

Contact Lens Policy

Contact lens examination or fitting includes ONE set of trials, unless they are gas permeable/or made-to-order soft contact lens.

Once trials are dispensed, a contact lens follow-up is REQUIRED before contact lens prescription is finalized, released/or ordered. Patient needs to have the contact lens in for a minimum of 2 hours before the appointment to ensure proper contact lens evaluation. This follow-up needs to be WITHIN 30 DAYS of the initial contact lens dispensing. AFTER 30 DAYS, patient will be responsible for an office visit fee.

Warning: If you are having any unexplained eye discomfort, watering, vision change/or redness, remove your lenses immediately and consult your eye care practitioner before wearing your lenses again.

It is considered another contact lens fitting if any changes to a contact lens prescription are made after the initial contact lens Rx has been finalized by H2T. (Ex. Clear, color/or brand change; as the curvature and fitting properties of the contact lens will vary based on manufacture and material.)

±60 DAYS before its expiration date, contact lens shall be refilled, with no more than the sufficient quantity needed through the expiration date (Arizona State Board of Optometry, A.R.S 32-1774), patient will be considered for a set of trials, given that the same trial contact lens is available, to use until the next contact lens examination.

If contact lens supply is ordered through H2T office, exchanges are only granted to UNOPENED and UNMARKED boxes. If contact lens supply is ordered elsewhere, H2T will not offer any exchanges.

Glasses/ Frame Policy

ANY H2T prescription sunglasses/or glasses will have a 30 DAYS adaptation period. WITHIN 30 DAYS of dispensing, patient is responsible for scheduling a glasses follow-up appointment if he/she is having problems with their prescription. AFTER 30 DAYS of dispensing, there will be an office visit fee for a prescription recheck. There will be a charge for verification of glasses purchases elsewhere with H2T prescription.

NO RETURNS are granted once a purchase is made.

There are NO EXCHANGES for any purchased non-prescription sunglasses.

H2T is not responsible for any scratched, chipped/or broken frame that is not considered a manufacturer defect. Lenses/or frames will be sent out for verification. There will be a nominal fee to have the lenses or frames replaced.

If patient prefers to provide a frame and have H2T fit lenses to the frame, H2T is NOT RESPONSIBLE for any damages to the frame.

Frame adjustments are ALWAYS FREE. However, H2T is not liable for any frame adjustments that is not purchased through H2T. This is a courtesy service for H2T patrons, but we are NOT LIABLE for any damages or scratches that could happen during this complimentary service.

No Show/ Cancellation Policy

Effective September 1st, 2009, ALL scheduled no show appointments will be charged \$30.00 no show fee. Patient is responsible to CALL the office to reschedule or cancel any appointment at least 24 hours in advance.

Patient who is running 20 minutes late for his/her scheduled appointment will be rescheduled to the next available appointment/ day.

I, _____, have read and understand the policies stated above.

Signature _____

Date: _____

Effective September 2009

OPTOMETRY MEDICAL HISTORY QUESTIONNAIRE

Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Birth Date: ____/____/____ Social Security (opt): _____
 Occupation: _____ Employer: _____
 Primary Care Physician: _____
 PCP Address: _____
 Previous Eye Physician: _____

Guardian (If applicable): _____
 Today's Date: _____
 Home Phone: _____
 Email: _____
 Work Phone: _____
 Cell Phone: _____
 Last Medical Exam: _____
 Last Eye Exam: _____

Who may we thank for referring you? _____

Was the HIPPA – Notice of Privacy Practices form made available to you? _____ (Please initial)

1) EYE CHIEF COMPLAINT (today)

Blurred Vision	Yes <input type="checkbox"/> No <input type="checkbox"/>	Foreign Body Sensation	Yes <input type="checkbox"/> No <input type="checkbox"/>
Burning	Yes <input type="checkbox"/> No <input type="checkbox"/>	Glare/ Light sensitivity	Yes <input type="checkbox"/> No <input type="checkbox"/>
Eye/ Lid Infection	Yes <input type="checkbox"/> No <input type="checkbox"/>	Itching	Yes <input type="checkbox"/> No <input type="checkbox"/>
Distorted Vision/ Halos	Yes <input type="checkbox"/> No <input type="checkbox"/>	Loss of Side Vision	Yes <input type="checkbox"/> No <input type="checkbox"/>
Double Vision	Yes <input type="checkbox"/> No <input type="checkbox"/>	Loss of Vision	Yes <input type="checkbox"/> No <input type="checkbox"/>
Dryness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mucous Discharge	Yes <input type="checkbox"/> No <input type="checkbox"/>
Excess Tearing/ Watering	Yes <input type="checkbox"/> No <input type="checkbox"/>	Redness	Yes <input type="checkbox"/> No <input type="checkbox"/>
Eye Pain/ Soreness	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sandy/ Gritty Feeling	Yes <input type="checkbox"/> No <input type="checkbox"/>
Flashes/ Floaters in Vision	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tired Eyes	Yes <input type="checkbox"/> No <input type="checkbox"/>

If you answered *Yes* to any of the above or have a condition not listed, please explain: _____

2) OCULAR CONDITIONS

Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Blindness	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cataracts	Yes <input type="checkbox"/> No <input type="checkbox"/>	Crossed Eyes/Strabismus	Yes <input type="checkbox"/> No <input type="checkbox"/>
Macular Degeneration	Yes <input type="checkbox"/> No <input type="checkbox"/>	Lazy Eye/Amblyopia	Yes <input type="checkbox"/> No <input type="checkbox"/>
Eye Injury	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetic Retinopathy	Yes <input type="checkbox"/> No <input type="checkbox"/>
Retinal Disease/Condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	Dry Eyes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Other Ocular Condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	Refractive Surgery	Yes <input type="checkbox"/> No <input type="checkbox"/>

3) MEDICAL HISTORY

Do you have any allergies or allergies to medication? _____

List ANY medications you take prescription or over the counter: _____

List ALL major injuries, surgeries and hospitalization: _____

Are you pregnant or nursing?	Yes <input type="checkbox"/> No <input type="checkbox"/>	How old is your present pair?	_____
Do you wear glasses?	Yes <input type="checkbox"/> No <input type="checkbox"/>	How old is your current pair?	_____
Do you wear contact lenses?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you sleep in them?	Yes <input type="checkbox"/> No <input type="checkbox"/>
What type of contact lenses?	Rigid <input type="checkbox"/> Soft <input type="checkbox"/>	How often do you change/dispose of your CL?	_____
Are they comfortable?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Interested in refractive surgery?	Yes <input type="checkbox"/> No <input type="checkbox"/>		

4) FAMILY HISTORY

M:Maternal P: Paternal

Disease/ Condition:		Relationship to You											
Glaucoma	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mother <input type="checkbox"/>	Father <input type="checkbox"/>	Brother <input type="checkbox"/>	Sister <input type="checkbox"/>	Grandma M <input type="checkbox"/>	P <input type="checkbox"/>	Grandpa M <input type="checkbox"/>	P <input type="checkbox"/>	Self <input type="checkbox"/>	Other _____		
Cataracts	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mother <input type="checkbox"/>	Father <input type="checkbox"/>	Brother <input type="checkbox"/>	Sister <input type="checkbox"/>	Grandma M <input type="checkbox"/>	P <input type="checkbox"/>	Grandpa M <input type="checkbox"/>	P <input type="checkbox"/>	Self <input type="checkbox"/>	Other _____		
Macular Degeneration	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mother <input type="checkbox"/>	Father <input type="checkbox"/>	Brother <input type="checkbox"/>	Sister <input type="checkbox"/>	Grandma M <input type="checkbox"/>	P <input type="checkbox"/>	Grandpa M <input type="checkbox"/>	P <input type="checkbox"/>	Self <input type="checkbox"/>	Other _____		
Eye Injury	Yes <input type="checkbox"/> No <input type="checkbox"/>	Mother <input type="checkbox"/>	Father <input type="checkbox"/>	Brother <input type="checkbox"/>	Sister <input type="checkbox"/>	Grandma M <input type="checkbox"/>	P <input type="checkbox"/>	Grandpa M <input type="checkbox"/>	P <input type="checkbox"/>	Self <input type="checkbox"/>	Other _____		

Retinal Detachment/Disease Yes No Mother Father Brother Sister Grandma M P Grandpa M P Self Other _____

Other Diseases Yes No Mother Father Brother Sister Grandma M P Grandpa M P Self Other _____

Blindness Yes No Mother Father Brother Sister Grandma M P Grandpa M P Self Other _____

Crossed Eye/Strabismus Yes No Mother Father Brother Sister Grandma M P Grandpa M P Self Other _____

Lazy Eye/Amblyopia Yes No Mother Father Brother Sister Grandma M P Grandpa M P Self Other _____

Diabetes Yes No Mother Father Brother Sister Grandma M P Grandpa M P Self Other _____

Cancer Yes No Mother Father Brother Sister Grandma M P Grandpa M P Self Other _____

Heart Disease Yes No Mother Father Brother Sister Grandma M P Grandpa M P Self Other _____

High Blood Pressure Yes No Mother Father Brother Sister Grandma M P Grandpa M P Self Other _____

Kidney Disease Yes No Mother Father Brother Sister Grandma M P Grandpa M P Self Other _____

Lupus Yes No Mother Father Brother Sister Grandma M P Grandpa M P Self Other _____

Thyroid Disease Yes No Mother Father Brother Sister Grandma M P Grandpa M P Self Other _____

5) SOCIAL HISTORY

(This info is confidential. If you prefer, you can discuss them directly with the doctor)

Do you drive? Yes No

Any visual difficulties? Yes No

If yes please explain _____

Do you use tobacco products? Yes No If yes, what type/ amount/ how long? _____

Do you use illegal drugs Yes No If yes, what type/ amount/ how long? _____

Do you drink alcohol? Yes No If yes, how often? _____

Have you ever been exposed to or infected with any sexual transmitted diseases/ HIV? Yes No

6) REVIEW OF SYMPTOMS

Do you currently have or have ever had any of the following:

CONSTITUTIONAL		MUSCULOSKELETAL	
Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>	Arthritis/Rheumatoid	Yes <input type="checkbox"/> No <input type="checkbox"/>
Weight Loss	Yes <input type="checkbox"/> No <input type="checkbox"/>	Osteoarthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Weight Gain	Yes <input type="checkbox"/> No <input type="checkbox"/>	Muscle/Joint Pain	Yes <input type="checkbox"/> No <input type="checkbox"/>
CARDIOVASCULAR/VASCULAR		INTEGUMENTARY (Skin)	
Heart Condition	Yes <input type="checkbox"/> No <input type="checkbox"/>	PXE (Pseudoxanthoma Elasticum)	Yes <input type="checkbox"/> No <input type="checkbox"/>
High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	NEUROLOGICAL	
Vascular Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	Headache	Yes <input type="checkbox"/> No <input type="checkbox"/>
EAR, NOSE, MOUTH, THROAT		Migraine	Yes <input type="checkbox"/> No <input type="checkbox"/>
Allergies/ Hay Fever	Yes <input type="checkbox"/> No <input type="checkbox"/>	Seizures	Yes <input type="checkbox"/> No <input type="checkbox"/>
Chronic Cough	Yes <input type="checkbox"/> No <input type="checkbox"/>	PSYCHIATRIC	Yes <input type="checkbox"/> No <input type="checkbox"/>
Dry Mouth	Yes <input type="checkbox"/> No <input type="checkbox"/>	ENDOCRINE	
Ear Infection	Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sinus Congestion	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, your most recent blood sugar level?	_____
RESPIRATORY		Thyroid/ Other Glands	Yes <input type="checkbox"/> No <input type="checkbox"/>
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	HEMATOLOGIC/LYMPHATIC	
Bronchitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Anemia	Yes <input type="checkbox"/> No <input type="checkbox"/>
Emphysema	Yes <input type="checkbox"/> No <input type="checkbox"/>	Bleeding Problems	Yes <input type="checkbox"/> No <input type="checkbox"/>
GASTROINTESTINAL		IMMUNOLOGY	
Constipation	Yes <input type="checkbox"/> No <input type="checkbox"/>	Syphilis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diarrhea	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hepatitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
GENITOURINARY		ALLERGIES	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bladder	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Kidney	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Are you aware that we have screening for Vascular Disease, Neuropathy, & Osteoporosis available at this office? (Doctor recommends annual dilated fundus exam, photo and visual field testings to rule out and/ or detect cataract, glaucoma, macular degeneration, retinal diseases/ conditions and other possible causes that can relate to your vision concerns today. These services may not be covered/ partially covered by your insurance plan.)

Consent for DFE & VF today Reschedule to a later date DFE only VF only Photo only

Patient/Guardian Signature: _____ Date: _____