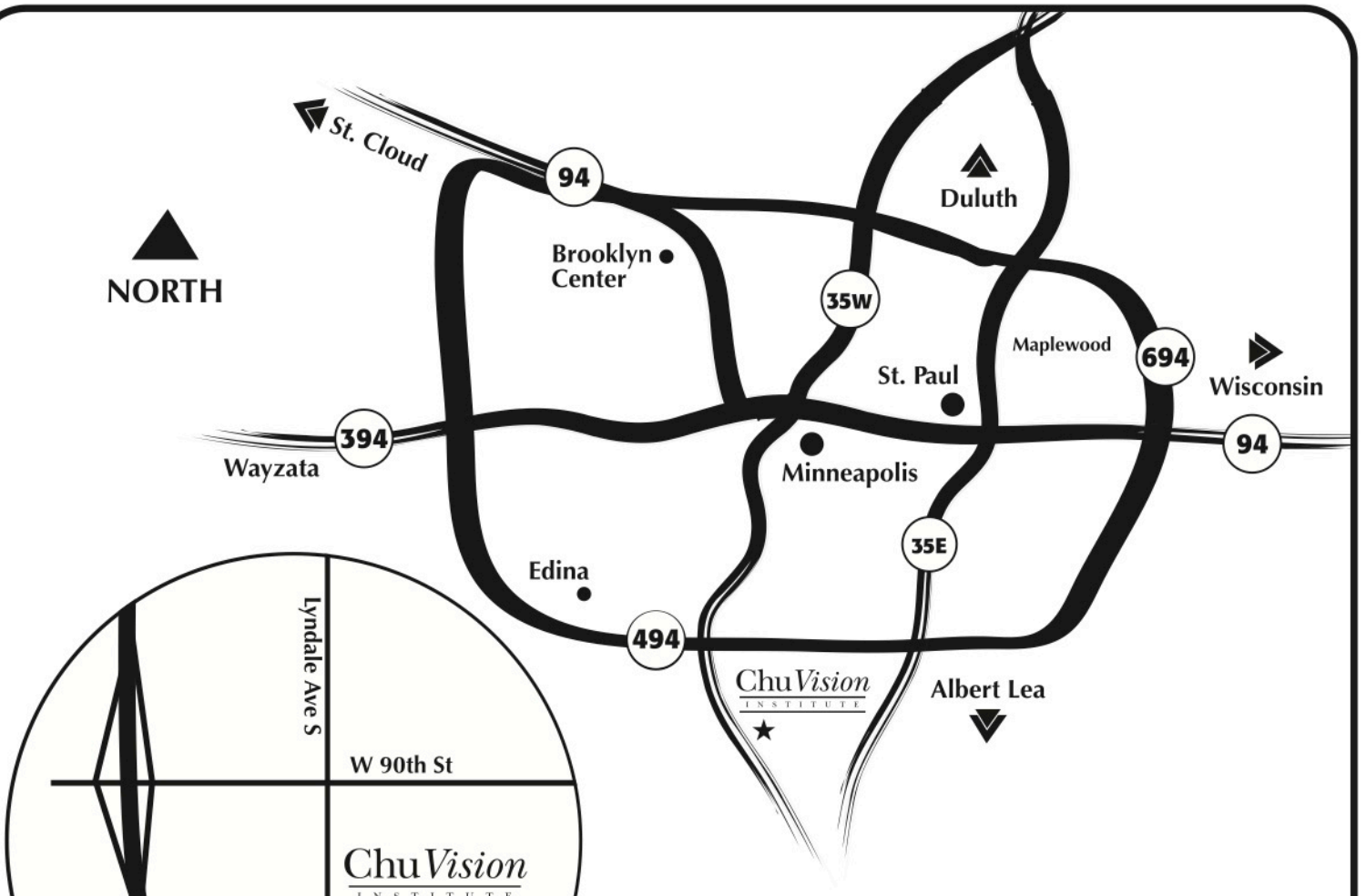

From Downtown Minneapolis
I-35W South for approximately 10.5 miles. Take Exit 7B for 90th Street, turn left onto West 90th Street. Go to Lyndale Avenue South, turn right and travel for 0.15 mile, turn left into Chu Vision Institute.

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.

ChuVision
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9117 Lyndale Ave. South
Bloomington, MN 55420
952.835.1235 phone
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952.835.0534 fax
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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.

WHAT IS A REFRACTION ?

A refraction is a test that is done to measure your best possible vision. During the 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 examination:

1. It is used to determine the correct prescription of glasses or contacts.
2. It is performed during a routine eye exam.
3. It is performed as part of the evaluation and monitoring of a medical condition such as diabetes, cataracts, glaucoma, and macular degeneration.
4. It is performed during pre-operative care.
5. It is performed during post-operative care.

Although a refraction is an essential part of an eye exam, it is considered a **non-covered** service by Medicare and other medical insurances; thus it becomes the responsibility of the patient to pay for the refraction portion of the examination unless it is covered under a vision plan. Expenses for all refractive procedures, whether performed by an ophthalmologist or any physician including an optometrist and without regard to the reason for performing the refraction, may be excluded from coverage.

The charge of the refraction is $107.44**.** (Includes 2% MN Care Tax)

_____ _____

Patient Signature Date

_____ _____

Staff Signature Date

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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.

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REFRACTIVE SURGERY QUESTIONNAIRE

From the choices below, which influenced your decision to visit Chu Vision Institute?
(Please X all that apply)

- ☐ Reputation
- ☐ Ease of scheduling
- ☐ Representative on the phone
- ☐ Location
- ☐ Friend/ Relative(Please specify whom)_____
- ☐ Local Marketing / Advertising: (Please specify)_____
- ☐ Optometrist / Ophthalmologist: (Please specify)_____
- ☐ Internet: (Which site)_____
- ☐ Other:_____

Have you had previous evaluations for refractive surgery? ☐ Yes ☐ No

If yes, where? _____ When? _____

Result of exam: ☐ Good Candidate ☐ Poor Candidate ☐ Other_____

Have you turned down refractive surgery in the past? ☐ Yes ☐ No

If yes, please indicate reason:_____

Have you had previous eye surgery? ☐ Yes ☐ No

Please check below type(s) of surgery:

☐ LASIK ☐ PRK ☐ RK / AK ☐ CATARACT ☐ OTHER:_____

Please check (√) if you have been diagnosed with any of the following conditions:

☐ Arthritis	☐ Dry eye syndrome	☐ Acne Rosacea
☐ Blepharitis	☐ Keloid	☐ Diabetes
☐ Immune System Disorders	☐ Skin disorders	☐ Seasonal Allergies
☐ Ocular Herpes Simplex Virus	☐ None	

Are you pregnant, nursing or planning on becoming pregnant in the near future? ☐ Yes ☐ No

Please check (√) if you use or have used any of the following medications:

☐ Accuntane	☐ Alternative Medications (i.e. herbal)	☐ Antihistamine
☐ Imitrex	☐ Prednisone	☐ Prozac
☐ Valium	☐ Hormone Replacement Therapy	☐ Xanax

When do you wear sunglasses?

☐ During the day ☐ At Night ☐ Occasionally

Please turn over and complete back side of this form

9117 Lyndale Ave S Bloomington, MN 55420
(952) 835-1235 toll-free (866) 400-EYES

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Are you a contact lens wearer? ☐Yes ☐No
(if NO please skip next question)

Please indicate what type of lenses you wear? ☐ Soft ☐ Soft Toric ☐ Hard /Gas ☐ Permeable
Date last worn? _____

Have you tried monovision? ☐Yes ☐No

If you tried monovision, did you like it? ☐Yes ☐No

If you did NOT like mono vision, please indicate why:
☐ Trouble with depth perception ☐ Difficulty with contrast ☐ other_____

What is your occupation?_____

What are your hobbies? _____

On average, I read_____hours per day
On average, I spend_____hours per day working on a computer

What are your expectations from the refractive surgery?
_____
_____

What do you want from your refractive surgery?
_____
_____

_____ _____ _____
Patient Signature Date Patient Name Printed

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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:_____

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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:	_____	☐ Yes	☐ No
Parent:	_____	☐ Yes	☐ No
Other:	_____	☐ Yes	☐ No
	_____	☐ Yes	☐ No

Patient Printed Name: _____

Patient/Parent/Guardian Signature: _____ Date: _____

Staff Signature: _____ Date: _____