An Optical Galleria, llc, COVID-19 Policies and Procedures

As of May 16, 2020

Thank you for choosing An Optical Galleria for all your eye care needs. As we enter the world of a “new normal”. We want you to feel comfortable as we ease into resuming patient care and optical services.
We all have been through a lot with this global pandemic and want you to understand that An Optical Galleria will be following CDC, OSHA, and AOA guidelines for infection control as begin in-office care .

Upon arrival things will be very different, we would like to take a few minutes to review our COVID Policies to make you fully aware of what to expect and needed upon arrival. Please understand these changes are to protect you and our staff to the best of our ability.

- We are managing appointments to allow for disinfecting and social distancing between patients.
- We will be seeing 1 patient per hour, unfortunately, that means that we will have to require a 35.00 prepaid no show fee which will be applied to your exam on the day of your appointment when you show up or lost if you do not show up.
- **MASKS ARE MANDATORY FOR ALL —AT ALL TIMES** - unless you are asked by the doctor or staff to remove it during your exam or while trying on glasses.
- Forms (our questionnaire and patient information form) MUST be completed in advance.
- Please come alone unless you need physical assistance from a caregiver or are accompanying a minor.
- **Bring any and all glasses that you currently wear with you or your boxes of contact lenses**.
- **Bring a list of any and all medications you currently take including vitamins.**

UPON ARRIVAL

Park in the parking lot and wait in the car. Call us at **(443) 262-9415 Centreville** or **(410) 390-3924 OC** to let us know you have arrived. We will guide you into the office to a designated seating area.

We will be checking temperature with a non-contact thermometer and will be asking you the recommended questions from the CDC again.

Do you have cough? _____ Shortness of breath or difficulty breathing? _____

fever ?_____ chills? _____ muscle pain? _____ sore throat? _____

Any new loss of your sense of taste or smell? _____

Have you been in contact with any person that has been Covid positive person? _____

If yes, is answered to any of the above questions, please call us to reschedule your exam to a later date.

Please bare with us, your health is of the utmost importance and we are taking every precaution to keep you safe. We GREATLY appreciate your support and patience thru these trying times.

Please be advised you are entering our office at your own risk. Although we are going above and beyond sanitizing and social distancing An Optical Galleria, llc, by no means, ways or forms, will not be responsible, IF by chance, you contact COVID-19 Virus in our office.

Name _____ ***Signature*** _____***Date***_____/_____/_____

THANK YOU FOR CHOOSING An Optical Galleria FOR ALL YOUR EYECARE NEEDS.

Payment is due in full today. A minimum deposit of 50% is required on all glasses or contact lens orders.

PLEASE READ THE HIPAA PRIVACY NOTICE THAT IS PROVIDED UNDER THIS FORM.

PATIENT INFORMATION

NAME _____

*Established Patients may initial here if your **address** has not changed.* _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE Home _____ **Cell** _____

E-MAIL _____

AGE _____ **DATE OF BIRTH** _____

PATIENT's UNDER 18 *PLEASE PROVIDE THE NAME OF ACCOMPANYING PARENT OR GUARDIAN RESPONSIBLE FOR PAYMENT:*

_____

ARE WE SEEING YOU TODAY FOR A : *(Please circle)*

ROUTINE EYE EXAM DIABETIC EYE EXAM MEDICAL EYE PROBLEM

Please provide a brief explanation of the problem you are experiencing:

_____

_____

When and what time did this problem begin ? _____

DATE OF LAST EYE EXAM: _____ *(approx)*

Any drivers license renewal form must be provided at the time of check-in.

HOW MANY HOURS PER DAY DO YOU SIT IN FRONT OF A COMPUTER? _____

FAMILY PHYSICIAN _____ Date of last visit? 20___

OCCUPATION _____

HOBBIES _____

HOW DID YOU HEAR ABOUT US? _____

HAVE YOU HAD COVID-19? _____ **HAVE YOU BEEN AROUND ANYONE w/COVID-19?** _____ **if so, when**_____

Medical insurance plans do not cover routine vision care. We are out-of-network providers for Davis Vision, VSP and a host of other vision plans. We will gladly complete any out-of-network paperwork for you to submit directly if you provide your paperwork for reimbursement.. An Optical Galleria, llc, participates in BCBS State of Maryland ONLY. If you are employed by the State of MD you must provide a copy of your card at check in. Additional information will be need to be completed.

I understand that I am financially responsible for payment for all charges whether or not paid by my insurance.

_____

I have received and reviewed the NOTICE OF PRIVACY PRACTICES information and am fully aware of privacy disclosures.

_____

Revised 2020

MEDICAL HISTORY

DO YOU HAVE GLASSES? ☐ yes or ☐ no

DO YOU WEAR CONTACTS ? ☐ yes or ☐ no

ARE YOU TAKING ANY MEDICATION(S):

☐ yes or ☐ no *If yes, please list*

_____

_____

_____

_____

HAVE YOU HAD CATARACT SURGERY?

☐ yes or ☐ no

HAVE YOU HAD LASIK SURGERY?

☐ yes or ☐ no

HAVE YOU BEEN DIAGNOSED WITH LYME'S DISEASE? ☐ yes or ☐ no *If so, when?*_____

ARE YOU EXPERIENCING ANY OF THE FOLLOWING:

- ☐ EYE STRAIN
- ☐ NEAR VISION BLUR
- ☐ DISTANCE VISION BLUR
- ☐ INTERMEDIATE VISION BLUR
- ☐ DOUBLE VISION
- ☐ HEADACHES
- ☐ SEEING SPOTS/LINES
- ☐ SEEING FLASHES
- ☐ SEEING HALOES

DO YOU SUFFER FROM OR KNOW YOUR FAMILY HISTORY REGARDING THE FOLLOWING?

CATARACTS	☐ SELF	☐ FAMILY
HIGH BLOOD PRESSURE	☐ SELF	☐ FAMILY
SEIZURES	☐ SELF	☐ FAMILY
DIABETES	☐ SELF	☐ FAMILY
HIGH CHOLESTEROL	☐ SELF	☐ FAMILY
MULTIPLE SCLEROSIS	☐ SELF	☐ FAMILY
CARDIAC DISEASE	☐ SELF	☐ FAMILY
SICKLE CELL ANEMIA	☐ SELF	☐ FAMILY
ALLERGIES	☐ SELF	☐ FAMILY
GLAUCOMA	☐ SELF	☐ FAMILY
LAZY EYE	☐ SELF	☐ FAMILY
CROSSED EYE	☐ SELF	☐ FAMILY
COLOR BLINDNESS	☐ SELF	☐ FAMILY
MACULAR DEGENERATION	☐ SELF	☐ FAMILY
RETINAL DETACHMENT	☐ SELF	☐ FAMILY
HEPATITIS	☐ SELF	☐ FAMILY
HIV/AIDS	☐ SELF	☐ FAMILY

OTHER: _____