VISIONARY EYE CARE
BRIAN GRANEK, O.D.

10995 Owings Mills Blvd · Suite 204 · Owings Mills · MD · 21117

COVID-19 Screening Form

Patient Name: _____ DOB: _____ Today's Date: _____

Please circle **YES** or **NO** to the following questions:

1. Have you or traveled outside of the USA in the last 14 days?	**YES**	**NO**
2. Have you traveled within the USA in the last 14 days?	**YES**	**NO**
3. Have you been on a cruise ship in the last 14 days?	**YES**	**NO**
4. Have you been in close contact with anyone who has traveled in the last 14 days?	**YES**	**NO**
5. Have you attended any events or gatherings with more than 100 people?	**YES**	**NO**
6. Have you been in close contact with a person known to have Covid-19?	**YES**	**NO**
7. Have you been asked to self-quarantine?	**YES**	**NO**

8. Do you currently have any of the following?

• Fever greater than 100	**YES**	**NO**
• Chills	**YES**	**NO**
• Difficulty breathing, shortness of breath	**YES**	**NO**
• Cough	**YES**	**NO**
• Sore throat	**YES**	**NO**
• New loss of taste or smell	**YES**	**NO**
• Runny nose	**YES**	**NO**

****Please email completed forms to jessica@visionaryicare.com****

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PATIENT UPDATE FORM

Todays Date_____

Patient's Name _____ Date of Birth _____
Patient's Address_____
_____
Patient's Phone Number_____-_____-_____
Patient's Email:_____

Primary Insurance _____
Policy # _____ Group # _____Copay _____
Policy Holder _____
Policy Holder's Social Security # _____Policy Holder's DOB _____

Secondary Insurance Information _____
Policy # _____ Group # _____Copay _____
Policy Holder _____
Policy Holder's Social Security # _____Policy Holder's DOB _____

Is the patient a dependent under the age of 18? **YES** **NO**
If yes, please provide:
Name of person responsible for bill_____
Address_____
_____
Phone # _____
Relationship_____ SS#_____

Authorizations:

I agree to be responsible for all charges for vision/medical services and materials not paid by my vision/medical plan, unless prohibited by law, or the treating vision or vision practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____

Patient Signature Date

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The **Optomap** exam is fast, painless and comfortable. Nothing touches your eye at any time. To have the exam, you simply look into the device one eye at a time (like looking through a keyhole) and you will see a comfortable flash of light to let you know the image of your retina has been taken. The **Optomap** ultra-widefield retinal image is a unique technology that captures more than 80% of your retina in one panoramic image while traditional imaging methods typically only show 15% of your retina at one time.

Early detection means successful treatments can be administered and reduces the risk to your sight and health.

Questions about an optomap...

Frequently Asked Questions about an optomap

Why is a retinal exam so important?
Some of the first signs of diseases such as stroke, diabetes and even some cancers can be seen in your retina, often before you have other symptoms. An **optomap** makes it easier to see them.

Is an optomap safe for children?
Yes. In fact, many vision problems begin in early childhood, so it's important for children to receive quality routine eye care.

What is an optomap?
The **optomap** is a panoramic digital image of the retina produced by **Optos** scanning laser technology. It is the only technology that can show a wide 82% view of your retina at one time.

Does it hurt?
No. It is completely comfortable and the scan takes less than a second.

How will optomap benefit me?
An **optomap's** wide view of the retina may help your eye doctor detect problems more quickly and easily. Unlike traditional retinal exams, the optomap image can be saved for future comparisons.

How often should I have an optomap?
This is a decision that should be made by your doctor. However, it is generally recommended that you have an **optomap** each time you have an eye exam.

Are there side effects?
Optomap images are created by non-invasive, low-intensity scanning lasers. No adverse effects have been reported in over 39 million sessions.

Information above can be found on www.optomap.com

PLEASE PROCEED TO THE NEXT PAGE

Dr. Granek strongly recommends this as part of your Routine Eye Exam, However some Vision Insurance plans DO NOT COVER The Optomap Retinal Exam, Which means that you may be responsible for an additional fee.

If Dr. Granek discovers a Medical Diagnosis during your Routine Eye Exam and decides to submit your exam Medically, your photos will be submitted also. Please keep in mind pertaining to all insurances, all visits are not a guarantee of coverage and they will take into consideration a Specialist copay and Deductible if you have one.

THE FEE FOR OPTOMAP IS $37 FOR PATIENTS OVER THE AGE OF 18 AND $25 FOR ALL PATIENTS UNDER THE AGE OF 18.

- **I (Patient / or Signature of Parent if under age 18)**

  _____, HAVE READ THE ABOVE INFORMATION AND AGREE TO PAY FEE ASSOCIATED WITH THIS EXAM.

- **I (Patient/ or Signature of Parent if under age 18)**

  _____, DECLINE THE OPTOMAP RETINAL EXAM.

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RIGHT TO NOTICE
As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPPA), Visionary Eye Care can use your protected health care information for treatment, payment and health care operations.

1. Treatment – We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
2. Payment – We may use and disclose your health information to obtain payment for services we provide you.
3. Health Care Operations – We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conduction training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION
Most uses and disclosure that do not fall under treatment, payment and healthcare operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

EMERGENCY SITUATIONS
In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgement. We will only disclose health information that is directly relevant to the person's involvement in your healthcare.

MARKETING
We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW
We may also use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT
We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health or safety.

NATIONAL SECURITY
We may disclose the health information of Armed Forces Personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

APPOINTMENT REMINDERS
We may use or disclose your health information to provide you with appointment reminders via phone, email or letter.

YOUR RIGHTS AS A PATIENT
You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or health care operations.

- You have the right to receive confidential communications regarding your protected health information.
- You have the right to inspect and copy your protected health information.
- You have the right to amend your protected health information.
- You have the right to receive an account of disclosures of your protected health information.
- You have the right to a paper copy of this notice of privacy practices.

LEGAL REQUIREMENTS
Visionary Eye Care is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are posted to this site, or are available within our office.

COMPLAINTS
If you have complaints regarding the way your protected health information was handled you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint.

CONTACT INFORMATION
For further information about Visionary Eye Care privacy policies, please contact us at:

Visionary Eye Care
Brian Granek, O.D.
10996 Owings Mills Boulevard, Suite 204
Owings Mills, MD 21117
410.363.0060 – phone
410.363.0911 – fax

PATIENT SIGNATURE: _____

DATE: _____