



Chu Vision

I N S T I T U T E

**9117 Lyndale Ave. South
Bloomington, MN 55420**

952.835.1235 phone

866.400.EYES toll free

952.835.0534 fax

www.chuvision.com

From Downtown Minneapolis

I-35W South for approximately 10.5 miles. Take Exit 7B for 90th Street, turn left onto West 90th Street. Go to Lyndale Avenue South, turn right and travel for 0.15 mile, turn left into Chu Vision Institute.

From the South (Burnsville)

I-35W (North). Take Exit 7B for 90th Street, turn right onto West 90th Street. Go to Lyndale Avenue South, turn right and travel for 0.15 mile, turn left into Chu Vision Institute.

From the West (Wayzata)

I-394/Highway 12 (East) to I-494 (South/East) to I-35W (Exit 5B). Take Exit 7B for 90th Street, turn left onto West 90th Street. Go to Lyndale Avenue South, turn right and travel for 0.15 mile, turn left into Chu Vision Institute.

From the East (St. Paul)

I-35E (South) to I-494 (West) to I-35W (South). Take Exit 7B for 90th Street, turn left onto West 90th Street. Go to Lyndale Avenue South, turn right and travel for 0.15 mile, turn left into Chu Vision Institute.

From the East (Wisconsin)

I-94 (West) to Woodbury area to I-494 (West) to I-35W (South). Take Exit 7B for 90th Street, turn left onto West 90th Street. Go to Lyndale Avenue South, turn right and travel for 0.15 mile, turn left into Chu Vision Institute.

What you need to know about Covered and Non-Insurance Covered Services

How is a routine eye exam visit different from a medical eye exam visit?

- A **routine eye exam**, also known as an annual eye exam, is a routine eye check-up or yearly eye exam. This is sometimes called “preventative care”, “wellness vision exam” or a “vision exam” by your insurance company. Medicare Part B does not offer this benefit. Commercial payers and certain Medicare Advantage Plans may offer this benefit. Be sure to check with your insurance company regarding this benefit. These visits are meant to prevent eye health problems. They do not include tests or treatments for specific medical issues.
- An **office visit** or “**medical eye exam**” is a clinic visit to check on a symptom or treat a specific concern. A cataract evaluation, dry eye evaluation, macular degeneration and glaucoma visits are all examples of a medical eye examination. The symptom or concern may be new or ongoing. Your provider might order tests or prescribe treatments. Some tests, regardless of your diagnosis, may not be covered by your insurance company. In planning for surgery, there are tests that are considered necessary to help develop a treatment plan but are not considered necessary by your insurance company. There will be costs associated with these tests that you will be responsible for at the time of service. They will be determined and discussed with you at the time of your visit.

What are my costs?

You will need to pay for any services that your plan won’t cover. Even if your plan covers the medical eye exam and services related to your condition, you may still have out-of-pocket costs. Examples:

- **Refraction.** A refraction is a test that is done to measure your best possible vision. During this test, lenses are placed in front of the eye and the patient is asked, “Which is better one or two?” A refraction is an essential part of an eye exam. Medicare and certain Medicare Advantage plans do not cover this test, even though it is a necessary part of an eye examination, and it is the responsibility of the patient.
Cataract Testing. Medicare and commercial insurance companies consider an eye exam and lens biometry to be the standard testing for traditional cataract surgery. However, there are additional tests that are not covered by insurance but provide necessary pre-operative information. During your evaluation, we will determine and discuss with you what tests are recommended.
- Your plan may offer a **wellness eye exam** or a **vision exam**. But you may owe a co-pay and other fees for services and tests received as part of an office visit. Co-pays are due at the time of service.
- **Co-pays** (co-payments). A co-pay is the amount you must pay at the time of service. It is a flat fee, decided by your insurance plan. Your fee may be different for wellness visits and office visits. Your plan will not cover this fee. The fee will not count toward your deductible. Your co-payment is due at the time of service.
- **Deductible.** This is a fixed amount that you pay each year before insurance will pay for services. When you have paid the full amount, you have “met” your deductible. After that, your plan will pay for part or all of your care. You are responsible for your deductible and other charges not fully covered by your insurance plan.

To find out what your total costs will be, you will need to call your insurance plan. Ask:

- What does my plan cover? What if I also had testing or treatment for a medical concern?
- How much do I need to pay? Ask about co-pays, co-insurance, your deductible and any other out-of-pocket costs.
- Are there any limits on what my plan will pay for?

Thank you for reviewing this information. Our staff is happy to help address any specific questions you may have.



INFORMATION REGARDING DILATING EYE DROPS

Dilating eye drops are used to dilate or enlarge the pupils of the eye to allow the doctor to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time, which varies from person to person and may make bright lights bothersome. It is not possible for the doctor to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating eye drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Chu and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

Patient Signature

Date

**VISUAL FUNCTION PREOPERATIVE QUESTIONNAIRE****RIGHT EYE ONLY**

1. Do you have any difficulty, even with glasses, reading small print such as labels on medicine bottles, a telephone book, or food labels? ☐ Yes ☐ No ☐ N/A
☐ a little difficulty ☐ moderate difficulty ☐ a great deal of difficulty ☐ unable to do activity
2. Do you have any difficulty, even with glasses, reading a newspaper or book? ☐ Yes ☐ No ☐ N/A
☐ a little difficulty ☐ moderate difficulty ☐ a great deal of difficulty ☐ unable to do activity
3. Do you have any difficulty, even with glasses, seeing steps, stairs, or curbs? ☐ Yes ☐ No ☐ N/A
☐ a little difficulty ☐ moderate difficulty ☐ a great deal of difficulty ☐ unable to do activity
4. Do you have any difficulty, even with glasses, reading traffic signs, street signs or store signs? ☐ Yes ☐ No ☐ N/A
☐ a little difficulty ☐ moderate difficulty ☐ a great deal of difficulty ☐ unable to do activity
5. Do you have any difficulty, even with glasses, doing fine handwork like sewing, knitting, crocheting or carpentry? ☐ Yes ☐ No ☐ N/A
☐ a little difficulty ☐ moderate difficulty ☐ a great deal of difficulty ☐ unable to do activity
6. Do you have any difficulty, even with glasses, writing checks or filling out forms? ☐ Yes ☐ No ☐ N/A
☐ a little difficulty ☐ moderate difficulty ☐ a great deal of difficulty ☐ unable to do activity
7. Do you have any difficulty, even with glasses, playing games such as BINGO, dominos, card games or mahjong? ☐ Yes ☐ No ☐ N/A
☐ a little difficulty ☐ moderate difficulty ☐ a great deal of difficulty ☐ unable to do activity
8. Do you have any difficulty, even with glasses, watching television? ☐ Yes ☐ No ☐ N/A
☐ a little difficulty ☐ moderate difficulty ☐ a great deal of difficulty ☐ unable to do activity

Have you been bothered by:**YES NO**

1. Poor night vision? ☐ ☐
2. Seeing rings or halos around lights? ☐ ☐
3. Glare caused by headlights or bright sunlight? ☐ ☐
4. Hazy and/or blurry vision? ☐ ☐
5. Seeing well in poor or dim light? ☐ ☐
6. Poor color vision? ☐ ☐
7. Double vision from one eye? ☐ ☐
8. Did you fail the vision portion of your driver's license exam? ☐ ☐

Medical Considerations:**YES NO**

9. Do you currently use the medication **Flomax**? ☐ ☐
10. Have you ever used the medication **Flomax**? ☐ ☐
11. Do you have a **Pacemaker** or a **Defibrillator**? ☐ ☐

If in thinking about these questions, you realize you're not really bothered by your vision, then you may not need cataract surgery at this time. Because cataract surgery is almost always elective, postponing it usually does not present a risk to the health of your eyes.

I read the questions above (or they have been read to me) and my vision is affecting my daily living activities enough that I would like to have cataract surgery at this time.

Patient Signature

Date

Patient Name Printed

Office Use Only

(C) # checked boxes in column

(F) factored amounts

A Little	Moderate Amt	Great Deal	Unable
X1=	X2=	X3=	X4=0

C = total number of **C**hecked boxes in column**F** = sum of the **F**actored amounts

Final Score: (F ____ / C ____) x 25 = V

Surgery Date: _____**Surgical Eye:** _____

**VISUAL FUNCTION PREOPERATIVE QUESTIONNAIRE****LEFT EYE ONLY**

1. Do you have any difficulty, even with glasses, reading small print such as labels on medicine bottles, a telephone book, or food labels? ☐ Yes ☐ No ☐ N/A
☐ a little difficulty ☐ moderate difficulty ☐ a great deal of difficulty ☐ unable to do activity
2. Do you have any difficulty, even with glasses, reading a newspaper or book? ☐ Yes ☐ No ☐ N/A
☐ a little difficulty ☐ moderate difficulty ☐ a great deal of difficulty ☐ unable to do activity
3. Do you have any difficulty, even with glasses, seeing steps, stairs, or curbs? ☐ Yes ☐ No ☐ N/A
☐ a little difficulty ☐ moderate difficulty ☐ a great deal of difficulty ☐ unable to do activity
4. Do you have any difficulty, even with glasses, reading traffic signs, street signs or store signs? ☐ Yes ☐ No ☐ N/A
☐ a little difficulty ☐ moderate difficulty ☐ a great deal of difficulty ☐ unable to do activity
5. Do you have any difficulty, even with glasses, doing fine handwork like sewing, knitting, crocheting or carpentry? ☐ Yes ☐ No ☐ N/A
☐ a little difficulty ☐ moderate difficulty ☐ a great deal of difficulty ☐ unable to do activity
6. Do you have any difficulty, even with glasses, writing checks or filling out forms? ☐ Yes ☐ No ☐ N/A
☐ a little difficulty ☐ moderate difficulty ☐ a great deal of difficulty ☐ unable to do activity
7. Do you have any difficulty, even with glasses, playing games such as BINGO, dominos, card games or mahjong? ☐ Yes ☐ No ☐ N/A
☐ a little difficulty ☐ moderate difficulty ☐ a great deal of difficulty ☐ unable to do activity
8. Do you have any difficulty, even with glasses, watching television? ☐ Yes ☐ No ☐ N/A
☐ a little difficulty ☐ moderate difficulty ☐ a great deal of difficulty ☐ unable to do activity

Have you been bothered by:**YES NO**

1. Poor night vision?
2. Seeing rings or halos around lights?
3. Glare caused by headlights or bright sunlight?
4. Hazy and/or blurry vision?
5. Seeing well in poor or dim light?
6. Poor color vision?
7. Double vision from one eye?
8. Did you fail the vision portion of your driver's license exam?

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Medical Considerations:**YES NO**

9. Do you currently use the medication **Flomax**?
10. Have you ever used the medication **Flomax**?
11. Do you have a **Pacemaker** or a **Defibrillator**?

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

If in thinking about these questions, you realize you're not really bothered by your vision, then you may not need cataract surgery at this time. Because cataract surgery is almost always elective, postponing it usually does not present a risk to the health of your eyes.

I read the questions above (or they have been read to me) and my vision is affecting my daily living activities enough that I would like to have cataract surgery at this time.

Patient Signature_____
Date_____
Patient Name Printed**Office Use Only**

(C) # checked boxes in column

(F) factored amounts

A Little	Moderate Amt	Great Deal	Unable
X1=	X2=	X3=	X4=0

C = total number of **C**hecked boxes in column**F** = sum of the **F**actored amounts

Final Score: (F _____ / C _____) x 25 = V

Surgery Date: _____**Surgical Eye:** _____

Lifestyle Vision Questionnaire

With modern lasers and lens implants, Dr. Chu can reduce and possibly eliminate your future need for glasses (and/or contact lenses). By combining surgical skill with the best technology available, Dr. Chu can give you the optimal combination of vision quality and lifestyle convenience. If it is determined that surgery is appropriate the following questions will help Dr. Chu to determine the kind of vision you desire. It is important that you understand that many patients still need to wear glasses for some activities after surgery.

● **Although I may currently need glasses, my preference after surgery is the ability to:**

- ☐ See both far and near objects without glasses.
- ☐ See far objects without glasses but wear glasses to see near objects.
- ☐ Require glasses to see both far and near objects.

Think of your vision in terms of three zones:

- Far (Driving, TV, Golf, Tennis)
- Mid-Range (Computer, Cooking, Gardening)
- Near (Reading, Cell Phone, Sewing, Make-Up)

● **If you had to wear glasses for at least one zone after surgery, for which zone would you be more willing to wear glasses?**

- ☐ Far
- ☐ Mid-Range/Near

● **At night. I'm okay with some halos around lights as long as I can drive comfortably.**

- ☐ Agree ☐ Disagree

● **How many hours per day do you spend:**

- ☐ Driving
- ☐ On the computer
- ☐ Reading books, newspapers

● **What is/was your primary occupation?**

- ☐ I'm retired (list previous occupation)

● **Please list up to three favorite hobbies:**

● **Please place an "X" on the following scale to describe your personality as best as you can:**

|-----|
Easy Going **Perfectionist**



DRY EYE QUESTIONNAIRE

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

☐ Yes ☐ No When? _____

Please indicate if you have had or are currently experiencing any of the following:

☐ Redness ☐ Dry eye feeling ☐ Mucous discharge ☐ Sandy/gritty feeling ☐ Burning
☐ Itching ☐ Constant tearing ☐ Watery eyes ☐ Foreign body sensation ☐ Light sensitivity
☐ Styes ☐ Tired" eyes ☐ Fluctuating vision ☐ Chronic eye or lid infection
☐ Contact lens discomfort ☐ Blurry vision ☐ Eye pain or soreness

Do you wear Contact Lenses? ☐ No ☐ Yes ***If yes, what type?*** ☐ Soft ☐ Toric ☐ Bifocal ☐ Rigid ☐ Gas Perm

How many hours a day do you wear your contacts: _____

Have you had any of the following surgeries? ☐ Cataract ☐ Glaucoma ☐ Refractive Surgery

Please indicate if you are experiencing any of the following symptoms:

☐ Congestion ☐ Sinus congestion ☐ Post nasal drip ☐ Chronic cough
☐ Allergy Symptoms ☐ Seasonal allergies ☐ Hay fever symptoms ☐ Sneezing
☐ Dry throat, mouth ☐ Headaches ☐ Asthma symptoms ☐ Arthritis
☐ Joint pain ☐ Cold ☐ Middle ear congestion ☐ Bronchitis symptoms
☐ Other: _____

Are you sensitive to any of the following?

☐ Heaters ☐ Blowers ☐ Air Conditioning ☐ Cigarette smoke ☐ Smog ☐ Dust
☐ Sunshine ☐ Wind ☐ Airplane Cabins ☐ Pollen ☐ Contact Lens Wear
☐ Other: _____

What have you used and/or are currently using to alleviate your dry eye symptoms?

☐ Artificial tears, gels or ointments: *please indicate brand(s)* _____
☐ Prescriptions Drops: _____
☐ Tear duct plugs ☐ Other: _____
☐ Nutritional supplements (e.g., flaxseed oil, omega-3) _____

Have you ever had punctal occlusion? Yes No

Patient Signature: _____

Date: _____



WRITTEN ACKNOWLEDGEMENT

I am a patient of Chu Vision Institute and I hereby acknowledge receipt of Chu Vision Institute's Notice of Privacy Practices. **Name [please print]:** _____

Signature: _____ **Date:** _____

OR

I am a parent or legal guardian of _____ **[patient name]**. I hereby acknowledge receipt of Chu Vision Institute's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____ **Date:** _____

____ Notice copy given

*A copy of the Notice of Privacy Practices is available for you in our office or on our website at <http://chuvision.com/>

PATIENT COMMUNICATION FORM

It is Chu Vision Institutes policy not to release confidential medical information regarding your treatment to family members or friends, except for (i)parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check the box next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse:	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Parent:	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other:	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Patient Printed Name: _____

Patient/Parent/Guardian Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____