health plans. With less information, your dependence on glasses after surgery is greater due to possible undetermined astigmatism, nearsighted or farsightedness. Our surgeons highly recommend several additional, advanced tests that we have bundled into a Package that includes: Corneal Topography (Atlas & Cassini) and Pachymetry to accurately evaluate and treat astigmatism; Wavefront Aberrometry for assessment of higher order aberrations that affect vision; Additional Optical Coherence Biometry for comparative lens implant calculations; Optical Coherence Tomography and Retinal Acuity Meter to screen for potential disorders of the retina and optic nerve, and Tearlab, Refraction and Cataract Patient Care Kits. These tests also provide a customized view of your suitability for advanced intraocular lens implants and outlook for less dependence on spectacles after surgery. If you have basic cataract surgery, these test results are used to ensure the best possible outcome. The optional fee for this package, including the Patient Care Kits, is payable at your consultation. If you select an advanced service such as laser cataract surgery with a standard or advanced intraocular lens implant, then these tests and Patient Care Kits are included and the additional fee is waived.

Cataract Patient Care Kits: These kits have been custom designed by our surgeons to include an Eye Shield (for use at night while sleeping), Paper Tape (to tape the night shield on), Solar Comfort Extra-Large Sunglasses, Large Sunglasses, Avenova, and a Tote Bag. You can reuse these items for future eye surgery. Patients have the option to buy these items independently, but our cost for the kit is less.

Laser Cataract Surgery, Advanced Lens Implants, Refractive Procedures (i.e., Lasik): Any procedure with the objective of making you free of spectacles is generally considered optional and is not covered by Medicare or private health plans. For Lasik, however, there is usually a cost savings if we are a contracted provider with your health plan. For patients interested in laser cataract surgery and/or an advanced lens implant, the fees for these optional services will be discussed in detail during your surgical consultation.

Dry Eye Tests (TearLab): Dry Eye Syndrome is one of the most common eye conditions. TearLab is an objective, quantitative test of one's tear osmolarity/quality for diagnosing and managing Dry Eye. When the quantity and quality of secreted tears is compromised, the eye is stressed and inflamed causing itching, burning, watering, redness and blurred vision. TearLab data allows patients to understand their level of Dry Eye disease and measure results of treatment. Medicare covers this test, but very few private health plans do. If you do not have coverage, but would like to have a TearLab test performed, we charge a small fee. Additionally, MGD (Meibomian gland dysfunction) is one of the most common diseases observed in clinics and is the leading cause of evaporative dry eye. When these glands are not healthy, it causes the tear film to rapidly evaporate, leaving the eye's surface exposed. This exposure can cause discomfort that increases over time and impacts quality of vision, which can result in irritating dry eye symptoms. LipiFlow® is a cutting edge thermal eyelid treatment for Evaporative Dry Eye, however it is not covered by health insurance.

Aesthetics: Cosmetic Botox, dermal fillers and rejuvenating skin lasers are non-covered services, payable at time of service.

Optical: Vision plan benefits may include some coverage for glasses and contact lenses with the option to purchase upgrades. Otherwise, all Optical items and services are payable at the time of order.

Clemson Eye

Medical History

Please complete this form, front and back.

Patient Name: _____

Birth Date: _____ Today's Date: _____

Past Medical History

☐ None Apply

☐ Allergies	☐ Coronary artery disease	☐ Heart attack	☐ Osteoporosis/Osteopenia
☐ Anemia	☐ Crohn's disease	☐ Hepatitis C	☐ Seizures
☐ Anxiety	☐ Breast Cancer	☐ High blood pressure	☐ Sleep apnea
☐ Arthritis	☐ Colon Cancer	☐ High cholesterol	☐ Stroke
☐ Asthma	☐ Ovarian Cancer	☐ Insomnia	☐ Thyroid disease
☐ Atrial fibrillation	☐ Other Cancer _____	☐ Irritable bowel syndrome	☐ Ulcers
☐ Benign Prostatic Hypertrophy	☐ Depression	☐ Kidney disease	☐ Ulcerative colitis
☐ Blood Clots	☐ GERD	☐ Migraines	

☐ Diabetes ☐ Oral ☐ Insulin ☐ Diet-controlled Year of Diagnosis: _____

Past Surgical History

☐ None Apply

☐ Angioplasty	☐ Joint replacement	☐ Catract extraction	Glaucoma laser in:
☐ Angio w/stents	☐ Knee surgery	☐ Cornea transplant	☐Right ☐Left ☐Both
☐ Back surgery	☐ Pacemaker	☐ Shunt tube	Laser of retinal tear in:
☐ Gall Bladder surgery	☐ Thyroid surgery	☐ "Filter" Trabeculectomy	☐Right ☐Left ☐Both
☐ Heart bypass		☐ LASIK	Retina surgery in:
			☐Right ☐Left ☐Both

Family History: Please indicate if you mother, father, or sibling(s) have or had any of the following:

☐ Adopted, Family History Unknown ☐ No Relevant Family History

	Mother	Father	Sister(s)	Brother(s)
Cataract	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐
"Lazy Eye"	☐	☐	☐	☐
Macular degeneration	☐	☐	☐	☐

Please continue on other side

Medical History

What is your tobacco use history?

Smoker status:
☐ Current every day smoker ☐ Current some day smoker ☐ Smoker, current status unknown
☐ Never smoked ☐ Former smoker ☐ Unknown if ever smoked

Medications

Antibiotics
☐ amoxicillin
☐ azithromycin (Z-Pak)

Allergy/Asthma/COPD
☐ albuterol (Proventil, Ventolin)
☐ loratadine (Claritin)
☐ montelukast (Singulair)
☐ fluticasone/salmeterol (Advair)

Autoimmune
☐ adalimumab (Humira)
☐ infliximab (Remicade)
☐ etenercept (Enbrel)

Blood Pressure
☐ amlodipine (Norvasc)
☐ hydrochlorothiazide (HCTZ)
☐ Lisinopril (Zestril)
☐ metoprolol (Toprol)
☐ valsartan (Diovan)
☐ olmesartan (Benicar)
☐ telmisartan (Micardis)

Blood Thinners
☐ aspirin
☐ dipyridamole (Aggrenox)
☐ clopidogrel (Plavix)
☐ dabigatran (Pradaxa)
☐ rivaroxaban (Xarelto)
☐ warfarin (Coumadin)

Cholesterol
☐ simvastatin (Zocor)
☐ rosuvastatin (Crestor)
☐ atorvastatin (Lipitor)

Depression/Bipolar/Alzheimer's
☐ aripiprazole (Abilify)
☐ duloxetine (Cymbalta)
☐ memantine (Namenda)

Diabetes
☐ metformin (Glucophage)
☐ sitagliptin (Januvia)
☐ insulin aspart (Novolog)
☐ insulin lispro (Novolog)
☐ insulin glargine (Lantus)
☐ insulin detemir (Levemir)
☐ linaglipton (Tradjenta)
☐ liraglutide (Victoza)
☐ saxagliptin (Onglyza)

Eye: REVIEWED W/ CLINICIAN

Gastrointestinal
☐ omeprazole (Prilosec)
☐ esomeprazole (Nexium)

HIV
☐ Atripla
☐ ritonavir (Norvir)
☐ Truvada

Pain
☐ hydrocodone (Norco)

Thyroid
☐ levothyroxine (Synthroid)

☐ **Other (Please Specify):** _____

_____

_____

Allergies

☐ No Known Allergies ☐ Penicillin ☐ Tetracycline
☐ Latex ☐ Non-steroidal (Aleve, ibuprofen) ☐ Sulfa
☐ Other: _____

_____ _____
Patient Signature Tech Signature

Clemson Eye

Toll-free: 855-654-2020
Web: clemsoneye.com

Medical Records Release

Authorization for Use

Patient Name: _____ Date: _____

SSN: _____ DOB: _____

Release records from: _____

Email: _____

I authorize the custodian of records of: _____ or other person/entity (specifically describe) to disclose/release all medical records to: _____

*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

Please send the records to: Clemson Eye Clinic (circled) at the **fax** number below **(area code 864)**:

Anderson	Clemson	Easley	Greenville	Simpsonville
622-5020	654-3275	855-6850	292-2020	963-3232

Disclosure of Protected Health Information

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Name: _____ Signature: _____ Date: _____

Patient / Guardian / Guarantor

Name: _____ Signature: _____ Date: _____

Witness

Anderson
2011 E Greenville St
Anderson, SC 29621
Office: 864-622-5000
Fax: 864-622-5020

Clemson
931 Tiger Blvd
Clemson, SC 29631
Office: 864-654-6706
Fax: 864-654-3275

Easley
15 Southern Center Ct
Easley, SC 29642
Office: 864-855-6800
Fax: 864-855-6850

Greenville
360 Pelham Rd
Greenville, SC 29615
Office: 864-268-1000
LASIK: 864-297-8777
Fax: 864-292-2020

Simpsonville
877 NE Main St
Simpsonville, SC 29681
Office: 864-967-8582

Clemson Eye

Dry Eye Questionnaire

Patient Name or ID: _____ Date: _____

Have you ever been diagnosed with Dry Eye Disease or Ocular Surface Disease?

☐ Yes ☐ No When? _____

1. Do you have any of the following symptoms?

- ☐ Redness
- ☐ Burning
- ☐ Light sensitivity
- ☐ Tired eyes, eye fatigue
- ☐ Foreign body sensation
- ☐ Fluctuating vision
- ☐ Scratchy feeling of sand or grit in the eye
- ☐ Itching
- ☐ Excess tearing / watering eyes
- ☐ Stringy mucus in or around the eyes
- ☐ Contact lens discomfort

Report the FREQUENCY of symptoms you are experiencing by using the numbering system below:

1 = Sometimes 2 = Often 3 = Constant

SYMPTOMS	1	2	3
Dryness, Grittiness or Scratchiness			
Soreness or Irritation			
Burning or Watering			
Eye Fatigue			

2. Are your symptoms related to or made worse by any of the following factors?

- ☐ Windy conditions
- ☐ Places with low humidity (e.g., airplanes / hospitals)
- ☐ Areas that are air conditioned / heated
- ☐ More than 2 hours of computer / PDA use per day

3. Are you being treated for any of the following conditions?

- ☐ Diabetes
- ☐ Arthritis
- ☐ Lupus
- ☐ Dry Eye
- ☐ Thyroid Condition
- ☐ Sjögren's Syndrome
- ☐ Rosacea
- ☐ Blepharitis

** For Technician Use Only***

Attending Clinician Signature: _____ Date: _____

Technician: _____

Tear Osmolarity: OD: _____ OS: _____