



Consent for Purpose of Treatment, Payment, or Health Care Options

I consent to the use or disclosure of my protected health information by Konowal Vision Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations.

I understand that diagnosis or treatment of me by Konowal Vision Center may be conditions upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations. The Konowal Vision Center is not required to agree to the restrictions that I may request. However, if the Konowal Vision center agrees to a restriction that I request, the restriction is binding on the practice.

I have the right to revoke this Consent, in writing, at any time, except to the extent that the Konowal Vision Center has taken action in reliance on this Consent.

My “protected health information” means health information, including my demographic information collected from me and collected or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Konowal Vision Center’s **Notice of Privacy Practices** prior to signing this document.

The Konowal Vision Center’s **Notice of Privacy Practices** has been provided to me.

The **Notice of Privacy Practices** describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or the performance of health care operations.

A summary of the **Notice of Privacy Practices** for Konowal Vision Center is also posted in the waiting room.

This **Notice of Privacy Practices** also describes my rights and the duties of the Konowal Vision Center with respect to my protected health information.

The Konowal Vision Center reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**.

I may obtain a revised **Notice of Privacy Practices** by contacting the Privacy Officer at:  
**9500 Corkscrew Road, Bldg 102, Suite 3 Estero, FL 33928**

\_\_\_\_\_  
Name of Patient (Please Print)

x \_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Patient or Representative (Please Print)

\_\_\_\_\_  
Employee Initial



Patient Consent to Release / Share Information

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Please Print (Last Name) (First Name) (M.I)

I (the patient) give permission to share appointment, billing, results or treatment information with the person or persons named below:

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Name of Person Relationship Phone #

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Name of Person Relationship Phone #

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Name of Person Relationship Phone #

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Name of Person Relationship Phone #

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Signature of Patient / Parent or Legal Guardian Date

NAME \_\_\_\_\_  
SEX: M \_\_\_\_\_ F \_\_\_\_\_

Review of Systems:

Please circle Yes or No to indicate which of the following health problems you have or have had:

Cardiovascular	Ear/Nose/Throat	Genitourinary
Y N Heart Disease	Y N Hearing Loss	Y N Kidney
Y N Heart Attack, Date _____		Y N Bladder
Y N Angina	Respiratory	Y N Prostate
Y N Stroke, Date _____	Y N Lung Disease	
Y N High Blood Pressure	Y N Tuberculosis	Hematologic/Lymph
Y N Elevated Cholesterol	Y N Chest	Y N Anemia
		Y N Bleeding
Endocrine	Musculoskeletal	Neurological/Psych
Y N Diabetes, yrs _____	Y N Arthritis	Y N Seizures
Y N Thyroid Disease		Y N Alzheimer's
	Gastrointestinal	Y N Depression
Skin and/or Breast Problems	Y N Ulcer	Y N Other
Y N Skin Cancer	Y N Colitis/Diverticul.	
Y N Keloids/Scarring	Y N Liver/Hepatitis	
	Y N Weight Loss _____	

Constitutional

Y N Weakness

Past MEDICAL HISTORY – Please list any major illnesses, injuries, prior operations, hospitalizations:

\_\_\_\_\_

Please list all MEDICATIONS that you are currently taking, including eye drops, vitamins, herbals:

DOSAGE	FREQUENCY	OTHER INSTRUCTIONS

Are you ALLERGIC to any medications? YES NO If yes, please list: \_\_\_\_\_

Eye History – Please circle Yes or No to indicate the items with which you have been diagnosed:

Cataracts	Y N	Macular Degeneration	Y N
Diabetic Retinopathy	Y N	Retinal Disorders	Y N
Glaucoma	Y N	Retinal Detachment	Y N

Other problems please list: \_\_\_\_\_

EYE SURGERY/EYE TRAUMA – Please list:

Right Eye \_\_\_\_\_ Left Eye \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



DO YOU HAVE ANY OF THESE COMPLAINTS? ( WITH OR WITHOUT  
YOUR GLASSES ON )

BLURRED VISION \_\_\_\_\_

OVERALL DECLINE IN VISION \_\_\_\_\_

GLARE, SENSITIVITY TO LIGHT \_\_\_\_\_

POOR NIGHT VISION \_\_\_\_\_

HALOS AROUND LIGHTS \_\_\_\_\_

LOSS OF DEPTH PERCEPTION \_\_\_\_\_

DOUBLE VISION \_\_\_\_\_

DIFFICULTY DRIVING AT NIGHT \_\_\_\_\_

READING TRAFFIC SIGNS \_\_\_\_\_

READING SMALL PRINT \_\_\_\_\_

PLAYING SPORTS (GOLF, TENNIS) \_\_\_\_\_

PATIENTS SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## **KONOWAL VISION CENTER'S FREQUENTLY ASKED QUESTIONS**

### **What is a refraction?**

A refraction is a vision test that determines your best visual acuity. This diagnostic information is used to determine if you need corrective lenses or if you any disease may be present that affects your ability to see clearly. **This test is a routine part of your annual comprehensive eye exam and is not covered by most Private Insurance Companies or Medicare. Konowal Vision Center charges \$20.00 per eye for this portion of your exam.**

### **Why do I need to be dilated?**

A comprehensive eye exam includes a thorough study of your eyelids, lashes and the external surface of your eye. Dr. Konowal and/or one of your Optometrists will examine the inside of the eye by dilating your pupils with drops. Once you are dilated the Doctor can study your retina, optic nerves and blood vessels in the back of your eye.

### **Why do I need a contact lens exam when I just had an eye exam?**

The contact lens evaluation and fit is not a medical exam of the eye. This is a series of tests to determine the accurate measurements of a medical device (contact lenses) that requires a prescription. During your routine eye exam the Doctor will check your eyes overall health and may write you a prescription for glasses. Contacts are placed on the surface of the eye. They can affect the shape of your eye, and if not fit properly cause abrasions to the eyes surface. Getting contact lenses to fit properly will determine your success in wearing contacts.

Insertion and removal training for new contact lens wearers is (per visit) \$15.00

Eye exams without insurance are \$205.00 for Dr. Konowal.

This does not include a Contact Lens Fit, which is a separate fee.

**LASIK CONSULTS DO NOT RECEIVE CONTACT LENS OR GLASS PRESCRIPTION  
AT THE TIME OF THE TIME OF THE CONSULT.**