A computerized optometric correspondence system

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A computerized optometric correspondence system

Abstract
It is recognized that personal communication skills can always be enhanced. And today, as the use of computers are becoming more prevalent, correspondence can be made more efficient. Contrary to common thought, computers can be utilized to give a more personal touch to correspondence. Instead of corresponding with patients and other health care professionals with forms that are filled-in by hand, word processors can be used to make correspondence appear much more professional and personal. Over one hundred forms were written and computerized to benefit all in the optometric field. You will find forms for most areas of optometric correspondence. They have been provided for you to copy at no cost. The intention of this project is to enhance doctor-patient communication, as well as communication between professionals, to better the optometric profession as a whole.

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Committee Chair
Nira R. Levine, D. Ed.

Subject Categories
Optometry

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A COMPUTERIZED OPTOMETRIC CORRESPONDENCE SYSTEM

By

RUSSELL L. QUIRING
DEAN E. RISKEDAHL

A thesis submitted to the faculty of the
College of Optometry
Pacific University
Forest Grove, Oregon
for the degree of
Doctor of Optometry
May, 1989

Adviser:

Nira R. Levine, D. Ed.
SIGNATURES

Authors:

Russell L. Quiring

Dean E. Riskedahl

Adviser:

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BIOGRAPHICAL INFORMATION

RUSSELL L. QUIRING: Attended Concordia College, Moorhead, Minnesota, from 1979 to 1983. Bachelor of Arts in Biology and Chemistry, cum laude, was conferred December, 1982. Received optometric education at Pacific University, Forest Grove, Oregon from 1985 to 1989. O.D. degree with honors was conferred May, 1989. Future plans center around private or small group practice in the midwest. Vice President of BSK, honorary optometric fraternity; Scholastic All-American, United States Achievement Academy; Scholarly Achievement recipient, National Collegiate Medical Professions Awards; and American Optometric Student Association.

DEAN E. RISKEDAHL: Attended the University of North Dakota at Grand Forks from 1977 to 1982. Bachelor of Science in Chemistry was conferred May, 1981. 1982-1984 was spent in the U.S. Peace Corps in the Fiji Islands as a secondary education instructor. Received optometric education at Pacific University, Forest Grove, Oregon from 1985 to 1989. O.D. degree with honors was conferred May, 1989. Plans for future work include a residency with the Veterans Administration in Los Angeles, California and private practice optometry. Member of BSK, honorary optometric fraternity, United States Achievement Academy All-American Scholars, Outstanding Young Men of America, and American Optometric Student Association.
ABSTRACT

It is recognized that personal communication skills can always be enhanced. And today, as the use of computers are becoming more prevalent, correspondence can be made more efficient. Contrary to common thought, computers can be utilized to give a more personal touch to correspondence. Instead of corresponding with patients and other health care professionals with forms that are filled-in by hand, word processors can be used to make correspondence appear much more professional and personal.

Over one hundred forms were written and computerized to benefit all in the optometric field. You will find forms for most areas of optometric correspondence. They have been provided for you to copy at no cost.

The intention of this project is to enhance doctor-patient communication, as well as communication between professionals, to better the optometric profession as a whole.

The Diskettes

The forms are present on three different diskettes, each saved using different formats. Refer to one of the following sections for the format that you plan to use.

**Diskette #1: Microsoft Works (Macintosh) Version**
The diskette with the Microsoft Works formatted documents are the "original" copies from which the other formats were derived. Because of this, the formatting characteristics, e.g. tab locations, margins, etc. are the most accurate. You will need a copy of Microsoft Works in order to use the forms.

**Diskette #2: Microsoft Word (Macintosh) Version**
The documents on the Microsoft Word diskette contain most of the formatting characteristics, but the location of "tabs" may have to be altered. You will need a copy of Microsoft Word in order to use the forms.

**Diskette #3: IBM (MS-DOS or DOS) Version**
The documents on the MS-DOS formatted diskette have not been saved using any particular word processor program, but have been saved as "text only." Almost all DOS word processors will read and write documents or files in "text only" format.

"Text only" means that all the words are present but the formatting characteristics, or styles, are not present. Therefore, you will have to invest some time to format the documents the way you want. In addition to needing a word processor, you will also need a copy of the Disk Operating System (DOS) software.

The Hardcopy (Copy of Printed Forms)

The forms are organized into directories, or folders. The forms are alphabetically listed in hardcopy, by specific categories named by the folders or directories.

To correlate the printed forms with those on disk, the hardcopy forms display the document name (saved by the computer) at the end of each form. Therefore, to find a document that you like in the hardcopy, look for the document name at the end of the form and then find
that name in the directory (folder) on the diskette. The name at the end of the form is intended for reference only and is meant to be deleted when the form is actually used.

You will probably decide to rename the documents that you use in order to increase your recognition of the document. The short abbreviated file names that have been used were necessary to save the documents in DOS (IBM) format.

**Printing The Forms**

Most of the forms contain blanks for you to fill-in information before printing the final completed forms. Some forms have "your name, your address" across the top of the form. Your letterhead is intended to replace this, so delete these lines and make room for your letterhead. You may want to experiment with the letters in order to better center the body of the letter on the page while using your letterhead.

ALWAYS use the "Save As..." command for saving any forms that have been modified either before or after printing. Saving documents with the "Save As..." command will not write over the existing form, but will allow you to save the completed form under a different name.

**Automating Your Correspondence**

You may decide to use some of these forms to setup a "mail merge" system to facilitate your office correspondence, that is, to set up a document management system. There are many database programs available that can be used in conjunction with a word processor program to accomplish mail merging.

To setup a merge system it will be necessary to modify the forms by replacing the blanks with merge commands. These merge commands hookup "fields" in your database to blanks in your word processor document so that after completing a merge, information from your database will automatically fill the blanks in your form. Refer to your word processor manual to help you setup a merge system.

**Credits**

This compilation of optometric forms was produced in 1989 by

Russell L. Quiring, O.D.
Dean E. Riskedahl, O.D.

under the supervision of
Nira R. Levine, Ed.D.
at
Pacific University College of Optometry

We hope you find this computerized optometric forms system useful and beneficial to you in your practice.

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IBM® is a registered trademark of International Business Machines, Incorporated. March, 1989.
ACKNOWLEDGEMENTS

We would like to take this opportunity to express our heartfelt thanks to our adviser, Dr. Nira R. Levine, for her assistance throughout this project. We would also like to thank our wives, Darcy and Amy, for their love and support throughout the rigors of optometry school.

Sincerely,

Russell L. Quiring

Dean E. Riskedahl
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COLLECTION
AND
BILLING
Dear ____________________________:

These past _______ months, I have been puzzled about your unpaid balance of ________________. You see, giving credit is the same thing as lending money, and naturally, we don't lend money (nor do you) to people we don't like or don't trust. I both like and trust you, hence I gave you the convenience of credit. That is why I am puzzled about this unpaid balance.

If you are dissatisfied or if there is some misunderstanding about the service my office provided, please contact me directly. Otherwise, please be considerate enough to pay your bill by return mail.

Thank you.

Sincerely yours,

Dr. ____________________________

FORM: BILLING1
Dear ____________________:

Our records show that you have an outstanding balance of $ _________ as of _____________.

The amount due includes the following:

<table>
<thead>
<tr>
<th>Professional Services</th>
<th>$ _________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$ _________</td>
</tr>
<tr>
<td></td>
<td>$ _________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Materials</th>
<th>$ _________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$ _________</td>
</tr>
</tbody>
</table>

Total $ _________

Please return check in the enclosed self-addressed, stamped envelope. Payment of _________ due now.

Thank you for your prompt attention to this matter. Looking forward to seeing you in the future for your visual needs.

Sincerely,

Dr. __________________

FORM: BILLING2
BUDGET PLAN AGREEMENT

EXPLANATION OF BUDGET PLAN

We are pleased to have this budget plan for the convenience of our patients who want extended payments.

For this service there is a small charge to cover the cost of processing and bookkeeping.

There is also a LATE PAYMENT CHARGE of $3.00 for every payment made after the 18th of the month.

Payments are due WITHOUT NOTICE. They must be on time to AVOID late payment charges. Addressed envelopes are provided as a reminder.

DELINQUENT ACCOUNTS

If no payment has been made within 30 days of agreed date the plan becomes VOID. Interest will continue on the balance at the rate of 1.5% per month, which is an annual rate of 18%. Collection thereafter will be through our commercial collection company.

PAYMENT SCHEDULE

INITIAL PROCESSING CHARGE ...................................................... $3.00
MONTHLY BOOKKEEPING CHARGE ........................................... $1.00

INITIAL PAYMENT
Minimum-- 40% of account

PAYMENT DATE
Once a month by the 18th
Limit-- 6 months

NO PART PAYMENTS
You must pay each month the full amount of your agreement

LATE PAYMENTS
A late charge of $3.00 for each one past the 18th of the month

NOTICE OF PAYMENTS
No notice is sent-- you must keep track of payments due

MONTHLY PAYMENT
$15.00 is minimum-- it varies according to the balance due

FOR FURTHER DETAILS--SEE OUR RECEPTIONIST

FORM: BUDGET
BUDGET PLAN RECEIPT

NAME

PLEASE READ THIS AGREEMENT CAREFULLY

EXTENDED PAYMENT PLAN

AMOUNT OF ACCOUNT.......................................................... $ _______
BUDGET PLAN CHARGE ................................................... $ _______

TOTAL................................................................................. $ _______
DOWN PAYMENT................................................................. $ _______
BALANCE DUE..................................................................... $ _______

PENALTY CHARGE: $3.00 FOR EACH LATE PAYMENT

PAYMENT AS FOLLOWS PER MONTH:
$ ________________ by the 18th FIRST PAYMENT DUE __________
for ____________ months

PAYMENTS ARE DUE AS INDICATED ABOVE WITHOUT NOTICE

If no payment has been received within 30 days of an agreed upon date, this plan becomes VOID. A finance charge of 1.5% per month (18% APR) will be charged on all unpaid balances. Collection then will be through our commercial collection company.

I HAVE READ AND UNDERSTAND THE ABOVE AGREEMENT. I WILL MAKE MY PAYMENTS IN THE FULL AMOUNT, FOLLOWING THE ABOVE TIMETABLE.

PLEASE PRINT NAME................................................................

SIGNATURE..............................................................................

DATE ________________

PATIENT'S COPY--KEEP FOR TAX PURPOSES

FORM: BUDGET2
Dear Valued Patient,

We have selected your name from our files to offer a new service of our office. You will find enclosed an application for a new credit card which is, we think, an innovative new idea in caring for your eyecare needs. This card is yours to keep and use in our office as you so choose. It comes to you free of charge and there is no cost in using it should you choose to pay your account in full when billed. *It is a way for us to say thank you for your trust in us.*

The *Family Vision Card* is an exclusive of our office. It can be used to charge any of our many services from vision examinations to spectacles, contact lenses, and gift certificates. Since it can only be used in our office, there is no risk in losing it or having the card stolen. It is available when you need or want it. For your convenience, you will be billed for all services at the end of the month in which you use the card rather than at the time of the purchase.

We hope you find this to be a valuable new service for you. Should you have any questions about the *Family Vision Card*, please give us a call.

Sincerely,
Family Eyecare Card Application

Please print clearly and provide all information requested.

Information about Yourself

Last Name: ___________________________ First Name: ___________________________ MI: ______

Date of Birth: _____/_____/______ Social Security #: ____________________________

Street Address: ________________________________________________________________

City: ___________________________ State: ___________________________ ZIP: __________

Home Phone: (___) _________ How long at this address? ___ yrs. ___ mos. _Own home _.Rent home

Previous address, if less than 2 yrs: ________________________________________________

City: ___________________________ State: ___________________________ ZIP: __________

Name of nearest relative not living with you: __________________________________________

Street Address: ________________________________________________________________

City: ___________________________ State: ___________________________ ZIP: __________

Relationship: ___________________________ Phone: (__) _______________________

Employment Information

Employer: ________________________________________________________________

Employer Address: __________________________________________________________

City: ___________________________ State: ___________________________ ZIP: __________

Nature of Business: __________________________________________________________

Your Position: ___________________________ Bus. Phone: (___) ____________________

How long have you been employed there? _____ yrs. ____ mos.

Gross Monthly income* (see below): $ _______

Former Employer (if less than 1 year with present employer)

_________________________________________ How long? _____ yrs. ____ mos.

Other income, if any* (see below) ___________ per month

Other Income Source: ____________________________

*Alimony, child support or separate maintenance need not be revealed if you do not wish to rely on it.
Bank Accounts and Credit Reference

Checking Account Number: __________________________________________________

Bank Name: ______________________________________________________________

City: _____________________________ State: __________________________ ZIP: _______

Savings Account Number: __________________________________________________

Bank Name: ______________________________________________________________

City: _____________________________ State: __________________________ ZIP: _______

Major Credit Card: _________________ Acc. # ________________________________

List two other credit cards (stores, oil, etc.) and account numbers

Credit Card: _________________ Acc. # ________________________________

Credit Card: _________________ Acc. # ________________________________

By signing below, I ask that an account be opened for me and a credit card issued to me. I understand that you may verify and exchange information about me including reports from credit reporting agencies. I am aware that this information is used to determine my eligibility for the care and that, if my application is approved, you may contact these sources to update this information at any time. I understand that this card is only to be honored at the offices of the optometrist or optometrists through which it is being offered.

It is my understanding that there is no initial fee for the Family Eyecare Card and that there is no annual fee. I may use it for the purchase of eyecare services from my family optometrist. I understand that my optometrist reserves the right to limit the number or amount of charges made to this credit card account.

Applicant's Signature _____________________________ Date ______________________

Spouse's Signature _____________________________ Date ______________________

Form: CreditApp
Patient Insurance Reimbursement For Eyecare Services

Patient Name: ____________________________  Date of Service: ____________________________

Date of Birth: ____________________________

Diagnosis: ____________________________

Rx Prescribed: OD  OS  Add

Reason For Change: ____________________________

Costs:

Eye Exam With Refraction $__________

Tonometry $__________

Lenses (type) ____________________________ 1 or 2 (circle) $__________

Frame $__________

Tint (type) $__________

Contacts $__________

Other $__________

TOTAL $__________

_________________________ O.C.

Your Name, O.D.

Form: Insur
Patient's Name: ____________________________________________

Patient's Medicare Number: ________________________________

I request that payment of authorized Medicare benefits be made to me or on my behalf to:

________________________________________________________________________

for services furnished me by that physician/clinic/supplier. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine the benefits payable for related services.

I permit a copy of this authorization to be used in place of the original.

________________________________________
Patient's signature

________________________________________
Date

Form: MediAuth
Doctor's Name and Address
IRS #
SS#

Patient Name: ________________________________ Date: __________________

<table>
<thead>
<tr>
<th>Examinations</th>
<th>New</th>
<th>Established</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Office Visit</td>
<td>90000</td>
<td>90040</td>
</tr>
<tr>
<td>Limited Office Visit</td>
<td>90015</td>
<td>90050</td>
</tr>
<tr>
<td>Intermediate Eye Exam</td>
<td>92002</td>
<td>92012</td>
</tr>
<tr>
<td>Comprehensive Eye Exam</td>
<td>92004</td>
<td>92014</td>
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</table>

<table>
<thead>
<tr>
<th>Independent Diagnostic Procedures</th>
<th>New</th>
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<tbody>
<tr>
<td>Gonioscopy</td>
<td>92020</td>
</tr>
<tr>
<td>Visual Fields Screening</td>
<td>92081</td>
</tr>
<tr>
<td>Quantitative Perimetry</td>
<td>92082</td>
</tr>
<tr>
<td>Extended Ophthalmoscopy</td>
<td>92225</td>
</tr>
<tr>
<td>Extended Color Vision Exam</td>
<td>92283</td>
</tr>
</tbody>
</table>

### Diagnosis ICD-9-CM

- Abrasion - cornea 918.1
- Accommodation insuff. 367.5
- Amblyopia 368.00
- Anisocoria 379.41
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- Blepharitis 373.0
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- Blepharoconjunctivitis 372.2
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- Kruegerenberg spindle 371.13
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- Vitreous hemorrhage 379.23
- Xanthelasma, eyelid 374.51

Form: MediForm
Dear Patient,

Because we have received no response to our two reminders about the delinquent status of your account, we believe there is a special reason why you have not paid. The $____ balance has been outstanding for ____ months.

Please do one of the following:
1. Send a check for half the amount as partial payment
2. Send an explanation of your plans for taking care of the next payment

If necessary, call us so we can work out some satisfactory plan. However, we must hear from you regarding this matter.

Sincerely,

Dr. ____________________

Form: OverDu2
Dear Patient,

Your account has a one month past due balance of $\_

Since there was no response to our last letter requesting payment, we believe there must be a good reason why you have been unable to pay.

Please send us either a check, or an explanation for your inability to pay at this time, within the next week. We are confident some method for you to clear up your account can be worked out.

Sincerely,

Dr.  

Form: OverDue
COLLECTION/PRE-CALL PLANNING FORM

Name of Patient

Address

Account No.

Telephone No.

1. Basic Information
   * Date of visits
   * Treatment rendered
   * Amount due
   * Name of Responsible Party

2. Previous Collection Steps
   * Bills (dates)
   * Calls (dates)
   * What happened with previous collection attempts?

3. Past Payment Record
   * How often has patient been past due?

4. Prepare Fact-Finding Questions
   * Patient's reason for not paying
   * What can you do to help bring account up to date?

5. Payment Plan
   * What payments are acceptable?
   * Dates payments must be received:

FORM: PRECALL
OFFICE ORGANIZERS
Dear Community Resident,

I am writing to inform you and your family that I am now available in your community to offer professional eye care (family vision) services. My family and I have recently moved to ______ from ____________ and we are very impressed with the community and its residents. My wife, _______, and I have ___ children; _________, __ years old, ________, __ years old, etc. My family and I look forward to meeting you and your family.

I graduated in 19___ from __________________ with a Doctor of Optometry degree. I have been practicing optometry for ___ years and have had a _______ state license for ___ years. I practice general optometry with an emphasis in the field of contact lenses. I have had special training in the field of contact lenses at ______________. I pride myself in quality eye care and consider patient satisfaction as utmost importance.

Myself and my staff, ___________, my assistant, ______, my receptionist would like to extend a very warm welcome to you and your family. Our office is located downtown at ______________ street, near the ______________. It would be a pleasure to serve you in your eye care needs. We look forward to meeting you and your family and welcoming you to our practice.

Sincerely,

Dr. _________________________

Office Address:
Address
City

Office Hours:
Monday - Wednesday 8AM - 5PM
Thursday 8AM - 8PM
Friday 8AM - 5PM
Saturday 9AM - 12Noon

Office Telephone:
Home Telephone:

Form: IntroLt
Dear Newspaper,

I am writing to inform you that I am available to write short articles pertaining to vision. I have been practicing in ____________ for ____ years now. An important role for any professional is educating the public in their field of expertise. I consider the opportunity to write articles an excellent opportunity to give to the community.

I am willing to write on any subject that relates to vision, including nutrition for healthy eyes, proper lighting, eye safety in the home and workplace, learning disabilities, vision and reading, alternatives to eye surgery for misaligned eyes, cataracts, sun protection, contact lenses, and ____________.

Contact me at my office at least two months in advance to request an article. I do not charge a fee for writing articles for the community newspaper.

Sincerely,

Dr. ________________________

Form: Newspap
Dear Group,

An important role for any professional is educating the public in their field of expertise. I consider the opportunity to speak to any group an excellent opportunity to give to the community. I am available to speak to your group in the future. I have been practicing in ______________ for ______ years now.

I am willing to give a talk on any subject that relates to vision, including nutrition for healthy eyes, proper lighting, eye safety in the home and workplace, learning disabilities, vision and reading, alternatives to eye surgery for misaligned eyes, cataracts, sun protection, contact lenses, and ____.

Contact me at my office at least two months in advance to request a speaking engagement. I do not charge a fee for speaking in the community.

Sincerely,

Dr. ________________________

Form: Public
**TELEPHONE INQUIRY LOG**

<table>
<thead>
<tr>
<th>Name</th>
<th>Tel</th>
<th>Date</th>
</tr>
</thead>
</table>

**Address**

City, State, ZIP

Inquiry Regarding: Eye Exam | CL Exam | CL Fees |
-------------------------------|--------|--------|
Cost of Frame | Cost of Spectacle Lenses | Difference between OD and MD |
Are Lenses for Self or Someone Else? | Age |
Currently Wearing CL? | Yes | No |
If Yes, Type: Hard | Soft | RGP | Bifocal | Extended Wear |
Were fees quoted? | If Yes, Amount |
Appointment Made? | Yes | No |
How Did You Choose Our Office? | Friend/Relative | Yellow Pages | Newspaper |
Other, Explain |
Information Sent |
Comments |
When to Call Again | Call Made |
Follow-Up Results |

**Another Page**

<table>
<thead>
<tr>
<th>Name</th>
<th>Tel</th>
<th>Date</th>
</tr>
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</table>

**Address**

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Were fees quoted? | If Yes, Amount |
Appointment Made? | Yes | No |
How Did You Choose Our Office? | Friend/Relative | Yellow Pages | Newspaper |
Other, Explain |
Information Sent |
Comments |
When to Call Again | Call Made |
Follow-Up Results |

FORM: TIL
OFFICE WEEKLY WORK SHEET

NUMBER OF APPOINTMENTS MADE _____

NUMBER OF APPOINTMENTS KEPT _____ PERCENT KEPT ________ %

RECALLS:

1. Recalls Made
   
2. Recall Appointments Set _____ Percent Set ________ %

3. Recalls Who Cancelled ______

4. Recalls Rescheduled ______

NEW PATIENTS:

1. Total Number ______

2. Number from Yellow Page ______

3. Number from Location ______

4. Number from Word of Mouth ______

5. Other __________

NUMBER OF CONTACT LENS PATIENTS ______

1. NEW PATIENTS FIT ______

2. RETURN PATIENTS FIT ______

3. Daily Wear, Soft ______

4. Extended Wear, Soft ______

5. RGP ______

6. Bifocal ______

7. Monovision ______

8. Tinted Lenses ______

9. Follow-up (all types) ______

10. Plano Sunglasses ______

CASH FLOW: TOTAL RECEIPTS $________________

1. Cash/Check $___________ 2. Credit Cards $___________ 3. Billed $___________

4. Adjustments/Refunds $________________ FORM: WEEK
Dear ___________________.

Our records indicate your last eye examination was on ____________, 19__. It is now time for a complete visual examination and analysis. After the age of 40, the chances of developing glaucoma increase by 2% each year.

Periodic visual evaluations enable you to maintain good vision in sure comfort, and more importantly, preserve good eye health. Please call our office to schedule your appointment.

Sincerely,

Dr. ___________________.
Your Family Optometrist

P.S. In addition to having the latest in visual examination equipment, our office offers the following to better serve our patients:

* "NO LINE" bifocals for a younger look
* Colored soft lenses that enhance the color of your eyes and are easier to see and handle.
Dear ____________________ ,

The last time I examined your eyes, ____________________ , I advised you about your cataract condition.

Cataracts can lead not only to changes in your vision and prescription, but also can increase the chance of glaucoma.

It is now time for your check-up and visit. Please call my office so that we may arrange a convenient time for your cataract examination and glaucoma testing.

Sincerely,

Dr. ____________________

FORM: CATRE
Dear Parents of ________________,

____________'s last vision evaluation was on ________________, and so it is important to schedule another eye health exam.

Young eyes grow and mature rapidly, while visual demands at school increase. Reading becomes more and more important to a child's education as the print size in books becomes smaller in the higher grades.

____________'s visual system is working harder and longer at the task of learning while constantly growing and changing. For these reasons, I feel that a vision check up is advisable every twelve months. Please call to make an appointment for one now.

Sincerely,

Dr. ________________

FORM: CHILDRE1
Dear Parents of ________________,

According to our records, ____________'s last examination was on ___________. It is now time for a complete re-evaluation of visual abilities and skills, since eyes do undergo changes during these growing years.

Research has shown that vision is the most important sense involved in classroom learning. Help to make ____________'s learning easier. Please call our office for a convenient appointment.

Sincerely,

Dr. ______________________
Your Family Optometrist

FORM: CHILDRE2
Dear ________________________________.

According to arrangements previously made with you, we are sending this card to assist you in maintaining your contact lens preventative recall program with our office.

The following time has been reserved for you. Your call will confirm that the appointment is still convenient. Please give us at least 48 hours notice if you wish to reschedule.

Appointment time and date:

Form: CLappoin
Dear ___________________________________,

During your last vision examination we talked about how diabetes is the disease with the greatest effect on the eye.

Diabetes can lead to wide-spread retinal hemorrhages, or blood leakage from the vessels of the eye, and these are gradual changes you cannot feel.

We have reserved an appointment on ______________ at ______ for your diabetic eye examination and glaucoma testing.

Please call our office if this time is inconvenient and you need to reschedule.

Sincerely,

Dr. ____________________________________

FORM: DIABRE
Dear ________________,

During your last visit to our office we discussed my concern for _________________. It is now time for your ____ month recall so that I may continue to provide the best possible care for you.

We look forward to seeing you on ________________ at ___________. Please call to reschedule if this time is inconvenient.

Sincerely,

Dr. ________________

FORM: DISRE
Dear ________________,

Sorry that you missed your appointment.

Your eye health care is more than checking when your glasses or contact lenses need replacement. We need to check regularly for signs of glaucoma, cataracts, and complications caused by high blood pressure. These vision problems may show no symptoms until they are in their later stages.

We will call you to reschedule your eye health examination.

See you soon!

Sincerely,

Dr. ________________ and Staff

FORM: MAPTRE
Dear __________________________,

We missed you! Your __________________________ exam was scheduled for __________________________ at __________________________. It's easy to forget appointments; however, your vision is very important and precious.

Remember, many diseases or changes in your eyesight can only be detected by a complete examination.

We will be calling you next week to reschedule your appointment.

Sincerely,

Dr. __________________________ and Staff

FORM: MISSRE
Dear M ______________________________

It is time for your periodic visual examination which was recommended during your last visit. To safeguard your eye health and vision, regular examinations are essential.

We will call soon to arrange for an appointment; or, if you prefer, please call us.

Sincerely,

Dr. ____________________________

FORM: PERRE
We Hope To Brighten Your Day

Happiness is
Crystal Clear Vision
and
Healthy Sparkling Eyes

It is time for your yearly examination
so call for an appointment
to brighten your vision
and
brighten your day!

your phone number
your name

Form: RenAppt
CONTACT LENSES
Dear ____________,

You have had your contact lenses for one month

... and should be making good use of them by now. At this point, many contact lens wearers "relax" and forget some of the rules they followed when the lenses were new.

You will get a good deal of advice from other persons who have contacts. If it is contrary to the things you learned in our office, please call before you change your manner of lens handling. Don't worry about bothering us, we will be glad to hear from you.

Referral of friends who may wish to wear contact lenses is another matter which our patients do not always understand. We are never too busy to discuss visual problems with your friends or other members of your family. Your kind words mean more than any advertisement ever could, and are deeply appreciated.

We will certainly enjoy caring for anyone you send to us. Meanwhile, if you have any difficulty which you feel is out of the ordinary before your next scheduled appointment, please call.

Sincerely,

Dr. ________________ and Staff

FORM: 1 month
Dear ____________________,

Our records indicate that your eyes and contact lenses have not been examined by us for over two years. We felt that another reminder was in order at this time.

From routine experience, we have found that contact lenses often need minor adjustments after two years. This means that you are probably not getting the best possible wear from your lenses at the present time.

In addition, new developments in contact lens technology could allow us to update the type of contact lenses you are wearing to afford optimum performance and eye health.

For your good eye health, please do not wait for any additional reminders. Make an appointment immediately.

Sincerely,

Dr. ____________________

FORM: 2YEAR
Contact Lens Appointment Confirmation

Time has been reserved for you on _____________ at ________. If you will be unable to come to our office, please let us know at your earliest convenience so that the time can be made available to someone else. Please note the checked item(s) below. Thank You.

__Contact Lens Examination__
- This includes tests to determine contact lens acceptance, careful measurement of your eyes with diagnostic fitting of rigid gas permeable (hard) or soft contact lenses, and consultation following a study of your ability to wear the lenses. This will take about one and a half hours.
- You will probably not get your lenses at this time. The actual fitting takes about four hours more and an appointment will be set for you to return.

__Basic Eye Examination (Refraction)__
- The initial examination of the eye and prescription of the correct lens power for contact lenses or glasses is necessary if your present glasses are not satisfactory or if it has been more than one year since you last examination. This will take an additional half hour.

__Old Glasses and Contacts__
- Please bring all glasses that you are currently using, whether or not they are satisfactory. Also bring a copy of your current eyeglass prescription if you have one, and even though they may not be worn regularly, bring all of your old contact lenses. (Be sure that old soft lenses have been recently disinfected if we are to check the fit of them.) These will provide useful background information and enable us to take better care of your eyes.

__Cosmetics__
- You may wear cosmetics with contact lenses (in fact that is one of the real advantages of wearing contact lenses) but eye makeup must be removed for the examination. You will save time and trouble if you do not wear it to the office.

__Medicare__
- If you have a Medicare card, contact lenses after surgery or injury will be covered. Please bring you Medicare card with you. We will take care of all claim forms for you.

__Insurance Claims__
- Our office staff will also try to assist you in making claims for any benefits due you under any insurance plan, but please be sure to read the form over and fill out as much as you can before bringing it to the office. If you are in doubt as to whether contact lens charges are covered by your insurance (many are not), please check before you go to the trouble of filling out lengthy forms.

__Teenage Patients__
- Most persons who are old enough to wear contact lenses have a good sense of responsibility and can generally handle matters quite well without adult assistance. Nevertheless, we believe that eyes are very important and that most parents want to know what is involved. For the examination, then, we ask that minors be accompanied by a responsible parent or guardian. This will be unnecessary on subsequent visits.

__Payment__
- Accounts may be paid in cash or by personal check. Master Card, VISA, and Mastercard are accepted.

We look forward to seeing you at your appointment.
CONTACT LENS DO'S AND DON'TS

In order to have successful wear and optimal service of your contacts, it is important that you follow our instructions on the care and cleaning of the lenses. A teaching session will be scheduled with you to build confidence in lens insertion and removal as well as proper cleaning procedures.

To stress the importance of good care, we have provided you with a list of "Do's" and "Don'ts" to follow. Please review the list and feel free to ask our staff any questions or concerns you may have.

DO'S

1. Before handling lenses, wash your hands using a mild soap.
2. Take the time to clean your lenses well.
3. Follow your wearing schedule.
4. Soak your lenses in the recommended solution when not wearing them.
5. Remove your lenses if blurring or discomfort occurs.
6. Use proper eye protection or sunwear when needed.
7. Keep all appointments for follow-up care.
8. Contact our office immediately if problems occur.
10. Use eye make-up designed for contact lens wearers to avoid lens discoloration.
11. Have a complete visual examination once a year.

DON'TS

1. Overwear your lenses beyond the recommended schedule.
2. Sleep with your lenses on (daily wear patients only.)
3. Shower, sauna, or swim with your lenses on.
4. Wear your lenses around aerosol sprays or noxious fumes.
5. Use any products other than those recommended, for example Visine or Murine.
6. Take the advice of other contact lens wearers without consulting our office.

Please bring your eyewear and contact lenses case with you each time you visit our office. Thank you!

FORM: CLD&D
CONTACT LENS FITTING AGREEMENT

FITTING PERIOD
The fee for contact lenses includes all examinations, visits, and materials during the fitting period. Any changes in lens type or power during this period will be the responsibility of this office and is covered under the contact lens fitting fee. The fitting period includes all examinations and progress visits (no limit) until Dr. __________________ is satisfied you have a proper fit. You will usually be dismissed for six months at this time. The sixth month examination is not included in the fitting fee.

YOUR RESPONSIBILITY
It is essential to periodically evaluate your contact lenses after they have been worn several days, weeks, and months. Failure to return for a progress examination may jeopardize the health of your eyes as well as cause unnecessary discomfort. If you cannot keep an appointment, please advise our office as soon as possible so that we may schedule another patient. It is your responsibility to reschedule any progress examinations that have been cancelled.

FEES
The total fee for your contact lenses is not due until they are dispensed. Should you or Dr. __________________ then decide that contact lenses prove to be unsatisfactory for you, and the decision is made to terminate the fitting procedure, you will pay only for the total professional time spent in examinations and fittings for the contact lenses. A refund will be issued for the balance.

LOSS AND INSURANCE
Contact lens insurance is available through our office. It is optional and the cost of the insurance is not included in the fitting fee. The replacement cost of a contact lens will include one progress visit to evaluate the fit of the new lens. Should a new or replacement lens perform in a defective manner, please return it to our office as soon as possible. All contact lenses are warranted by the manufacturer for a limited period of time.

We hope this policy information sheet is helpful and will avoid any misunderstands both now and in the future. Should you have any questions, please let us know.

_________________________  __________________________
Signature of Patient  date

FORM: CLFAI
Contact Lens History Report

Please forward the following information to my eye doctor so that he may compare the status of my contact lenses and cornea to their previous condition. Thank you very much.

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient's Name</th>
<th>Patient's Signature</th>
</tr>
</thead>
</table>

Original Contact Lens Refraction and Date

<table>
<thead>
<tr>
<th>R</th>
<th>VA</th>
<th>L</th>
<th>VA</th>
</tr>
</thead>
</table>

Original Keratometer Readings (Horizontal/Vertical)

<table>
<thead>
<tr>
<th>R</th>
<th></th>
<th>L</th>
<th></th>
</tr>
</thead>
</table>

Contact Lens Type and Name

______________________________

Tint Number and Color

______________________________

Base curve

<table>
<thead>
<tr>
<th>R</th>
<th></th>
<th>L</th>
<th></th>
</tr>
</thead>
</table>

Secondary Curve

<table>
<thead>
<tr>
<th>R</th>
<th></th>
<th>L</th>
<th></th>
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</thead>
</table>

Third Curve

<table>
<thead>
<tr>
<th>R</th>
<th></th>
<th>L</th>
<th></th>
</tr>
</thead>
</table>

Power

<table>
<thead>
<tr>
<th>R</th>
<th>VA</th>
<th>L</th>
<th>VA</th>
</tr>
</thead>
</table>

Follow up Keratometer Readings and Date

<table>
<thead>
<tr>
<th>R</th>
<th></th>
<th>L</th>
<th></th>
</tr>
</thead>
</table>

Other pertinent information:

______________________________

Send To: _______________________________, O.D.

Form: CLhistRT
Dear ____________,

Thank you for calling our office with your questions about contact lenses.

We've enclosed information as a guide to our professional services and special contact lens care. Also enclosed is some background information on contact lenses which will be very helpful to you.

Your contact lens care will begin with a complete eye examination consisting of a total evaluation of your internal and external eye health and visual corrections needs. Following your complete examination, Doctor ________________ will measure your eyes to determine the correct contact lens design for you. Once you receive your contact lenses, we will instruct you on proper care and handling of the lenses.

You will be given a wearing schedule and instructions, and your progress will be closely monitored over the next several months.

Our total contact lens care is based on professional, individualized attention, modern diagnostic instrumentation, and the highest quality contact lenses available.

Our patients love the freedom and comfort contact lenses provide. Please feel free to call for additional information or for an appointment. We'll be happy to discuss in further detail all the benefits contact lenses can offer you!

Sincerely,

Dr. ________________ and Staff

FORM: CLITY
Dear ____________________,

Though contact lenses are becoming very commonplace, we think that our contact lens patients are very special.

We like to consider you as part of our practice family, for it was our pleasure to fit you with contact lenses.

Feel free to call if you have any questions, and thank you for trusting your visual needs to me and my staff.

Very sincerely,

Dr. ____________________ and Staff

FORM: CLPTY
CONTACT LENS SELECTION QUESTIONNAIRE

Please Circle the appropriate score for each item and total the points. The purpose of this form is to help us determine how easily you will adapt to contact lenses. Please note: a high score does not mean you cannot wear contact lenses, only that adaptation to the lenses may be more difficult.

1. Environment you live in
   - Clean air (rural) 1
   - Mild Polluted (suburban) 2
   - Polluted (urban) 3
   - Highly polluted (industrial) 4

2. Allergies
   - none 1
   - mild 2
   - moderate 3
   - severe 4

3. Skin type
   - normal 1
   - dry or oily 3
   - sensitive 5

4. Medications
   **Antihistamines**
   - never use 0
   - occasional use (colds) 1
   - frequent use 2
   **Diuretics**
   - never use 0
   - less than once/week 1
   - frequent use 3
   **Birth Control Pills**
   - no 0
   - yes 3
   - sensitive 5

5. Tearing
   - normal 0
   - mild 1
   - excessive 3
   - dry eyes 5

6. Light Sensitivity
   - none 0
   - moderate 3
   - mild 1
   - severe 5

7. Eye Itching
   - never 0
   - rarely (once a year) 1
   - frequently 3
   - continual 5

8. Smoke & Chemical Sensitivity
   - none 0
   - mild 1
   - moderate 3
   - severe 5

9. Anticipated Wearing Time
   - casual-
   - few hours now & then 0
   - less than 8 hours 2
   - over 8 hours 3
   - extended wear
     - (more than 24 hours) 5

TOTAL SCORE: __________

KEY:
- 0-13: Excellent Potential
- 14-24: Good Potential
- 25-29: Unlikely Potential
- 30+: Poor Potential

FORM: CLQUEST
CONTACT LENS SERVICE AGREEMENT

_________, 19 __

Patient: __________________________

Address: ____________________________________________________________

City: _______________ State: ___________ ZIP: ______________

Fee for One Year: $ __________ Warranty in Effect until: ______________

Manufacturer of Contact Lens Covered: R _________ L _____________

Type of Lens: RGP ___ Soft ___ Toric ___ Bifocal ___ Colored ___

While in effect we agree to:

1. Unlimited Lens Replacement for any reason at $ ______ per lens.

2. Provide ____ Contact Lens Progress Exams at regular intervals.

3. Provide Maintenance Contact Lens Inspection if needed.

4. Supply Contact Lens Solutions at ______% off.

Other professional services and materials not specifically mentioned above will be at our customary fees.

This Agreement is not transferable or cancellable and is valid only at our office.

FORM: CLSERAG
NEW PATIENT CONTACT LENS SERVICE POLICY

Coverage for one year $________

Issue Date ____________ Expiration Date ____________ by ________________________

Patient ________________________________________________________________

Address ______________________________________________________________

City __________________________ State ____________ ZIP ________________

During this period we agree to:
1. Replace or duplicate your present type of contact lenses at a reduced price regardless of the number of claims made.

   Lens Type:   __ Daily Wear __ Extended Wear

   __ Soft       __ Rigid Gas Permeable

   Right Lens:  __ Sphere __ Toric  __ Bifocal
   Left Lens:   __ Sphere __ Toric  __ Bifocal

2. Provide other contact lens office visits for check-ups or unexpected problems at the reduced rate of $________ (regular $________). This does not cover the yearly vision examination.

Conditions of this policy:
Policy must be in force at the time a lens is originally received in order to make a replacement claim. If coverage is allowed to lapse, there is a required waiting period of 30 days before any new claims can be made. All lens replacements and office charges are at the regular prices during this time.

Form: CLserv
A PROGRAM FOR COMPREHENSIVE CONTACT LENS CARE

Introduction

The purpose of this contract is to provide the necessary service incidental to the wearing of contact lenses at a reasonable cost.

Therefore, for the sum of $____ the office will provide you,


with one year's service in regard to your contact lenses. These services are listed below.

In order to ensure no interruption in services this agreement will be automatically renewed, upon receipt of payment, on the anniversary date. In the event of my incapacitation, service will be made available by my successor.

Services Rendered at No Charge

Two check-ups per year. At these visits the fit of the lenses, integrity of the eyes and visual acuity are investigated. The lenses are inspected, cleaned, and polished if necessary.

If at any time between check-ups the lenses become bothersome you will be cared for at no charge for up to a total of six visits.

Laboratory Charges

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Replacement Lens</td>
<td>$____ per lens</td>
</tr>
<tr>
<td>Repower Your Lens</td>
<td>$____ per lens</td>
</tr>
<tr>
<td>Resurface Lenses</td>
<td>$____ per lens</td>
</tr>
</tbody>
</table>

__________________________________________

Patient Name

__________________________________________

Patient Signature

__________________________________________

Date of Issue

Form: CLserv2
Your Name
Your Address

Contact Lens Yearly Service Policy

Coverage for one year $ ________

Issue Date ________________ Expiration Date ________________ by ________________

Patient __________________________________________________________________________

Address __________________________________________________________________________

City __________________ State ------- ZIP ________

Lens Type: Daily Wear or Extended Wear Soft or Rigid Gas Permeable

with policy without policy

Right Lens: Sphere Toric Bifocal $ ________ $ ________

Right Lens: Sphere Toric Bifocal $ ________ $ ________

During this period of time we agree to:

1. Replace or duplicate your present type of contact lenses at a reduced price regardless of the number of claims made.

2. Provide one complete yearly examination and contact lens evaluation as required for all contact lens patients at $ ________ (regular $ ________).

3. Provide other contact lens office visits for check-ups or unexpected problems at the reduced rate of $ ________ (regular $ ________).

Conditions:
Policy must be in force at the time a lens is originally received in order to make a replacement claim. If coverage is allowed to lapse, there is a required waiting period of 30 days before any new claims can be made. All lens replacements and office charges are at the regular prices during this time period.

*******************************************************************************

I have read and thoroughly understand the provisions of this contact lens service policy.

Patient Signature

Form: CLserv3
CONTACT LENS SERVICE WARRANTY

"Offering Security and Service for Your Contacts"

WHAT THE "6 POINT" WARRANTY OFFERS:

1. Reduced Cost on Replacement Lenses for any reason or for a Spare Pair. Your Deductible: $ ________ per lens.

2. Office visits after the fitting period for any reason at $ ________.
   (Regular Fee: $ ________.)

3. Inspection of Lenses for Damage or Deposits: No Charge

4. Polishing of Gas Permeable Lenses for $ ________ per pair.
   (Regular Fee: $ ________.)

5. Remove and Clean Extended Wear Lenses once per Month at No Charge.
   (Regular Fee: $ ________.)

6. 10% Discount on all Eyewear and Contact Lens Solutions.

This agreement covers all services which might prove necessary in case of loss or damage to your lenses and provides for the eye care required for optimum results.

Name of Patient: __________________________________________.

Warranty Effective From ________, 19__ until ________, 19__.  

FORM: CLWARR
COSMETICS AND YOUR CONTACTS

Contact lenses make your eyes look lovely. Eye makeup makes your whole face prettier. But if makeup gets in your eyes, it's a disaster for looks and lenses alike.

Contact lenses should be put on before applying any cosmetics. It is always important that hands have been cleaned up with an oil free soap before lens insertion. Soft lenses will absorb oil, dirt, and cosmetics, and thus lead to eye irritation.

We recommend that contact lens patients use only thimerosol-free cosmetics and eye makeup removers.

Good vigorous cleaning procedures will help minimize cosmetic related problems. It takes 20-30 seconds per lens side to loosen surface particles so that they can be flushed off the lens when rinsed with saline.

Here are some hints for safe and comfortable use of such items:

1. Never use oily makeup near your eyes, because it tends to travel as the warmth of your body melts it down.
2. Avoid using liquid or powder eyeliner very close to the eye. Flaking is a real danger. If you line your eyes, do so only outside the lash line.
3. Use pressed powder eye shadow, rather than liquid or cream; if powder does get into your eyes, your tears will wash it out more readily than an oil based preparation. A pressed powder is easier to keep out of your eyes than a loose powder. Never use pearlized or frosted products as they have tinsel in them which can cause rust spots on your lenses. Smooth shadow with a makeup sponge rather than a brush to keep under control.
4. Mascaras should be water soluble so that small particles that may get into the eye are dispersed and flushed out by tear action.
5. Patients who have cosmetic sensitivities should try hypoallergenic products, such as Almay, Clinique, and Aller-creme.
6. Aerosol products such as hairspray and deodorant should be used before lens insertion. Use extreme caution if you must use hairspray. Keep your eyes closed while spraying and then leave the area, since the spray is still circulating in the air.

If despite all your precautions you still get something in your eyes while applying makeup, rinse your eye with your lens lubricant. If irritation persists, remove the lens and cleanse thoroughly. Still have a problem? Remove the lens again and contact our office.

FORM: COSM&CL
Extended Wear Contact Lens Care And Handling

Proper care is necessary for successful wear, normal lens life, and good eye health. You will be provided with products to clean, disinfect and store your soft lenses. Use them as instructed.

Your...

- Daily lens cleaner
- Lens disinfectant
- Soaking solution
- Rinsing solution
- Eyedrops to use before and after sleep

NOTE: These products have been prescribed specifically for you to use with your lenses. Do not substitute brands unless you check with us first. Use of improper solutions may result in lens irritation.

Special Instructions: ____________________________________________________________

_____________________________________________________

Please note that although certain brands of lenses may be FDA approved for 7, 14, or even 30 days of continuous wear, the adaptability of your eyes is the key factor in determining wearing time. Trust us to recommend a schedule suited to your individual needs. And remember, like any medical device contact lenses must be monitored on a regular basis. Professional follow-up care is the most important element in successful long term lens wear.

In the beginning it is normal if:

1. Your lenses itch or feel funny.
2. One lens is more noticeable than the other.
3. Your vision seems fuzzier than with glasses.
4. One eye sees better than the other.
5. You have trouble handling your lenses.

Remove your lenses if:

1. You develop unusual pain or redness.
2. You develop unusually cloudy or foggy vision.
3. You experience a sandy feeling.
4. You experience an increase drainage or "sleep" from your eyes.
3. You suspect something is wrong.
Wearing schedule


Next appointment: __________

After you fully understand the presented information, please sign below.

________________________________________                     Date
Patient

________________________________________                     Date
Dispenser

Form: EWcare
The Care and Handling of Your Extended Wear Contact Lenses

Wearing contact lenses for extended periods of time requires considerable responsibility on the part of the patient. We require that you follow our instructions listed below and keep all appointments that are scheduled for you. If you do not, we cannot be responsible for the safe and comfortable wear of your contact lenses for extended periods of time.

Lenses approved for extended wear are those that allow a sufficient amount of oxygen to pass through the lenses to nourish the cornea while they are being worn. These lenses are typically more fragile than the daily wear lenses, so care must be taken when handling them to avoid damaging them. Having a spare set of prescription lenses is wise. Some patients also like to have a spare set of contact lenses to use while disinfecting one pair and to provide an immediate replacement should a lens be lost or damaged.

The following simple instructions should help guide you to success:

1. Your extended wear lenses should remain comfortable as long as they are clean and are fitting properly. Over period of time, it is reasonable to expect that the lenses will become coated with tear debris and that the fitting relationship between the lenses and the eyes may change. We want you to do a 3-point safety check every day to monitor how your lenses and eyes are doing. The lenses should “FEEL GOOD, LOOK GOOD, AND SEE GOOD (WELL) at all times. You can do your 3-point check as follows:

   1. **FEEL GOOD**: Blink 6 to 8 times and concentrate to feel if your eyes and the lenses still are comfortable.
   2. **LOOK GOOD**: Look in a mirror to see if there is any excess mucus discharge or any redness on the “whites” of your eyes.
   3. **SEE GOOD (WELL)**: Gaze at a distant picture or calendar and alternately cover one eye and then the other to make sure the ability to see clearly has not changed.

   If you cannot pass any one of the above 3 safety check points, the lenses should be removed, cleaned, and re-applied according to the instructions you received. If the lenses and/or eyes still are uncomfortable, remove the lenses, clean them again, disinfect them and hand-carry them back into the office at your earliest convenience. We will want to examine your eyes and lenses with our microscopes to see if your eyes are irritated or infected or your lenses are soiled or damaged.

2. Wash your hands thoroughly prior to handling your lenses! For those whose hands are excessively soiled, especially smokers who often have nicotine on their fingers and hands, the use of a fingernail brush to scrub the fingers and hands is especially recommended. It is very important to use pure soaps that do not contain oils, creams and other lotions as these are difficult to remove from the hands and often damage the lenses. Be sure to rinse your hands well to rid them of any soapy residue.

3. Use only solutions that we have recommended to you! If you see something on sale, please check with us before buying them as they may cause problems for you if they are not compatible with your lenses. Never use rigid (hard) contact lens solutions on your soft lenses and never use soft contact lens solutions with your rigid (hard) lenses. Remember that some solutions are not compatible with each other. *It is strongly recommended that you do not change your solution regimen that has been prescribed with your lenses.*

4. Whenever you need to remove your extended wear contact lenses, please follow the instructions that we provided you detailing how to use the various solutions to clean and disinfect them. Lenses should ideally be removed anytime they bother or irritate the eyes no matter how short or long a time they have been on the eyes. While the FDA recommends that most lenses worn on an extended wear basis be removed and cleaned on a 30 day cycle, our experience has been that, “if it ain’t broke, don’t fix it!” Frequent removal sometimes creates problems with loss or damage to the lenses.
5. Prior to removing your lenses, be sure to clean your case. do not use soap on your case. Rather, use the Plagel daily surfactant cleaner on the case and rinse vigorously. If you like, you can soak the container with the Lensept hydrogen peroxide solution as this will disinfect the case and kill any "bugs" that may have grown in the case between uses. ALWAYS THOROUGHLY RINSE THE LENSEPT BEFORE RETURNING THE LENSES TO IT!

6. Always inspect your lenses prior to re-applying them to your eyes. If you see any defects or dirty deposits that you are unable to remove, do not wear the lenses. Call us instead. In may cases, we can replace a dirty or damaged lens the same day.

7. If a lens should "pop" out of the eye while wearing or if it should get lost in the bathroom, do not attempt to pick it up when you find it in a dry, shriveled up state. Soak it with the saline solution until it is soft and supple again. Otherwise, it will crumble like a cracker. If there is any discomfort, the lenses should be checked to see if there was any permanent lens damage.

8. NEVER...

   - force the removal of a lens that appears to be sticking to the eye; if a lens should stick to the eye, place a few drops of saline or lens lubricant in your eye and allow the lens to hydrate and move freely on the eye.
   - place your lenses in your mouth to wet or clean your lenses; your mouth contains a lot of bacteria that could cause a serious eye infection.
   - use aerosols or hairsprays without first protecting your eyes and lenses as these products can adhere to your lenses and permanently damage them.
   - wear your lenses when you are ill; viral problems, especially the flu and common colds, make you susceptible to serious eye infections as your resistance is lowered during these illnesses; also, some medications will adversely affect your lenses and eyes.
   - try to pull apart a lens that has folded over and become stuck together; Soak it in saline and gently massage it with the cleaning solution until it opens; If you can't get it open call us and bring it to us to open it for you.

9. Please notify us should there be any change in you eye or general health. Even going on a salt-free diet or altering your liquid intake can adversely affect you lens wear. Certain medications affect your entire circulatory and nervous systems.

10. If your eyes or lenses feel very dry during the day, especially when working in an air-conditioned office, you may not be blinking completely or often enough to keep the lenses sufficiently lubricated. Remind yourself to blink fully and more often helps. Use of the in-eye non-thimerosal lens lubricants will also help.

11. If you think your lenses may be switched or inverted, you can first try to switch them to see if your vision and the comfort improves. If it does not and if you are still unsure, call us and come in so that we can check to see if they are correct.

12. We strongly recommend that after the initial 12 months that you continue to seek our professional contact lens care at least once every 3 months for as long as you are wearing your lenses on an extended wear bases. Our concern is that your eyes as well as your lenses may have changed in shape. Further, your lenses may have accumulated surface deposits that could irritate your eyes.

IF YOU ARE IN DOUBT ABOUT ANY ASPECT OF YOUR EXTENDED WEAR CONTACT LENS CARE PROGRAM, DO CONTACT US! WE DO WANT TO BE THE FIRST TO HEAR IF YOU ARE HAVING ANY DIFFICULTIES WITH YOUR LENSES.

Office telephones:
Dr. ________'s Home: ______________________
24 Hour Answering Service: ____________________ Form: EWcase2
Extended Wear Soft Lens Fee Schedule

One pair of Extended Wear Soft Lenses .................................................. $ ___
Contact lens Evaluation .......................................................................... $___
   Includes a contact lens eye examination plus specific tests to determine your ability to wear and
   adapt to the extended wear soft contact lenses.
Professional Services and Follow-up Care .............................................. $___
   Includes contact lens design and prescription, professional instructions on care and handling,
   plus follow-up care for ____ months.
Care Kit and Solutions. ........................................................................... $___
   FDA regulations require that your lenses be dispensed with a proper cleaning and disinfection
   system. Depending on your particular lenses, we may use either a heat or chemical disinfection
   system.
Special Fees
   Toric lenses for astigmatism, add ...................................................... $___
   Tinted lenses, add ................................................................. $___
   Bifocal soft lenses, add ........................................................... $___
   High plus powered lenses for post cataract fit ................................ $___
   Monovision fittings for bifocal correction, add ................................. $___
   Special custom design lenses ........................................................ $___
   Total special fees .......................................................................... $___

The total contact lens fee is ................................................................. $ ___

Replacement costs
The lifespan of your lenses will depend directly on the care you give them. However, due to loss,
damage, or prescription change, the average extended wear patient will replace about one lens a year. To
substantially reduce the cost of the lens replacements and office visits, you may purchase a contact lens
service policy.

First Year Coverage . . . $ ___

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<td>Office Visit...</td>
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Refund policy
Your lenses may be returned within ____ days from the original dispensing date for a ____% refund.
The main expense in professional contact lens care is our time and expertise.

Low Contact Lens Prices Can Be Misleading
Quotes can be confusing because several elements are involved in complete contact lens care. People who perceive
buying contacts as just the purchase of a pair of lenses fail to recognize the importance of specialized eyecare. When
you get contact lenses, you should have a professional eye examination before the fitting as well as follow-up care
after the lenses have been worn.

While the costs for contact lenses and these services will vary from office to office, you most important consideration
should be getting quality care, not finding the lowest price. Your level of success and satisfaction with contacts will
be determined by the skill and expertise of your eye doctor. Do not sacrifice quality of care and service for a bargain
price.
Your Doctor's Professional Judgment is More Important than the Contact Lens Brand

Patients frequently ask about certain well known brands because they are highly advertised and enjoy a good reputation. Please be advised that there are many excellent quality contact lenses on the market today for a variety of vision problems. Our job is to know which kind is going to work in your particular case. After examining you and evaluation such things as your lens prescription, the shape and size of your cornea and your visual needs, we will be able to recommend the type of contacts that are best for you. Our office provides professional and specialized contact lens care.
Follow-up Care Agreement For
Extended Wear Contact Lens Patients

Patients wearing contact lenses for extended periods of time require additional professional follow-up care to more closely monitor how their lenses are fitting since the lenses are not removed on a daily basis.

All extended wear contact lens patients must adhere to the following office visit schedule of periodic follow-up evaluations:
- After 24 hours of extended wear
- After 3 days of extended wear
- After 1 week of extended wear
- After each month of extended wear for the first six (6) months
- After each three (3) month period of extended wear, thereafter, and
- Anytime any discomfort, increased sensitivity to light, redness, increased mucus discharge, blurry vision, etc., is experienced.

Your eyes should always "FEEL GOOD, LOOK GOOD, AND SEE GOOD!" If your eyes bother you at ANYTIME, or if you have any questions or concerns, we want to be the first to know. You can always reach one of our staff members 24 hours a day, 7 days a week.

Office Telephones:
Dr. __________'s Home:
24 Hour Answering Service:

While many patients are successful in wearing their contact lenses for extended periods of time, there are certain environmental, personal, physical, and psychological factors that may adversely affect your wearing the lenses successfully on an extended wear bases. Some of these are:
- Uses of certain medications to control changes in your health
- Development of allergies
- Poor personal or lens hygiene
- Pollutants in the environment
- Deterioration of the contact lenses
- Severe emotional stress, etc.

************************************************************************************************

I understand that it is important for me to keep my scheduled follow-up office visits and I agree to keep them. I will contact my optometrist immediately should my eyes or lenses bother me in any way. I further understand the importance of the proper maintenance and care of these contact lenses and will follow the professional contact lens care advice given to me.

_________________________  ____________________________  ____________________________
Date                      Patient's Name               Patient's Signature

Form: EWfollow
Dear ______________,

Contact lens wear requires routine follow-up visits to ensure good eye health. When you received your extended-wear contact lenses, we agreed on a specific follow-up visit schedule. Our records indicate you missed a routine follow-up visit on _________. Our mutual interest in continuous good vision prompts us to send you this important reminder.

Please phone to reschedule this appointment as soon as possible.

Sincerely,

Dr. ________________________
ADDRESS
PHONE

FORM: EWMISAP
Dear ________________,

Thank you for choosing our office to care for your contact needs. Enclosed you will find an appointment card confirming your appointment, as well as a copy of our office brochure and an article about contact lenses. Our patients find them informative and useful.

Every effort will be made to give you the finest visual care while making your contact lens evaluation a pleasant experience. We look forward to seeing you. Please bring with you your most recent pair of eyeglasses and sunwear.

Sincerely,

Dr. ________________ and Staff.

FORM: NCLPAPT
Dear ________________,

During your last exam we reminded you that a follow-up exam is essential for successful contact lens wear.

To ensure that you're getting the best wear and comfort from your lenses, we've reserved an appointment for you on ____________ at _______. We look forward to seeing you then!

Sincerely,

Dr. ________________

FORM: RECSAPT
Rigid Gas Permeable
Contact Lens Care And Handling

Proper care is necessary for successful wear, normal lens life, and good eye health. You will be provided with products to clean, disinfect and store your soft lenses. Use them as instructed.

Your...

Daily lens cleaner

Overnight soaking solution

Lens wetting solution

Eyedrops to use when the lenses are on

NOTE: These products have been prescribed specifically for you to use with your lenses. Do not use other brands unless you check with us first. Use of improper solutions may result in lens damage or infection.

Special Instructions: ________________________________________________________________

In the beginning it is normal if:
1. Your lenses itch or feel funny.
2. One lens is more noticeable than the other.
3. Your vision seems fuzzier than with glasses.
4. One eye sees better than the other.
5. You have trouble handling your lenses.

Remove your lenses if:
1. You develop unusual pain or redness.
2. You experience a decrease in vision that does not clear up.
3. You suspect something is wrong.

Wearing schedule

<table>
<thead>
<tr>
<th>Day</th>
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After you fully understand the presented information, please sign below. Next appointment: ____________________

Patient Date

Dispenser Date Form: RGPcare
Rigid Gas Permeable Lens Fee Schedule

One pair of Rigid Gas Permeable Lenses ............................................. $___

Contact lens Evaluation ................................................................. $___
Includes a contact lens eye examination plus specific tests to determine your ability to wear and adapt to contact lenses.

Professional Services and Follow-up Care ........................................ $___
Includes contact lens design and prescription, professional instructions on care and handling, plus follow-up care for _____ months.

Care Kit and Solutions ................................................................. $___
FDA regulations require that your lenses be dispensed with a proper cleaning and disinfection system. Depending on your particular lenses, we may use either a heat or chemical disinfection system.

Special Fees
Toric lenses for astigmatism, add .................................................. $___
Tinted lenses, add ........................................................................... $___
Keratoconus fit ............................................................................. $___
High plus powered lenses for post cataract fit ............................... $___
Monovision fittings for bifocal correction, add ............................. $___
Special custom design lenses ....................................................... $___

Total special fees ........................................................................... $___

The total contact lens fee is ............................................................ $___

Replacement costs
The lifespan of your lenses will depend directly on the care you give them. However, due to loss, damage, or prescription change, the average soft lens patient will replace about one lens a year. To substantially reduce the cost of the lens replacements and office visits, you may purchase a contact lens service policy.

First Year Coverage . . . $_______

Wind Replacement
Spherical soft Lens... ................................................................. $___
Toric Soft Lens... .......................................................................... $___
Bifocal Soft Lens... ....................................................................... $___
Office Visit... ................................................................................ $___

Refund policy
Your lenses may be returned within ____ days from the original dispensing date for a ___% refund.

The main expense in professional contact lens care is our time and expertise.

Low Contact Lens Prices Can Be Misleading
Quotes can be confusing because several elements are involved in complete contact lens care. People who perceive buying contacts as just the purchase of a pair of lenses fail to recognize the importance of specialized eyecare. When you get contact lenses, you should have a professional eye examination before the fitting as well as follow-up care after the lenses have been worn.

While the costs for contact lenses and these services will vary from office to office, you must important consideration should be getting quality care, not finding the lowest price. Your level of success and satisfaction with contacts will be determined by the skill and expertise of your eye doctor. Do not sacrifice quality of care and service for a bargain price.
Your Doctor's Professional Judgment is More Important than the Contact Lens Brand

Patients frequently ask about certain well known brands because they are highly advertised and enjoy a good reputation. Please be advised that there are many excellent quality contact lenses on the market today for a variety of vision problems. Our job is to know which kind is going to work in your particular case. After examining you an evaluation such things as your lens prescription, the shape and size of your cornea and your visual needs, we will be able to recommend the type of contacts that are best for you. Our office provides professional and specialized contact lens care.

Form: RGPfees
CARE AND HANDLING FOR SOFT CONTACT LENSES

Chemical Disinfection

Evening Procedure:
1. Wash your hands before handling lenses.
2. Remove lenses from eyes and place in the palm of your hand.
3. Apply two or three drops of cleaning solution on each side of the lenses and rub in a spoke like fashion for about 20 seconds.
4. Rinse all the cleaning solution off the lenses with saline solution.
5. Place lenses in the case and fill with disinfectant to immerse the lenses.
6. Allow lenses to remain in solution for at least six hours or overnight.

Morning Procedure:
1. Wash your hands before handling lenses.
2. Remove lenses from case and rinse thoroughly with saline solution.
3. Place lenses on eyes.

Heat Disinfection

Evening Procedure:
1. Wash your hands before handling lenses.
2. Remove lenses from eyes and place in the palm of your hand.
3. Apply two or three drops of cleaning solution on each side of the lenses and rub in a spoke like fashion for about 20 seconds.
4. Rinse all the cleaning solution off the lenses with saline.
5. Place lenses in the case, fill with saline and place case in the heating unit and press the button. The heat unit will run from 45 minutes to one hour. Lenses can be left in the unit overnight.

Morning Procedure:
1. Wash your hands before handling lenses.
2. Remove lenses from the case and rinse thoroughly with saline.
3. Place lenses on the eyes.
   Lubricating drops may be used as needed if desired.

Recommended Solutions:

 Recommended Solution:

Recommended Solution:

Wearing Schedule:

Day 5: _____ hr. Day 6: _____ hr. Day 7: _____ hr.

FORM: SCL CARE
Dear _________________________________:

Enclosed is/are your contact lens/es. Before wearing, please clean and wet the lens/es with appropriate solutions that have been prescribed.

If you have lost wearing time, begin again slowly and call our office for an appointment upon reaching ______ hours wear.

__ A followup visit is required.
   Please call our office for an appointment upon reaching _____ hours wear.

__ No immediate followup visit is required.
   You will be notified for your regular ______ month examination.

form: SendCL
Soft Contact Lens Care And Handling

Proper care is necessary for successful wear, normal lens life, and good eye health. You will be provided with products to clean, disinfect and store your soft lenses. Use them as instructed.

Your...
Daily lens cleaner
Weekly lens cleaner
Lens disinfection method
Overnight soaking solution
Rinsing solution
Eyedrops to use when the lenses are on

NOTE: These products have been prescribed specifically for you to use with your lenses. Do not use other brands unless you check with us first. Use of improper solutions may result in lens damage or infection.

Special Instructions:

In the beginning it is normal if:
1. Your lenses itch or feel funny.
2. One lens is more noticeable than the other.
3. Your vision seems fuzzier than with glasses.
4. One eye sees better than the other.
5. You have trouble handling your lenses.

Remove your lenses if:
1. You develop unusual pain or redness.
2. You experience a decrease in vision that does not clear up.
3. You suspect something is wrong.

Wearing schedule

Day | Hours | Day | Hours
---|---|---|---
1 | | 8 |
2 | | 9 |
3 | | 10 |
4 | | 11 |
5 | | 12 |
6 | | 13 |
7 | | 14 |

After you fully understand the presented information, please sign below. Next appointment: 

Patient: ______________________ Date: ______________________

Dispenser: ______________________ Date: ______________________

Form: Softcare
Daily Wear Soft Lens Fee Schedule

One pair of Soft Lenses .......................................................... $____

Contact Lens Evaluation .......................................................... $____
   Includes a contact lens eye examination plus specific tests to determine your ability to wear and
   adapt to contact lenses.

Professional Services and Follow-up Care .................................................. $____
   Includes contact lens design and prescription, Professional instructions on care and handling,
   plus follow-up care for ______ months.

Care Kit and Solutions .......................................................... $____
   FDA regulations require that your lenses be dispensed with a proper cleaning and disinfection
   system. Depending on your particular lenses, we may use either a heat or chemical disinfection
   system.

Special Fees
   Toric lenses for astigmatism, add ............................................ $____
   Tinted lenses, add .......................................................... $____
   Bifocal soft lenses, add .................................................. $____
   High plus powered lenses for post cataract fit ................................ $____
   Monovision fittings for bifocal correction, add .......................... $____
   Special custom design lenses .............................................. $____

Total special fees .......................................................... $____

The total contact lens fee is .................................................. $____

Replacement costs
The lifespan of your lenses will depend directly on the care you give them. However, due to loss,
damage, or prescription change, the average soft lens patient will replace about one lens a year. To
substantially reduce the cost of the lens replacements and office visits, you may purchase a contact lens
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First Year Coverage . $____

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Refund policy
Your lenses may be returned within ____ days from the original dispensing date for a ____% refund.
The main expense in professional contact lens care is our time and expertise.

Low Contact Lens Prices Can Be Misleading
Quotes can be confusing because several elements are involved in complete contact lens care. People who perceive
buying contacts as just the purchase of a pair of lenses fail to recognize the importance of specialized eyecare. When
you get contact lenses, you should have a professional eye examination before the fitting as well as follow-up care
after the lenses have been worn.

While the costs for contact lenses and these services will vary from office to office, you most important consideration
should be getting quality care, not finding the lowest price. Your level of success and satisfaction with contacts will
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Your Doctor's Professional Judgment is More Important than the Contact Lens Brand

Patients frequently ask about certain well known brands because they are highly advertised and enjoy a good reputation. Please be advised that there are many excellent quality contact lenses on the market today for a variety of vision problems. Our job is to know which kind is going to work in your particular case. After examining you an evaluation such things as your lens prescription, the shape and size of your cornea and your visual needs, we will be able to recommend the type of contacts that are best for you. Our office provides professional and specialized contact lens care.

Form: Soft Fees
EYEWEAR
Dear:

We have been unable to reach you by telephone. Please call our office regarding the following...

____ Your glasses/contact lenses have arrived. A dispensing appointment is necessary.

____ There has been a delay in your glasses/contact lenses. You will be notified when they arrive.

Sorry for the inconvenience.

Form: DispNoti
LETTERHEAD

CARE INSTRUCTIONS FOR FRAME AND LENSES

No matter how careful you are, spectacle frames will get out of adjustment, and you should return to our office for periodic re-adjustments. There is no charge for this service (for the first ____ visits).

CARE OF PLASTIC LENSES: Plastic lenses need to be cleaned with care to avoid scratching. Rinse lenses thoroughly with tap water to remove dirt and dust. Then use a plastic or glass cleaning solution (eg. Windex, Glass Plus), rub gently, and then rinse again with cool tap water. Dry with a soft cotton cloth. Do not use tissues or paper towels. Never try to wipe off the lenses when they are dry. Remember to use a case when not wearing your glasses, and be sure to never set your glasses down on the lenses!

CARE OF FRAMES: Always use two hands when placing frames on or off the face to maintain proper adjustment. If frames should become loose and slide down your nose, you should bring them into the office for an adjustment. Do not try to bend them yourself. To clean, periodically bring frames in and have them professionally cleaned in our ultrasound cleaner.

A second pair of eyeglasses is often valuable as insurance against lost time at work and the annoyance of being without glasses in the event of accidental breakage or loss. A second pair is especially important if you have a strong prescription.

Remember, taking good care of your eyewear is important to good vision and comfort!

We know you will enjoy wearing your new prescription eyewear.

Dr. __________________ and Staff

FORM: EW CARE
LETTERHEAD

100 % EYEWEAR WARRANTY

_________________________________________, warrants that the lenses and frames are manufactured of materials of high quality and strength and are free of defects in material and fabrication. The patient named below is entitled to the following, upon return to our office during a period of one (1) year from the date shown below:

1. Any lens that is broken or damaged will be replaced free of charge.
2. Any frame part that is broken or damaged will be replaced free of charge.

There is no limit to the number of repairs or replacements under this certificate during the one year period. This warranty does not include loss, theft, or disappearance of the glasses, or scratching of the lenses. Presentation of this certificate at time of repair or replacement will assist us in servicing you quickly.

Patient Name ___________________________ Date ____________

Frame ________________________________

FORM: EWWARR1
LETTERHEAD

EYEWEAR REPLACEMENT POLICY

We take pride in informing you, our patient, that your new eyewear prescription has been manufactured from quality ophthalmic materials and is free from defects. If a lens or any part of your frame breaks under normal use within one year from this date, ________________, we will repair or replace it at no charge. This warranty does not cover loss, theft, or scratching of the lenses.

Patient's name ____________________________

EWWARR2
I am aware that I am using my old, used frame in making my new pair of spectacles. I will not hold Dr. _____________, his staff, or the laboratory responsible if the frame should break during lens insertion, or subsequent adjustments.

Date: ________________

Name of Patient: _______________________________________

Signature: ______________________________________________

FORM: FRREL
PATIENT MANAGEMENT
GLASS LENSES RELEASE/ADULT

I have been advised that plastic or polycarbonate spectacle lenses are safer vocational lenses than glass spectacle lenses, due to the nature of glass lenses to fragment on severe impacts. Glass fragments can lead to perforating injuries to the eye and to loss of vision. Despite this information, it is my desire to have glass lenses in my spectacles.

Name of Patient: ________________________________

___________________________________________
Signature of Patient                          date

FORM: ADGLR
Dear ________________,

It is understandable that on occasion it is impossible to keep appointments. Unforeseeable problems do arise in everyone's lives from time to time. Hopefully the problem has been resolved which kept you from keeping your appointment today.

Another appointment has been scheduled for you on the enclosed card. If the time is convenient, please sign it and return to our office. If it is not convenient, please call our office as soon as possible.

Sincerely,

Form: BrokeApp
I have been advised that plastic spectacle lenses have been deemed safer for children than glass spectacle lenses. Perforating injuries to the eye are more common with glass lenses, and may result in loss of sight. Despite this information, it is my decision that my child should be fit with glass lenses in his/her spectacles.

Name of Patient: ________________________________

Name of Parent/Guardian: ________________________________

_________________________ _________________________
Signature of parent/Guardian date

FORM: CHGLR
Dear Dr. ______________:

I recently saw our mutual patient, __________________________, whom you are currently treating for __________________________.

The eye health examination revealed some/no presence of disease. Best corrected visual acuity was _____ OD and _____ OS. Manifest refraction was OD: __________________ and OS: ________ ____________. External slit lamp examination revealed _________________. Goldmann applanation tonometry was _____mm Hg OD and _____ mm Hg OS.

Dilated fundus examination revealed __________________________________________________________________________

________________________________________________________________________________________

Visual field testing with ________________ indicated ____________________________.

If there is any additional information you would like, or if there are any other aspects of this case you feel I should know about, please call.

I plan to see __________________________ again in _____ months, and I will urge _________ to follow your recommendations and to continue to see you on a regular basis.

Sincerely yours,

Dr. ___________________________

enclosure
Dear ________________,

In any profession a man can go only so far in establishing rapport with his patients. A rapport which I consider essential so that you can receive the best care possible.

For some reason in our relationship there is either a total lack of or breakdown in communications. Under these conditions, it would be inadvisable for me to continue attempting to treat you.

In the interest of you receiving maximum vision care, I reluctantly recommend that you consult with someone else in the profession.

Sincerely,

Form: DismisPT
# Eye Examination Report

Patient Name and Age: ___________________________ Date Examined: ________

Subjective Complaint/History:

**Objective Findings:**

<table>
<thead>
<tr>
<th>Visual Acuity</th>
<th>Far</th>
<th>Near</th>
<th>old Rx</th>
<th>Far</th>
<th>Near</th>
</tr>
</thead>
<tbody>
<tr>
<td>unaided</td>
<td>OD 20/</td>
<td>OS 20/</td>
<td>OU 20/</td>
<td>OD 20/</td>
<td>OS 20/</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intra Ocular Pressure</th>
<th>mm Hg</th>
<th>mm Hg</th>
<th>Method:</th>
</tr>
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<tbody>
<tr>
<td>OD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OS</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Methods: Slit Lamp Biomicroscopy

- Normal
- Other

<table>
<thead>
<tr>
<th>Anterior Chamber Angle</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>narrow</th>
<th>wide</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Refraction</th>
<th>OD 20/</th>
<th>OS 20/</th>
<th>Add: OU 20/</th>
</tr>
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<td></td>
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</table>

Other tests were done during the examination. Please call if further information is desired.

**Assessment:**

**Plan:**

__________________________________________ O.D.
Dear _______________,

It's been ______ years since we last had the opportunity of seeing you and taking care of your visual needs.

We've enjoyed having you as a patient and would like the chance to continue to provide you with the quality eye care that you deserve.

If you've chosen another office to care for your needs, please let us know so we may remove your records from the active file.

Our office will always be available to you in the future, should the need arise.

Sincerely,

Dr. ____________________ and Staff
Dear __________,

It is our wish to develop and maintain a close rapport with our suppliers. Since our future business arrangement promises to be a long and productive one, we wish at this time to state how you can be of help to us. And let us know how we can better provide you with necessary information.

Was there a breakdown in communication on the glasses for account number ___________? They are incorrect according to our Rx and they were not ______________. We hope the corrections have been made and that we will receive them shortly.

Kindly let us know if there was some failure on our part to be explicit enough concerning what we wanted.

Sincerely,

Form: LabRemak
Dear ________________________,

My accountant informs me that your account is past due. It would be regrettable for both of us if we are forced to take action. Certainly we wish to avoid any unpleasantness in our doctor-patient relationship.

If your financial condition is such that full payment would work an undue burden, perhaps we can work something out on a monthly basis.

I expect to hear from you in a few days.

Sincerely,

Doctor

Form: OverDuAc
Dear Parent:

In a few short weeks your child will begin his/her formal education. I would like to take this opportunity to let you know of a special visual wellness program I have developed for children beginning school. It is a brief examination to assure you that your child's vision is ready and capable of handling the demands of school. It includes a check of near and far visual acuity, color vision, nearsightedness or farsightedness, eye movement and eye teaming ability, eye focusing ability, internal and external eye health, and eye pressure. The fee for this service is only $  ____.

This vision check will let you be assured that an unknown visual problem will not hinder your child's learning experience.

Sincerely yours,

Dr. ____________________

FORM: PRESCH
Complete Eyecare is More Than Just a Vision Test

Your eye examination consists of various tests to evaluate the health of your eyes and determine the prescription lenses needed for the best possible sight. It is an interesting and totally comfortable experience.

Referrals and Second Opinions
We want you to know our office will refer any patients to the appropriate specialist if we detect or suspect any pathology or visual problem not treated by us.

Eye Health
We use several instruments and procedures to evaluate the health of your eyes. With the ophthalmoscope, your doctor can actually see inside your eye to check for cataracts, retinal problems and evidence of systemic diseases such as diabetes and high blood pressure. A pressure test for glaucoma is done with the tonometer. Other special tests include visual fields and slit lamp biomicroscopy.

Lens Prescriptions
The refraction is a series of lens tests to determine the proper prescription for glasses or contact lenses. Your special needs and preferences must be taken into consideration before the final correction is determined. We strive for the utmost in accuracy and precision.

Eyeglasses
As a part of our eyecare service, we offer a complete selection of high quality eyewear. Our professional staff is trained to help you select frames that look good, fit properly and are compatible with your lens prescription. We want you to have glasses you are proud of and enjoy wearing.

When Should You Have Your Next Eye Examination?
Many people equate the need for an eye examination with replacing their eyeglasses. While it's certainly important to see well, undesirable changes in your eyes can occur which do not adversely affect vision in their early stages. Unlike the rest of your body, your eyes rarely hurt when something is wrong. Do not rely on changes in your vision or broken glasses to remind you of your next appointment. Follow the advice of experts, have your eyes examined on a regular basis.

Contact Lenses
Contact lenses are available in prescriptions for nearsightedness, farsightedness, astigmatism and some bifocal corrections. We provide complete professional care from the initial examination to follow-up visits after you receive your lenses. As a prospective patient, you will be carefully evaluated to determine if you are a good candidate before fitting.
Dear Patient:
Our practice continues to grow because of referrals from satisfied, enthusiastic patients. Would you kindly take a moment of your time to answer the following questions so that we may improve our services to you?

1. When making your appointment were you treated politely and promptly over the telephone? ______ yes ______ no

2. Are you pleased with your new glasses/contact lenses? ______ yes ______ no

3. Is there any staff member(s) who stands out as giving extra friendly or extra courteous service to you? _____ yes _____ no if yes, name __________

4. Is there any staff member(s) who stands out as being unfriendly or discourteous to you? _____ yes _____ no if yes, name __________

5. Did Dr. __________ give you a full explanation of your visual condition and the recommendation for correction? ______ yes ______ no

6. How would you rate the overall quality of care received in our office? (Circle one) fair average above average outstanding

7. How would you rate the overall appearance of our staff and office? (circle one) fair average above average outstanding

8. Do you plan on recommending Dr. __________ and our office to your friends? _____ yes _____ no

9. How can we improve our service to you? _________________________________

Thank you,

Dr. ________________________

FORM: PTSUR
Patient Survey

To our valued patients:

We would like your help in improving our practice. Will you please take the time to fill out this survey so that we can better serve you in the future. Circle your responses to each question, and make comments if you desire. Mail this survey to us with the postage paid envelope that is included. Signing your name is optional. Thank you!

General
Did the doctor listen and understand your problem?  
Yes  No  Unsure
Was your condition explained to you in a satisfactory manner?  
Yes  No  Unsure
Was your problem solved?  
Yes  No  Unsure

comments

Our Fees
Are our fees fair?  
Yes  No  Unsure
Are our payment policies fair?  
Yes  No  Unsure

comments

Our Staff
Were you treated courteously by telephone?  
Yes  No  Unsure
Was our receptionist courteous and helpful?  
Yes  No  Unsure
Was the doctor courteous, helpful, and professional?  
Yes  No  Unsure
Was the assistance courteous, helpful, and professional?  
Yes  No  Unsure
Was the optician courteous, helpful, and professional?  
Yes  No  Unsure

comments

Our Office
Is our office comfortable and professional?  
Yes  No  Unsure
Did you feel at ease while at our office?  
Yes  No  Unsure
Was your waiting time in the office reasonable?  
Yes  No  Unsure

comments

Your Overall Impression
Are you satisfied with the optometric care you received?  
Yes  No  Unsure
Would you refer your friends and relatives to us?  
Yes  No  Unsure
Do you feel you have a good understanding of optometric care?  
Yes  No  Unsure

comments

Your name (optional)

Date  
Thank You Very Much! Thank You Very Much! Form: PTsurv
LETTERHEAD

Request for Transfer of Records

Attending Doctor: ____________________________________________

I hereby agree that the above named doctor may release any and all information concerning my/my child's eye and visual status, while acting in a professional capacity, waiving all provisions of law to the contrary, including photographs.

Patient's Full Name: _______________________________________

Current and/or Previous Address: _______________________________________

Current Telephone Number: _______________________________________

Signature: ________________________ Date __________

PLEASE SEND THE APPROPRIATE RECORDS TO:

Dr. ______________________________________

________________________________________

FORM: RECREL
I have just completed an examination of Jane Patient who called my office because she noticed some blurred vision with her right eye and is now experiencing increased pain and redness. This 30 year old white woman stated that she noticed very slight pain with this right eye the last two days. The pain seemed to increase last night and the right eye became more red and sensitive to light.

Examination today revealed the following:

**VISUAL ACUITY**

<table>
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<td>Pinhole -</td>
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**MANIFEST REFRACTION**

Not carried out - patient has never worn glasses.

**COLOR VISION:** A. O. Pseudoisochromatic Plates

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**EXTERNAL EXAMINATION**

Lids, lashes, and puncta were normal bilaterally and the conjunctiva of the left eye was normal. The right eye manifested conjunctival injection and a slight watery discharge.

**PUPILS**

The right eye pupil was 2mm and the left was 4mm. The left pupil was briskly reactive to light and accommodation; no Marcus Gunn Pupil was noted with either eye. The right pupil was slightly sluggish.

**BIOMICROSCOPY**

The left eye exhibited a normal cornea, anterior chamber, iris, lens, and anterior vitreous.

The right eye revealed a slightly cloudy cornea with ciliary flush. The corneal light reflex was regular, there was a mild flare, and 2-3 cells were observed. Small, nongreasy keratic precipitates were observed. There were no nodules in the iris or on the pupillary margin. The lens and anterior vitreous were clear.

**GOLDMANN APPLANATION TONOMETRY**

<table>
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FUNDUSCOPIC EXAMINATION
OU Normal Fundus

My tentative diagnosis is unilateral anterior nongranulomatous uveitis. Do you concur?

I look forward to receiving a report of your findings, diagnosis, and therapy so that it will be part of the patient's permanent record.

It would be very helpful if you would notify the patient when she may return to this office so that I may continue her vision care.

Sincerely yours,

Dr.____________________
ADDRESS
CITY, STATE, ZIP
PHONE

FORM: REFSAMP
**Student Vision Report**

Name of Student ___________________________  Grade ______  Age ______

Address ___________________________  Parent's Name ______

School ___________________  Teacher ________________

This vision examination report is being sent to you so that you may be familiar with the student's vision needs and abilities. Please do not hesitate to ask for any further information that may be helpful.

**Information for the Teacher and Parent**

**Analysis of Visual Status:**

**Should Return for Future Care:**

Glasses:  _Prescribed  _Not Needed  _Present Rx Satisfactory

Glasses Should Be Worn:  Constantly  Classroom  Desk Work  Reading  TV  Homework  Distance  Movies  Playing

**Summary of Findings**

**Visual Acuity:**

- **Without glasses:**
  - R.eye 20/  L.eye 20/  Both 20/
- **With glasses:**
  - R.eye 20/  L.eye 20/  Both 20/

**At Reading Distance ______ inches**

- R.eye 20/  L.eye 20/  Both 20/

**Binocular Efficiency:**

1. **Maintenance of Binocular Fixation:**
   - Ability to look at the same object with both eyes for a sustained period of time
   - **Distance:**  _Adequate  _Inadequate  Remarks: ________________________________
   - **Near:**  _Adequate  _Inadequate  Remarks: ________________________________

2. **Ability to Maintain Focus at Near:**
   - _Adequate  _Inadequate  Remarks: ________________________________

3. **Ability to Change Focus Quickly and Easily:**
   - Example: chalkboard to book
   - _Adequate  _Inadequate  Remarks: ________________________________
4. Rotations:
   Eye's ability both independent of each other and together as a team to move freely up, down, right, and left.

   Adequate  Inadequate Remarks: ____________________________

5. Suppression of Vision:

   Absent  Inadequate Remarks: ____________________________

6. Binocular Depth Perception:

   Adequate  Inadequate Remarks: ____________________________

7. Color Perception:

   Normal  Inadequate Remarks: ____________________________

Date ___________________ Signed ____________________________, O.D.
Address ________________________________

TERMS:
Vision Analysis
An adequate vision analysis includes the following:
A. An examination of the eyes to determine the absence of disease.
B. An examination of the eyes to insure visual acuteness at all distances. Primary consideration for the school child is the reading distance and of course the chalkboard distance.
C. An evaluation of the visual skills necessary to insure adequate coordination and fusion of the eyes at all distances.
D. An examination of the vision skills necessary to insure adequate focus of the eyes at all distances.
E. An examination of the visual perceptual abilities of the individual.

Vision Training
A physiopsychological procedure for re-educating the two eyes to function at a level of efficient and comfortable binocular vision and to enhance visual perception.

Visual Acuity
Acuteness or keenness of vision. At distance: 20 feet or beyond (chalkboard, charts, movies, and television. At near: Within arm’s reach.

Binocular Efficiency
Functioning of the two eyes so as to enable comfortable and efficient visual performance at all distances.

Suppression
The blocking out mentally of the image of either eye when such image interferes with the fusing or blending of the two eye’s images into a single image.

Binocular Depth Perception
The ability to perceive and judge depth or relative distances in space.
Optometric Vision Report

Name _______________________________ Address _______________________________

Age __ Grade ___ School _______________________________ Teacher ________________

Parent or Guardian _______________________________ Date of Exam ________________

This vision examination report is to inform you regarding your child's seeing ability. It will be of considerable value to your child's teacher should you wish to forward it to the school. A description of the terms as they relate to typical classroom performance can be found on the second page. As parent or teacher, do no hesitate to ask for further information if such will be helpful. Circled items, checked recommendations and written comments relate to the patient named above.

Eye Health

External is: Normal Abnormal Internal is: Normal Abnormal

comments: ____________________________________________________________

Eye Structure

Right eye is: Farsighted Nearsighted Astigmatic _____________________________
Left eye is: Farsighted Nearsighted Astigmatic _____________________________

comments: ____________________________________________________________

Visual Acuity (sight)

Right eye is: Adequate Restrictive at far; and Adequate Restrictive at near
Left eye is: Adequate Restrictive at far; and Adequate Restrictive at near

comments: ____________________________________________________________

Visual Performance

Eye movement control is: Skilled Passable Unskilled _________________________
Focusing ability is: Skilled Passable Unskilled _____________________________
Eye Teaming ability is: Skilled Passable Unskilled _________________________

___________ is: Skilled Passable Unskilled _____________________________

Recommendations To Parents

__ No care is required
__ Further testing is indicated
__ Lenses are indicated
__ Contact lenses are indicated
__ Optometric therapy is indicated
__ Low vision care is indicated
__ Other ____________________________
Suggestions For Home And/Or School

Terms
Eye Health: External and internal examination of the eyes to detect evidence of eye disease or systemic (body) diseases creating eye changes.

Eye Structure (refractive Status): The measurement of farsightedness, nearsightedness, astigmatism, etc., as part of a vision examination. This is influenced by over-all vision development, the individual's adaptation to environmental stress and hereditary factors.

Visual Acuity: The measurement of sight sharpness. For example, 20/20 means that a target approximately 5/16ths of an inch in height was recognized at 20 feet. 20/50 means that the person can only see at 20 feet what a normal person (20/20) can see at 50 feet. Restrictions in sight may hinder achievement.

Eye Movement Control: This skill allows easy shifting of the eyes along the lines of print in a book, a rapid and accurate return to the next line, effective scanning of vertical columns, quick and accurate shifts from desk to chart or chalkboard and return, easy visual inspection of three dimensions with arts and crafts materials, etc., and sure tracking in sports activities.

Focusing Ability: This skill allows rapid and accurate shifts in visual inspection with instantaneous clarity at differing distances, such as: from desk to chalkboard to teacher, etc. It also relates to the ease with which visual attention may be sustained.

Eye Teaming Ability: This skill is intimately related to movement control and focusing ability and allows simultaneous alignment and inspection for accurate and immediate object symbol awareness. Difficulty in matching right and left eye fields may result in strabismus (one eye turns in or out), suppression (blocking out of the vision of one eye), task rejection (daydreaming, avoidance behavior, etc.), or the use of excess compensatory effort often with minimal academic accomplishment.

Visuo-Motor Skill: Relates to a general visual awareness and specific ability to visually direct and coordinate body activity. It involves gross visual discrimination and perception, spatial awareness, visualization and motor programming (e.g. catching kicking, copying throwing, etc.). Inconsistencies in learning are often related to visuo-motor disabilities.

Perceptual-Motor Skill: Involves more specific seeing skills related to language symbols (letters, numbers, words, etc.). It is dependent upon visuo-motor abilities and the development of precise visual discrimination and perception, a sound concept of body schema, well organized laterality and directionality, consistent spatial and spatial-temporal relationships, visualization of detail, refined motor programming and motor skill (e.g. writing). School achievement is directly related to perceptual-motor ability.

Visual-Integrative Skill: Involves the visuo-motor and perceptual-motor skills and the ability to integrate that which is visual with appropriate auditory, tactual and kinesthetic input or motor output. Difficulty in spelling, oral or silent reading, expressive speech, higher level mathematics, etc., are almost always associated with visual-integrative dysfunction.
Dear Dr. __________________,

At the request of ________________________, we are attaching a brief report of the visual analysis performed on her on (date)________. You may wish to include the report in his/her file.

If you have any questions concerning the report or this patient's vision problems, I will be happy to confer with you at your convenience.

Sincerely,

Form: ReportDR
Your Vision Examination Report

Patient:

Right eye

- Farsighted
- Nearsighted
- Astigmatism
- Presbyopia
- Amblyopia

Left eye

- Farsighted
- Nearsighted
- Astigmatism
- Presbyopia
- Amblyopia

Visual Acuity

Far: Right _______    left _______
Near: Right _______    Left _______

Eye teaming:   _______Good    _______Fair    _______Poor
Depth perception:  _______Good    _______Fair    _______Poor

A Vision Correction is:  _______Not indicated    _______Definitely needed    _______Optional

Glasses should be worn:  _______All the time    _______As needed    _______Far only    _______Near only

Recommendations:

Contact Lenses

- Soft
- Rigid Gas Permeable (RGP)
- Extended Wear

- Toric Soft (for astigmatism)
- Toric RGP (for astigmatism)

Glasses

- Single Vision
- Invisible bifocals
- Bifocals
- Sunglasses
- Vocal

Type of Lens material:  _______Plastic    _______Glass    _______Safety

Tint:  _______Optional    _______Recommended    _______Light    _______Medium    _______Dark    _______Color

Rx:  Right (OD) ___________________________

Left (OS) ____________________________

By Dr. ____________________________, O.D.

Your Next Examination Should Be In:

____ 3 months  ____ 6 months  ____ 9 months  ____ 1 year  ____ 2 years  ____ other ______

Signed ____________________________, O.D.  Date __________________

Form: ReportPT
Your Name
Your Address

Date: ________________

Patient's Name ___________________________ Age ______
Address ___________________________ Referred ______
City ___________________________ State _______ ZIP ______

Refractive:

Binocular:

Accommodation:

Eye Health:

Special:

Recall Date _____________

Signed ________________________, O.D.          Form: ReportST
Telephone

Your Name
Optometrist

Street Address

City, State,  

-----------------------------------------------

-----------------------------------------------

PATIENT NAME_______________________________ DATE __________

ADDRESS __________________________________________

City ____________________________ STATE __________ ZIP ______

TELEPHONE __________________________________________

Rx

____________________________________________, O.D.

Your Name

Optical Dispenser: In accepting this Rx, you assume obligation to accurately fill the Rx, to make frame adjustments, and/or lens power adjustments if required. Do Not Accept Otherwise.

Form: RXform
To Whom It May Concern:

Please excuse ________________ from school on __________
from ______ to ______. ________________ had a scheduled eye appointment at our office.

If you desire a report of __________’s visual examination, please don’t hesitate to call the office.

We always welcome students into our practice.

Sincerely,

Dr. ________________

Form: SchExcus
Dear ________________,

Please accept our deepest sympathy on your tragic loss of _______________________. That death is a part of life does not lessen the blow, but only makes it a little more understandable.

Our thoughts are with you during this trying time.

Respectfully,

Form: Sympathy
Dear Teacher,

You are to be commended for your alertness in observing _____________'s visual problem. Too often, the subtle signs of inadequate vision are overlooked and the student misses a lot of valuable knowledge.

Enclosed is a summary of the visual analysis that I completed on _____________ today. I have prescribed (visual training, orthoptics, glasses, reading glasses) and will let you know if there is any way that you can help him/her.

If you notice any change in his behavior or any continuation of the behavior noted, I would appreciate hearing from you.

Thank you again for referring _____________ to my office.

Sincerely,

Dr. ________________

Form: TeachRe
Your Name
Your Address

Date:

Teacher:
School:

Dear ____________________________________________,

Outstanding instructors do more than teach, they are aware of a student's ability to comprehend and analyze his environment. With this in mind, I wish to thank you for referring _________ for a visual examination.

_______'s visual system is currently very inefficient in coping with the visual demands school presents. He is now undertaking an extended program of visual therapy under my direction.

If you have any questions regarding ____'s visual therapy, please contact me through my office.

I have also expressed to the superintendent, my interest in meeting with you and other teachers to discuss vision and how it relates to one's learning ability.

Thank you again for referring ______________________ to my office.

Sincerely,

Dr. ____________________________

Form: TeachRe2
Dear Teacher,

Your suspicion that _____ had a visual problem was verified by the examination I made today. She suspends vision in the left eye and uses only her right eye most of the time.

The School Child's Vision Report form enclosed provides specific information about _____'s eyesight. She will be taking vision training during the next several months to correct this condition.

Her mother was especially appreciative of your having detected her difficulty and was most anxious that I write you about it. Please let me know if you see any improvement in _____'s school work after a month or so.

Thank you again for referring _________________ to my office.

Sincerely,

Dr. ____________________________

Form: TeachRe3
Dear Ms. Scholastica:

I recently had the opportunity to perform a vision examination on your student, Junior Smith. Junior presented to my clinic complaining of headaches and eye strain after trying to read for a short time. He further reported difficulty in understanding his reading.

Junior's entrance visual acuities were 20/70 in the right eye and 20/80 in the left eye. Upon further examination I found that this was due to astigmatism being present in both eyes. As a result, I have prescribed glasses for Junior which should be worn full time. It might take Junior two or three weeks to get used to these glasses, but full time wear is necessary if the headaches and eye strain are to be eliminated. Junior also shows a difficulty in focusing his eyes and pointing his eyes at his reading material. To help correct this problem, I have prescribed a series of visual training exercises for Junior which will be continuing for the next two months.

I hope that by correcting these visual problems that Junior's time in your classroom will become more productive. I would appreciate hearing from you if you have any further observations concerning Junior that might relate to his vision care. It would also be helpful if you could remind Junior to always remember to wear his glasses. Thank you.

Sincerely yours,

Dr. ________________________
TESTING RELEASE FORM

I have been informed by Dr. __________________ and/or his staff of the importance of __________________ testing.

I have chosen not to have __________________ testing performed, and will not hold Dr. __________________ and/or his staff responsible for any disease or pathology that goes undetected due to the lack of diagnostic information that could have been obtained through __________________ testing.

DATE ________________________________

NAME (PRINT) ________________________________

SIGNATURE __________________________________

WITNESS ___________________________________

FORM: TESTREL
TO: ____________________________  RE: ____________________________

ADDRESS: _______________________________________________________

Dear Doctor:

( ) I am referring the above patient to you for continued vision care, and hereby submit the following information.

( ) The patient named above has come to me for continued vision care. Please supply the information listed below. Thank you.

Pertinent refractive, ocular, general health information, and comments (continue on reverse side if necessary):

Date of Last Examination: __________________________________________

Chief Complaint at last examination: __________________________________

Visual Acuity:

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<th>FAR</th>
<th>NEAR</th>
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<tr>
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<td>O.S.</td>
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<tr>
<td>Best Corrected O.D.</td>
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<tr>
<td>O.S.</td>
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Were new glasses/contact lenses prescribed? yes ____ no ____

K's

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<td>O.D.</td>
<td>@ ______ @ ______</td>
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<td>O.S.</td>
<td>@ ______ @ ______</td>
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Last Rx dispensed:

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<tbody>
<tr>
<td>O.D.</td>
<td>______ - ______ X ______</td>
<td>Add ______</td>
</tr>
<tr>
<td>O.S.</td>
<td>______ - ______ X ______</td>
<td>Type ______</td>
</tr>
</tbody>
</table>

Prism ______ Base ______ Far P.D. ______ Near P.D. ______

Tint ______ Material: Glass Hard Resin Polycarbonate

Prescribed to wear: Far only ____ Near only ____ Full time ____

Contact Lens: Base Curve ______ OAD ______ Power ______

Material/Manufacturer ______

Peripheral Curve Design ______

I hereby grant permission for the above named to exchange information from my (my child's) case records. Check if applicable: ( ) Parent or ( ) Guardian

Signed ____________________________  Date ____________________________

FORM: TRANSFER
To Whom It May Concern:

Please excuse ____________________________ from work on ____________________________ from ______ to _______. ____________________________ had a scheduled eye appointment at our office.

Sincerely,

Dr. ____________________________

Form: WorkExcu
PATIENT INFORMATION
WELCOME TO OUR OFFICE!

Date ______________________

Patient’s Name __________________________________________________________

last first middle

Date of Birth ______-____-19___

Address _________________________________________________________________

City __________________________ State _____ ZIP _______

Home Phone _______________ Work Phone _______________

Employer _____________________ Occupation _____________________________

Whom may we thank for referring you to this office?

name ________________________________________________________________

_____ family _____ friend _____ phone book _____ add

_____ other, please explain: ______________________________________________

Other Family members, still living at home:

Spouse ____________________________________ Age _______

Name ____________________________________ Age _______

Name ____________________________________ Age _______

Name ____________________________________ Age _______

Name ____________________________________ Age _______

Please check the preferred method for today’s professional service:

_____ cash _____ check _____ credit card _____ insurance

_________________________ _______________________
Signature of Party Responsible for Payment relationship

FORM: ADULTPII
PATIENT INFORMATION
(FOR STAFF USE)

Name ___________________________ Date of Birth ____________
First Visit? yes ___ no ___ Date of last eye exam _____________
What brings you in to see us today? ____________________________

__________________________________________
Are you sensitive to lights? yes ___ no ___
  Fluorescent lights ___ glare ___ snow ___ sun ___
Do you work with a computer? yes ___ no ___
Have you ever thought about contact lenses? yes ___ no ___
Are you presently wearing contact lenses? yes ___ no ___
  If yes, type: ____________________________

__________________________________________
Have you ever worn contact lenses? yes ___ no ___
  If yes, type: ____________________________

General Health: Good ___ Fair ___ Poor ___
Name of Family Physician: ____________________________

Do you have any of the following conditions:
  Allergies ___ High Blood Pressure ___ Glaucoma ___
  Diabetes ___ Drug Allergy ___ Headaches ___
  Eye Surgery ___ Eye Disease ___ Other ___________

What leisure/sports activities do you enjoy? ____________________________

__________________________________________

FORM: ADULTP12
Welcome to our Office! Please take a few minutes to carefully fill out this information form. This allows us to personalize your visual examination and makes your time with Dr. _____ most effective. Although a question may seem trivial, your answer could be just the information we need to help you. Our office staff will be very happy to assist you with all or part of this form. This information becomes part of your permanent record and as such is held in confidence unless you authorize its release.

(please print)

PATIENT INFORMATION

Name: Mr/Ms/Miss ___________________________ Birthday ________________
Address ___________________________________ Home Phone _____________
City, State, Zip _____________________________ Work Phone _______________
Marital Status _____________________________ Name of Spouse _____________
Occupation ________________________________ Employer __________________

(if student, indicate school, grade, and teacher name for grade 1-6)

Selected this office: ____ Because Other Family Members are Patients Here ____ From Yellow Pages
By referral from: ____________________________ Other ____________________
Address: _________________________________ ___________________________
City, State, ZIP: ____________________________ __________________________
We Can Best Reach You By: ____ Home Phone ____ Work Phone ____ Postcard ____ Other _____________

HEALTH INFORMATION

Date of Last Visual Examination ________________ Doctor ___________________
Address _____________________________________ ______________________
What was prescribed/Told to You ____________________________ __________________

Spectacles Used Presently ___ yes ___ no How Old ________ When Used ______
Effectiveness ___________________________________________________________
Contact Lenses Used Presently ___ yes ___ no How Old ________ When Used ______
Effectiveness ________________________________ lens type __________________

Other Vision Related Devices Used Presently _____________________________

Previous Eye Diseases/Injuries/Surgery ______________________________________

Do You Frequently Experience/Have:
___ Blurred Vision ___ Distorted Vision ___ Double Vision ___ Tired Eyes ___ Red Eyes ___ Watery Eyes ___ Itchy Eyes ___ Burning Eyes ___ Dry Eyes ___ Painful Eye ___ Gritty/Sandy Eyes ___ Aching Eyes ___ Drawing/Pulling ___ Dizziness ___ Headaches ___ Excessive Blinking ___ Excessive Squinting ___ Seeing Spots ___ Seeing Rings Around Lights ___ Color Vision Difficulties ___ DistanceJudgement Difficulties ___ School/Work Performance Difficulties ___ Loosing Place While Reading ___ Difficulty Seeing at Night ___ Extreme Light Sensitivity ___ Discharge From Eyes ___ other ____________________________
Date of Last Complete Medical Exam ____________________________ Physician ________________________________

Address ______________________________________________________________________________________

Do You Wish a Summary of Today's Exam sent to Your Physician? _____ Yes _____ No

Do You or Blood Relative(s) Have a History of:

YOU RELATIVE(S) RELATIVE(s)

___ Glaucoma _____________________________ ___ High Blood Pressure _____________________________

___ Cataracts ____________________________  _____________________________ ___ Heart Condition _____________________________

___ Diabetes __________________________  _____________________________ ___ Thyroid Condition _____________________________

___ Blindness _____________________________ _____________________________ ___ Sinus Condition _____________

___ Eye Turn _____________________________ _____________________________ ___ Head Injury _____________

___ Low Blood Sugar ______________________ _____________________________ ___ Dental Condition _____________

___ Other Please Explain _____________________________ _____________________________

FINANCIAL INFORMATION

Person Responsible for this Account ____________________________

Relationship ____________________________ Address ____________________________

Phone ____________________________ City, State, ZIP ____________________________

Payment Preference  ____ Check/Cash  ____ Visa/Mastercard  ____ Agency: ____________________________

FEE COLLECTION POLICY: Service fees are collected when services are rendered; 50% of material costs are collected when ordered and the balance is due when material is dispensed. In extreme cases, special arrangements can be made. You will receive a statement which you may file with your insurance company for fee reimbursement.

I Understand and Agree to the Above Fee Policy:

________________________________________________________________________

Signature (parent or guardian if for minor patient) _______________ Date __________________

WOULD YOU LIKE INFORMATION ON:

___ Pediatric (preventative) Vision Care  ____ Controlling Nearsightedness

___ Vision Therapy  ____ Reading Improvement

___ Visual Enhancement  ____ Computers and Visual Stress

___ Sports Vision Aids/Therapy/Protection  ____ Sun Protective lenses

___ Low Vision Aids  ____ Invisible Multifocals

___ Contact Lenses  ____ Safety/Occupational Lenses

___ Orthokeratology  ____ Visual Hygiene

Comments/Questions: __________________________________________________________________________

THANK YOU! Dr. __________ will review this information and be with you shortly. FORM: ADULTPI3
CHILD'S PATIENT INFORMATION

Date __________

Patient's Name __________________________ Date of Birth __________

Address __________________________ Home Phone __________

City __________________________ State _______ ZIP __________

School

Grade ____ Teacher's Name __________________________

Parent's Name __________________________

Employer __________________________ Business Phone __________

Spouse's Employer __________________________ Bus. Phone __________

Whom may we thank for referring you to us? Name __________________________

____ family ____ friend ____ phone book ____ other: __________

1. Are you having problems in school with:

   Reading ____ Writing ____ Math ____ Other __________

2. Are you usually seated toward the: front ____ middle ____ back ____

3. Do you blink or rub your eyes often? yes ____ no ____

4. Do you have:

   Headaches ____ Nausea ____ Dizziness ____ Itching ____

   Burning ____ Blurred or double vision ____ Restlessness ____

5. Do you read with your head close to the book? yes ____ no ____

Please Check the Method of Payment for Today's Professional Services:

   Cash ____ Check ____ Credit Card ____ Insurance ____

__________________________________________

Signature of Party Responsible for Payment

__________________________________________

Relationship

FORM: CHILDPI1
Your Eye and Vision Examination

The examination which you are about to receive is based on the most modern optometric techniques, and consists of a series of tests. All of these test results are studied and compared to one another before the final spectacle prescription is written. The examination is divided into four sections as follows:

Section One
This series of tests is designed to determine whether or not your eyes are healthy and free of disease. Certain body diseases can manifest themselves in the eyes and this is also checked carefully.

Section Two
A number of objective tests are taken. These test are performed by means of instruments which also us to observe and measure your eyes without your active participation. While you look in a certain direction we do the rest. These tests give us very accurate measurements. They also allow us to examine small children of preschool age.

Section Three
Now a number of subjective test are taken. This part of the examination will probably be more familiar to you if you has your eyes examined in the past. Here you will be actively participating. We will ask you a number of questions and will expect you to answer them as well as you can. For this section it is well to keep several things in mind:

1. Many people are afraid that they might give the "wrong" answer and will eventually get the wrong prescription. DO NOT WORRY ABOUT THIS. You can not mislead us since we are constantly checking your answers against themselves and against the finding of the objective tests. At no time will the results of the examination depend on any one answer.

2. Do not worry if one answer you give seems to contradict a previous answer. It is our job to sort out your answers. If at times you are not sure, simply tell us. If, for example, we have you look through different lenses and ask you through which one you can see better and you cannot tell the difference or you are not sure- just tell us so. Your indecision or hesitation actually gives us important information.

3. At times throughout the examination you will be able to see very well and times you will see very blurry. It will be necessary to make your vision blurry for a while. It does not mean that you will get glasses that you will see blurry with.

Section four
A series of tests will be performed to determine the muscular balances of your eyes, to find out how smoothly your eyes are working as a team and also how your eyes are functioning for reading, close work, or your particular visual tasks. Here you may see blurred or double for a short time.

As a final reminder: Do not worry about making a mistake. Tell us all about your eye or vision difficulties, tell us all about your vision tasks at work, at home for your hobbies and your recreation... then let us give you options for solving your visual needs.

Form: Examinfo
Welcome Back to Our Office

Dr.______ is very happy and pleased to welcome you back to our office! Your confidence in us is much appreciated!

Please take a few minutes to complete the following form to help us serve you better.

Mr./Mrs./Ms./Miss ____________________________________________
If married, spouse's name ______________________________________
If child, parents' name _________________________________________
Address _______________________________________________________
City_________________________ ZIP ___________ Phone_____________________
Occupation ___________________________ Employed by _______________________
School ________________________________________________________ Grade __________
Business Phone __________________________
Date of Last Visual Exam _________________

Physician _______________________________ Last General Health Exam _________________

Payment in full for vision services to be made via:

__ Cash
__ Check
__ Insurance
__ Mastercard/Visa/Bankamerica
__ Medicare
__ Other _____________________________

Do you have:

__ Headaches
__ Blurry vision
__ Pain in or around your eyes
__ High blood pressure
__ Diabetes
__ Glaucoma
__ Other conditions

Have you ever received vision training "eye exercises"? _____________________________

Are you interested in wearing contact lenses? _________________________________
What medications (with dosages) do you take? ____________________________________________

Do you have any other eye or vision problems? ____________________________________________

---

**Visual Demands**

<table>
<thead>
<tr>
<th>Business/Work</th>
<th>Recreation</th>
<th>Social</th>
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</thead>
<tbody>
<tr>
<td>Reading</td>
<td>Golf</td>
<td>Movies</td>
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<tr>
<td>Writing</td>
<td>Boating</td>
<td>Entertaining</td>
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<tr>
<td>Computing</td>
<td>Hunting</td>
<td>Dances</td>
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<tr>
<td>Inspecting</td>
<td>Fishing</td>
<td>Cards</td>
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<tr>
<td>Typing</td>
<td>Flying</td>
<td>Clubs</td>
</tr>
<tr>
<td>Art work</td>
<td>Tennis</td>
<td>Church</td>
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<tr>
<td>Machine work</td>
<td>Needle work</td>
<td>Shopping</td>
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<tr>
<td>Photography</td>
<td>Sewing</td>
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<tr>
<td>Bookkeeping</td>
<td>Television</td>
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<tr>
<td>Assembling</td>
<td>Driving</td>
<td></td>
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<tr>
<td>Drafting</td>
<td>Work with power tools</td>
<td></td>
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<tr>
<td>Welding</td>
<td>Musical instrument</td>
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</table>

Do you have any concerns or questions for Dr. ___________________?

---

Dr. ______ and staff thank you very much!

---

Form: Preexam1
Welcome to our office! Our objective it to provide you with the best vision care possible. In order to do this, we would like to know more about you, your eyes, your visual needs, and your health.

Please answer all questions applicable. What may seem a simple answer to you might be the very thing that will make your problem clearer to us so we can help you attain eye comfort and visual efficiency. Our staff would be happy to assist you in completing the form.

General Information

Mr./Mrs./Ms./Miss ____________________________

Address ____________________________________________

Telephone: home __________________ work ___________ message _________________

How can we best reach you? _______Telephone _______ Postcard

Occupation ____________________________________________

Business Address ________________________________

If married, spouse's name ____________________________________________

If child, parent's or guardian's name ________________________________

Spouse's (or parent's/guardian's) employer ________________________________

Address ________________________________ Business Phone ________________

To whom may we thank for your referral?

Name ____________________________________________

Address ________________________________

Visual Needs

Work Environment (lighting, safety lenses, distance of task from you, etc.)

________________________________________________

Student grade level _______ If currently in school, name of school ____________________________

Leisure activities ____________________________________________________________

Do you...

watch television? _______ No _______ Yes, about _______ hours/day

leisurely read? _______ No _______ Yes, about _______ hours/day

work related reading? _______ No _______ Yes, about _______ hours/day
Vision History

First vision exam __________ results _____________________________

Last vision exam __________ results _____________________________

Do you currently wear...
- Glasses? __No __Yes, about ______ hours/day
  if yes, how effective are they? Good Fair Poor
- Contact lenses? __No __Yes, about ______ hours/day
  if yes, how effective are they? Good Fair Poor

Have you ever had an eye...
- disease? __No __Yes, specify _____________________________
- injury? __No __Yes, specify _____________________________
- surgery? __No __Yes, specify _____________________________

Last medical exam __________ (results) _____________________________

Physician's name ______________ City _____________________________

Do you or any of your family members (blood relatives) have...

<table>
<thead>
<tr>
<th>High blood pressure</th>
<th>You</th>
<th>Family</th>
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<tbody>
<tr>
<td>Diabetes</td>
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<td>Thyroid condition</td>
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<td>Glaucoma</td>
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<tr>
<td>Eye turn (cross-eyed or wall-eyed)</td>
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<tr>
<td>Cataracts</td>
<td></td>
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<tr>
<td>Blindness</td>
<td></td>
<td></td>
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<tr>
<td>Sinus problems</td>
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<tr>
<td>Allergies</td>
<td></td>
<td></td>
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<tr>
<td>Head injuries</td>
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Present Visual Condition

Please check any of the following which you frequently experience.

- Blurred vision
- Hold reading material very close
- Hold reading material far away
- Double vision
- Excessively red eyes
- Itching eyes
- Burning eyes
- Tearing eyes
- Excessive blinking
- Excessive squinting
- Pain around eyes
- Bothered by bright lights
- Headaches
- Nausea
- Halos or circles around lights
- Other _____________________________
Would you like further information about...

- Contact lenses
- Bifocal or trifocal contact lenses
- Orthokeratology therapy
- Keratoconus therapy
- Myopia control (near-sightedness)
- Sports vision
- Low vision aids
- Pediatric vision
- Reading improvement
- Reading/Learning problems
- Vision training
- Sun protective lenses
- Invisible line bifocal
- Occupational lenses

Payment for services is expected at the time services are rendered. If today's vision exam is being covered by an insurance company, our staff would be happy to furnish the appropriate forms. Your payment today will be made by:

- Cash
- Check
- Insurance, company __________________________, policy # __________________________
- Medicare
- Charge Card: __________________________, number __________________________

Signed __________________________, Date __________________________

Form: Preexam2
PERSONNEL
CONFIDENTIAL JOB PERFORMANCE REVIEW

STAFF MEMBER ____________________________ DATE ____________

KEY:  E = Excellent   G = Good   RI = Room for Improvement

CIRCLE ONE FOR EACH QUESTION.

A. PERSONAL: Are you bringing the best YOU to each patient?
   1. How is your attire/uniform appearance?
      (Style, cleanliness, neatness, etc.)  E  G  RI
   2. How is your personal appearance?
      (Hair, nails, make-up, etc.)  E  G  RI
   3. How do you rate your enthusiasm?  E  G  RI

B. GENERAL: Is this office better because of you?
   1. How do you rate your punctuality?  E  G  RI
   2. How is your willingness to work?  E  G  RI
   3. How do you work at saving expenses?  E  G  RI
   4. How is your ability to act professional?  E  G  RI
   5. How is your ability to keep office information confidential?  E  G  RI

C. DUTIES: Do you earn your wages?
   1. How do you rate your abilities to work during slack time?  E  G  RI
   2. How do you rate the efficiency of your work?  E  G  RI
   3. How do you rate your striving for self improvement?  E  G  RI
   5. How do you rate your ability to conserve supplies and stock?  E  G  RI
   6. How do you rate your positive mental attitude?  E  G  RI
   7. How is your ability to leave home problems at home?  E  G  RI
   8. How is your ability to take responsibility?
      (Get the job done, find solutions to problems)  E  G  RI
D. PATIENT RELATIONS:
1. How is your ability to make each patient feel special? E G RI
2. How is your ability to treat everyone alike? E G RI
3. How is your ability to visit with patients? E G RI
4. How do you rate your striving to sell Optometry? E G RI
5. How is your ability to handle difficult patients? E G RI
6. How do you rate your ability to alert the Dr. to something special in a patient's life? E G RI

E. STAFF RELATIONS: Are you good to work with?
1. How do you rate your ability to pitch in and help out? E G RI
2. How is your ability to get along with other staff members? E G RI
3. How do you rate your "Member-of-the-Team" attitude? E G RI

F. EMPLOYER RELATIONS:
1. How do you rate your willingness to learn? E G RI
2. How do you rate your ability to accept constructive help and direction? E G RI

G. STAFF MEMBER'S COMMENTS:
1. How could this office be a better place to work?

2. What would you like to see changed?

3. Are you happy with your job?

4. Do you feel your salary and fringe benefits are fair?
5. What do you feel your strongest attribute is?

6. What do you feel your weakest attribute is?

7. What are your goals for the next year?

8. Any other comments/suggestions you wish to make:

Signature of Employee: ________________________________

Signature of Employer: ________________________________

Date ___________________________

FORM: CJPR
APPLICATION FOR EMPLOYMENT

In order that your application may be properly evaluated, it is essential that you answer all questions on this application carefully and completely.

You will be considered for employment without regard to your race, color, creed, sex, religion, marital status, national origin, status with regard to public assistance, disability, or age.

PLEASE PRINT

Full Name ____________________________________________________________

Present Address _____________________________________________________

Phone Number __________________________ How Long Have You Been Here? ______

Permanent Address (if different from above) __________________________________

________________________________________________________

Position Desired __________________________ Salary Desired ____________________

Are You Now Employed? ______ If Yes, Where? ________________________________

May We Contact Your Present Employer? ______

Are You Acquainted with or related to any person employed here? ______

If Yes, Who? __________________________ Relationship _________________________

Date Available For Work __________________________ Are You Bondable? ______

Physical Disabilities or Chronic Illnesses ________________________________

Days Absent From Work Last Year Due To Illness? ______ Can You Work Overtime? ______

Any Professional License or Certificate? ________________________________

License/Certificate Number __________________ State Issued _____________

Secretarial, Clerical and Office Applicants Only:

Can You Type? YES NO ______ WPM
Take Dictation YES NO ______ WPM
Run 10 Key Adding Machine YES NO ______ SPM
Operate A Computer YES NO
Understand Ophthalmic Terminology YES NO

List Any Other Skills Possessed: ____________________________________________
EDUCATION

High School ________________________________ Did You Graduate? ________
College/University ________________________________
Did You Graduate? __________ Degree and Major ____________________________
Other Training/Education ________________________________

EMPLOYMENT RECORD

Most Recent Employer ________________________________
Address __________________________________________
City, State, ZIP ___________________________ Phone ________
Name of Supervisor ________________________________
Employed From ___________ To ___________
Salary ___________ Duties Performed __________________
Reason For Leaving ________________________________

Previous Employer ________________________________
Address __________________________________________
City, State, ZIP ___________________________ Phone ________
Name of Supervisor ________________________________
Employed From ___________ To ___________
Salary ___________ Duties Performed __________________
Reason For Leaving ________________________________

PERSONAL REFERENCES (Not Relatives)

Name Address Phone Business
1. __________________________________________
2. __________________________________________
3. __________________________________________

PLEASE READ CAREFULLY BEFORE SIGNING

All statements on this application are true to the best of my knowledge. If I have submitted any false information it is grounds for immediate dismissal. If I am employed, I agree to give two weeks notice prior to leaving. At no time, whether I am an employee or not, will any information regarding a patient be revealed to anyone unless I have been specifically instructed to do so.

Signature __________________ Date ____________ FORM: EMPAP
JOB DESCRIPTION

POSITION TITLE: ________________________ SALARY ________________

Reports to: ____________________________________________________

General Areas of Responsibility: ________________________________

REQUIREMENTS:

Skills: _______________________________________________________

Experience: ___________________________________________________

Education/Licensure Requirement: _______________________________

Primary Duties: ______________________________________________

Secondary Duties: _____________________________________________

Authority Boundaries: _________________________________________

FORM: JDF
PERFORMANCE EVALUATION

INSTRUCTIONS:
Evaluate each component of performance on the following scale:
5 = Performance in all aspects not only materially exceeds the requirements, but also is outstanding and deserving of special commendation.
4 = Performance is in the upper limit of acceptability, being substantially above average, but not meriting special commendation: needs very little improvement.
3 = Performance is in the middle limit of acceptability; average.
2 = Performance is satisfactory, but in the lower limit of acceptability.
1 = Performance is considered to be unacceptable, being deficient to such a degree as to require major improvement.

ATTITUDE

INFLUENCE ON OTHERS
1. Cheerful and considerate toward patients
2. Cheerful and considerate toward staff
3. Sympathetic and confidential with patient problems
4. Helps and teaches others willingly
5. Contributes ideas
6. Shows enthusiasm in discharge of duties
7. Is loyal to employer

MENTAL FLEXIBILITY
1. Is cooperative
2. Is receptive to suggestions and ideas
3. Accepts constructive criticism

INITIATIVE
1. Is willing to undertake and learn new responsibilities
2. Seeks self-improvement
3. Keeps busy in finding duties when defined work is done

MANNERS AND DISPOSITION
1. Looks people in the eye when speaking to them
2. Honest in discharge of duties
3. Keeps personal finances and affairs unknown to office

APPEARANCE
1. Exhibits good posture
2. Exhibits good personal hygiene
3. Shows pride in personal performance and grooming

AVAILABILITY

PUNCTUALITY
1. Arrives at work on time
2. Is ready to work on time
ATTENDANCE
1. Exhibits good attendance on the job
days office open for business
   days absent, illness
   days absent, vacation
   days absent, other
Remarks: ________________________________

2. Is considerate in notifying others of absences

ABILITY

QUALITY OF WORK
1. Writes legibly and with correct grammar
2. Speaks clearly and with correct grammar
3. Is proficient in required skills of duties assigned
4. ________________________________
5. ________________________________

COMPREHENSION AND JUDGEMENT
1. Able to understand assignments clearly and perform them at once
2. Shows mental alertness
3. Able to reason and reach a logical conclusion
4. Responsive to directions and instructions
5. ________________________________

OVERALL ASSESSMENT

Staff Member: ________________________________
Evaluated by: ________________________________ Date: _____________
Title of Position: ________________________________
Date Hired: ________________ Hours worked per week: ________________
Paid hourly or salary? ________________
Present monthly compensation: ________________________________
Date of last raise and amount: ________________________________
Monthly compensation one year ago: ________________________________
TELEPHONE REFERENCE CHECK

APPLICANT'S NAME ____________________________________________

REFERENCE SOURCE ___________________________________________

RELATIONSHIP TO APPLICANT ___________________________________

1. State your identity and the purpose of your call. Give the reference source some basic information about the job the applicant is being considered for.

2. Confirm: Previous Position ________________________________
   Starting Date ___________________ Salary ____________
   Ending Date ___________________ Salary ____________
   Reason for Leaving ________________________________
   Tardiness or absenteeism? __________________________________

3. What can you tell me about this employee? ________________________

4. Strengths: _________________________________________________

5. Weaknesses: ________________________________________________

6. Would you rehire? _________

7. Reason? ___________________________________________________

8. Additional Comments: _______________________________________

Reference Checked by ________________________________
Date ________________________________

FORM: TRC
THANK YOU'S
Dear [Name],

Loved having you as a patient in our office. Your smiling face made our day brighter.

Taking good care of your eyes means being careful when you play.

Dr. [Name] and Staff

Form: ChildTY
Dear ________,

Loved having you as a patient in our office. Your smiling face made our day brighter.

Take care of your eyes.

                      Dr.__________ and Staff

FORM: CHILDTY1
Dear ________________.

Thank you for calling our office to make your __________ appointment. We look forward to meeting you and providing quality care and service.

Your appointment has been scheduled for __________ at __________. Please contact us should this date/time be inconvenient and need to be re-scheduled.

Sincerely,

Dr. ________________

Form: Confirm
Dear ___________________,

It's always a pleasure to see you and care for your eye health needs. My staff and I feel proud when our patients return. It's an indication of your confidence in us and our thoroughness.

Thank you for being part of our patient family.

Very Sincerely,

Dr. ___________________ and Staff.

FORM: FPTY
Dear __________________,

Every new patient is important to me and my staff. That is why I would like to take a moment to welcome you to the practice and thank you for becoming a patient.

Your support is appreciated and I would be equally grateful for any opportunity to provide eye care services to your friends and other members of your family. Meanwhile, if you have any questions or if we can be of assistance to you before your next scheduled visit, please call.

Sincerely,

Dr. _________________ and Staff
Dear ______________,

My staff and I are delighted you chose our office for your vision care. We pride ourselves in making our patients feel welcomed and cared for in and out of our office.

You can feel comfortable in referring your friends and family, knowing we will give them the same careful attention.

Welcome to our family of patients.

Sincerely,

Dr. _______________ and Staff.

FORM: NPTY2
Dear ____________________,

Your referral of ____________________ to our office is greatly appreciated. We are attaching a brief report of the visual analysis performed on her on ____________ for your files. Perhaps you would care to discuss the case further with us for diagnostic confirmation.

The best interest of patients are served through the continued cooperation of other specialists and we thank you for the privilege of working with you toward this end.

Sincerely,

Dr. ____________________, O.D.

Form: ProfRef
Dear _____________,

I genuinely appreciate the referral of your patient _____________________. It was indeed a pleasure to welcome him to our office.

We will continue to provide any future referrals from you with the same high quality care to which your patients are accustomed.

Sincerely,

Dr. _____________________, O.D.

Form: ProfRef2
Dear ________________,

Mr./Mrs. ________________ has today entered our patient roster on your kind recommendation. We appreciate not only your faith in us but the additional pleasure of meeting and serving your delightful friend.

We are looking forward to your next visit to our office so that we may express our gratitude to you in person.

Thank You,

Form: Premier
Proper functioning of the visual system is an important aspect in the daily well being of any individual. It is especially rewarding to have patients who recognize the importance of visual care, and suggest a visual examination to their friends.

Recently, ________________ visited by office on your recommendation.

Thank you for referring ________________ to me. Your confidence in my professional ability is greatly appreciated.

Sincerely,

Dr. ________________
Dear ____________,

Thank you for calling our office to make your __________ appointment. We look forward to meeting you and providing quality care and service. Your appointment has been scheduled for __________ at __________. Please contact us should this date/time be inconvenient and need to be rescheduled.

Sincerely,

Dr. ____________

FORM: TY/AFT
Dear ____________________.

Thank You Very Much for Recommending ____________________

I assure you that any friends or relatives you recommend will, as always, receive our consideration and thorough attention.

We are looking forward to your next visit to our office so that we may express our gratitude to you in person.

Dr. ____________________ and Staff

FORM: TY/REC
Dear ______________,

Thank you for referring ____________________________.

It's always a pleasure to receive referrals from happy and satisfied patients. A referral tells us you are pleased with our services and care. We appreciate the confidence you express by sending a friend or family member.

Thanks again. We will always strive to deserve your loyalty.

Sincerely,

Dr. __________________ and Staff

FORM: TY/REF
As a way of saying "Thank You" please accept this

Gift Certificate

This entitles you, ________________________, a family member, or a friend to a ________ credit toward any prescription eyewear, sunwear, or contact lenses.

It is valid until ________________________.

In Appreciation

Dr. _____________________________

FORM: TYCERT