Alan R. Faulkner, MD
Leslie Garay, MD
Kathryn Mau, OD

ALOHA LASER VISION
People Of Vision

1100 Ward Ave Suite 1000
Honolulu, HI 96814
Phone 808-792-3937

Aloha,

Thank you for trusting Aloha Laser Vision with your eye care. We look forward to seeing you for your cataract evaluation.

During your evaluation we will conduct a thorough dilated eye exam that will take **approximately 2-3 hours** to determine whether a cataract is affecting your vision. Our doctors will evaluate your overall eye health as well as your ability to see up close and at a distance.

If we determine that a cataract is affecting your vision, we will discuss your options for treatment based on your lifestyle and the current condition of your eyes. Recent advancements in intraocular lens technology have given us new options for restoring vision loss due to cataracts. We can now provide the ability to see at near (reading), intermediate (cooking or looking at a computer screen), and far (driving) distances – without depending on glasses in most situations.

In order to provide the best eye care for our patients, it is essential to understand your vision and lifestyle needs. Before your appointment, please fill out the Welcome Form, Patient Privacy Notice, Medical History, and Cataract Lifestyle Questionnaire. Your response to the Lifestyle Questionnaire will provide Dr. Faulkner and Dr. Garay additional information to develop a surgical plan customized especially for you. We also recommend bringing a family member or friend who can assist in this important decision making process.

Please bring all paperwork with you when you come for your visit, as well as valid identification & <u>ALL</u> insurance cards. If you have any questions before your visit, please call us at 808-792-3937.

Mahalo,
Leona Tamura
Surgical Coordinator

P.S. Please see back for pre exam instructions.

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Pre Exam Instructions

In order to obtain more accurate measurements we recommend, **but NOT mandatory,** starting over the counter PRESERVATIVE-FREE artificial tears preferably 3 days before your appointment, 4 times a day in each eye.

In addition, if you wear contact lenses, we ask that you discontinue using them as follows:

- Soft Contact Lenses – discontinue 3 days before exam.
- Toric (Astigmatism) Soft Lenses – discontinue 1 week before exam.
- Hard Contact Lenses/RGP's – discontinue as soon as possible, as it may take 4-6 weeks for your vision to stabilize.

If you wear contacts, please bring them along with the lens prescription information to your appointment. If you have any questions please give us a call at 808-792-3937.

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PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Street Address: _____ **Zip, City, State:** _____

Are you interested in advanced skin care and/or treatments? [ ] YES [ ] NO

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Marital Status: [ ] Single [ ] Married [ ] Widowed

Date of Birth: _____

Social Security #: _____

Race: [ ] American Indian or Alaskan Native [ ] Asian [ ] Black or African American [ ] Native Hawaiian/Other Pacific Islander
[ ] White [ ] Other Race [ ] Declined to Specify

Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Declined to Specify

Preferred Language: [ ] English [ ] Japanese [ ] Chinese [ ] Tagalog [ ] Spanish [ ] Other_____

Emergency Contact Information:

Name: _____

Relationship: _____

Phone #: _____

Primary Care Physician: _____

How were you referred to our office?

[ ] Doctor: _____

[ ] Long Time Patient [ ] Patent: _____

Social Media: [ ] Facebook [ ] Yelp [ ] Google [ ] Instagram

Other: [ ] Insurance Listing [ ] Magazine [ ] TV [ ] Radio

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE CARRIER: _____

SUBSCRIBER ID #: _____

SUBSCRIBER NAME: _____

SUBSCRIBER DOB: _____

RELATIONSHIP TO SUBSCRIBER:
[ ] SELF [ ] SPOUSE [ ] CHILD [ ] OTHER

SECONDARY INSURANCE

INSURANCE CARRIER: _____

SUBSCRIBER ID #: _____

SUBSCRIBER NAME: _____

SUBSCRIBER DOB: _____

RELATIONSHIP TO SUBSCRIBER:
[ ] SELF [ ] SPOUSE [ ] CHILD [ ] OTHER

OTHER INSURANCE INFORMATION: _____

PLEASE READ & SIGN:

In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. Payment from my insurance is to be paid directly to Aloha Laser Vision, LLC. I understand that my insurance will be billed. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

SIGNATURE: _____ **DATE:** _____

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PATIENT PRIVACY CONSENT FORM

PATIENT NAME: _____ ***DOB:*** _____

The Practice provides the top portion of this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment of health care operations. We are not required to agree to this restriction, but if we do, we shall honor this agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, or health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

Signature: _____ Date: _____

_____ / _____ _____
Patient Representative Representative Signature Date

REPRODUCTION RIGHTS

I HEREBY GRANT TO **ALOHA LASER VISION**, including its employees, agents, assigns, or other third party as the aforementioned business may authorize on its behalf, the nonexclusive rights to **photograph me, make recordings of my voice and make combined audio visual recording of me and my voice.**

I CONSENT TO THE USE OF THESE RECORDINGS BY ALOHA LASER VISION for educational materials, publications, websites, social media, and other consistent purposes. I hereby assign the transfer to Aloha Laser Vision all rights to these audio and visual recordings and all benefits and advantages to be derived from these. Editing, publication, distribution, broadcast and use of this material shall be at the sole discretion of Aloha Laser Vision. It is possible that individuals may find your image/video/story helpful and wish to link to it from their own personal websites. Owners of other personal and corporate websites do not need to ask our permission to link our website or Facebook page. As a result, you may find your story linked from other sites on the web. In addition, as our site is crawled regularly by internet search engines, your information may be found when searching the web via Google or other reputable search engines.

Patients' identity, as indicated below MAY be included in the resources as developed and published in print, electronic, or digital format including any authorized website. Consent takes effect when this agreement is signed.

☐ First & Last Name ☐ First Name Only ☐ neither First or Last Name

☐ I DO NOT CONSENT TO THESE RIGHTS

Signature: _____ Date: _____

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Medical History

NAME: _____ DOB: _____

Allergies: _____

Medical conditions (*example: Diabetes, High Blood Pressure, Osteoporosis, etc.)*

1)	6)
2)	7)
3)	8)
4)	9)
5)	10)

Surgeries	**Date**
1)	
2)	
3)	
4)	
5)	

Name of Medication	**Strength/Dosage**	**Frequency Taken**	**Form of Administration**
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			
12)			

☐ I do not know what medication I am currently taking.

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Print Name: _____ Date: _____

1. What is your preference regarding your **DISTANCE** vision after surgery?

___I prefer no **distance** glasses ___I don't mind wearing **distance** glasses

2. What is your preference regarding your **NEAR** vision after surgery?

___I prefer no **reading** glasses ___I don't mind wearing **reading** glasses

3. Ranges of Vision:

Range 1 **Near** ***(12-20 Inches)***	Range 2 **Intermediate** ***(2-4 Feet)***	Range 3 **Distance** ***(6 Feet & Beyond)***
News Print / Books	Items on Shelf	Driving
Price Tags	Computer	TV
Cell Phone	Car Dashboard	Golf

Which "Ranges of Vision" are the most important to you? Please choose only one of the following three options:

___Ranges 1 & 2 ___Ranges 2 & 3 ___Ranges 1 & 3

4. For which range would you be most willing to use glasses after surgery?

___ Range 1 (Near) ___ Range 2 (Interm.) ___Range 3 (Distance)

5. If you could have good distance and near vision without glasses, but you may see some halos around lights at night, would you be satisfied with your vision?

___Yes ___No

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6. Please check <u>one</u> statement that best describes your preference in terms of **night vision:**

___ Night vision is very important to me, I require the best possible night vision.
___ I want to be able to drive comfortably at night, slight imperfection is tolerable.
___ Night vision is not particularly important to me.

7. Would you be willing to pay an out of pocket expense for a lens that will allow you to be less dependent on glasses?

___Yes ___No ___ Maybe, I am not sure yet

8. Are you interested in financing your co-payments and/or surgical fees up to 24 months interest free?

___Yes ___No ___Maybe, I am not sure yet

9. Place an X on the following scale to describe your personality the best you can:

←Easy going----------II----------Perfectionist→

Signature_____ **Date**_____

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We are located in the **FIRST INSURANCE CENTER** on the corner of Ward Ave & Beretania St

You may enter the parking garage from BERETANIA ST ONLY

Hotel St. garage entrance is no longer open to the public

You will need to drive up to <u>P3 OR HIGHER</u> for parking

From the parking garage you will need to catch the elevator down to the lobby, then transfer elevator up to the 10th floor. **Our clinic is located on the 10th FLOOR SUITE 1000**

Please note that you are **<u>NOT</u>** allowed to make a left turn from Ward Ave on to Beretania St

Parking is partially validated down to $1 per half hour.

*Please refer to **www.alohalaservision.com** for further driving directions*