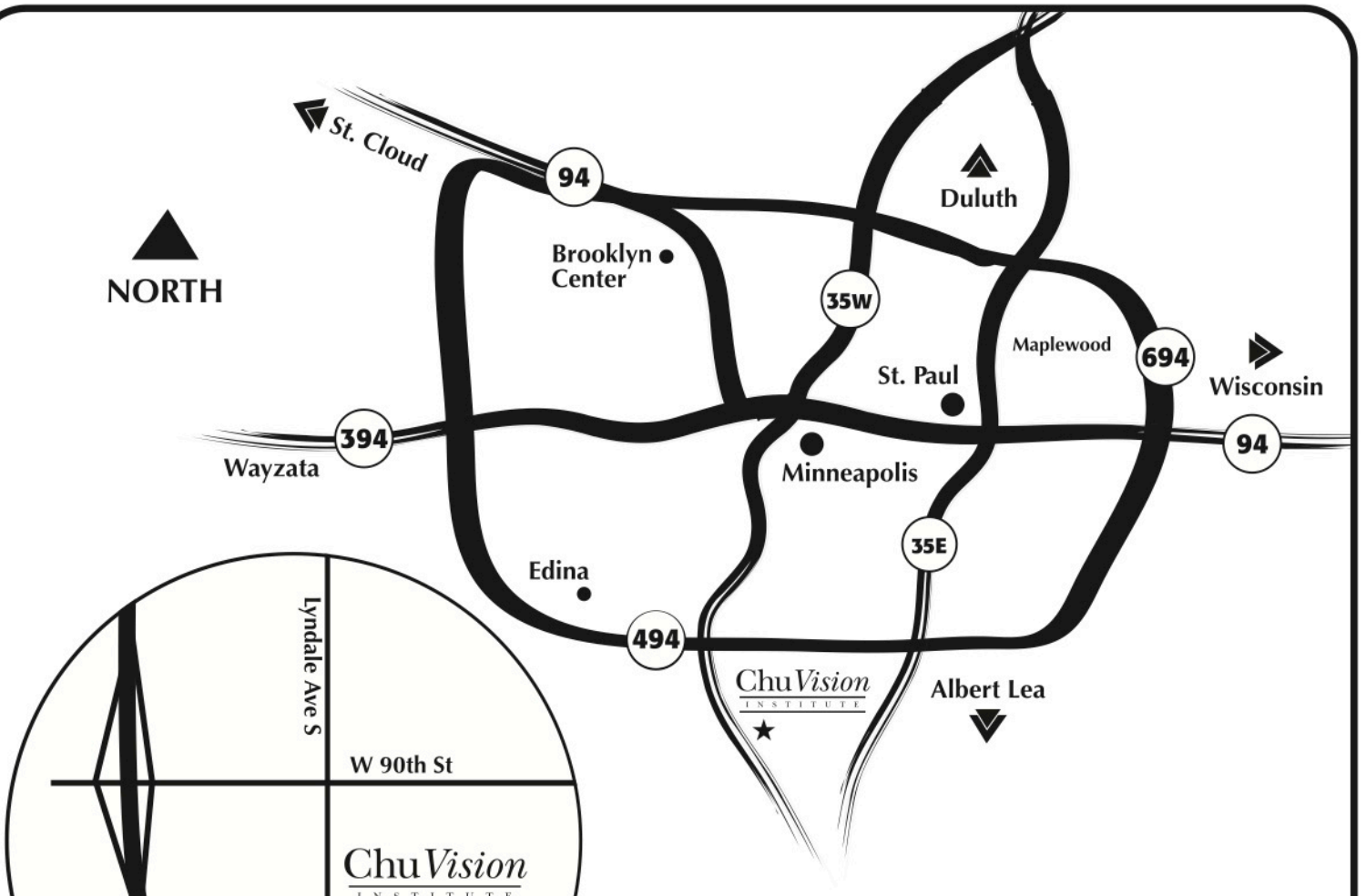

From Downtown Minneapolis
I-35W South for approximately 10.5 miles. Take Exit 7B for 90th Street, turn left onto West 90th Street. Go to Lyndale Avenue South, turn right and travel for 0.15 mile, turn left into Chu Vision Institute.

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
INSTITUTE

9117 Lyndale Ave. South
Bloomington, MN 55420
952.835.1235 phone
866.400.EYES toll free
952.835.0534 fax
www.chuvision.com

ChuVision INSTITUTE

Patient Demographics

Please review, make necessary changes, and supply any missing information.

First Name:	**Middle Name:**		**Last Name:**
Nickname:	**Salutation:**		**Date of Birth:**
Street Address:			
City:	**State:**	**Zip:**	**Country:**
Home Phone:		**Cell Phone:**	
Email:			
Marital Status:			
Primary Language:			
Race:			
Occupation:			
Employer:			
Your Maiden Name:			

Account Responsible (If other than Patient)	
Name:	
Street:	
City:	
State:	
Zip:	
Home:	
Cell:	
Relationship:	

HIPAA Authorization

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 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, please confirm this in writing or call our office.)

_____ _____ ☐ Yes ☐ No Phone: _____
Name Relation

_____ _____ ☐ Yes ☐ No Phone: _____
Name Relation

_____ _____ ☐ Yes ☐ No Phone: _____
Name Relation

_____ _____
Patient/POA Signature Date

Release of Information, Privacy Standards, Financial Agreement, Assignment of Benefits,

RELEASE OF INFORMATION and PRIVACY NOTICE: The Chu Vision Institute may disclose all or any part of my medical records and/or financial ledger, to any person or corporation (1) which is or may be liable or under contract to the Chu Vision Institute for reimbursement for services rendered, and (2) any health care provider for continued patient care. The Chu Vision Institute may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute, or regulation. A copy of this authorization may be used in place of the original. By signing this form, I am acknowledging that I understand the HIPAA compliance privacy regulations and that a copy of the Notice of Privacy Standards are available in paper form upon request.
I also acknowledge that Chu Vision Institute will not release confidential medical information regarding my treatment to family members or friends, except for (i)parent/legal guardian, (ii) other persons authorized by me, the patient, (iii) as Chu Vision may reasonably infer from the circumstances (for example, if I bring a family member or friend into the exam room, Chu Vision Institute may assume, that that person is entitled to receive information regarding my treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The of the Notice of Privacy Practices is available to me on Chu Vision's website at https://www.chuvision.com/privacy-policy and within the office.

FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by the Chu Vision Institute, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to the Chu Vision Institute for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, are hereby assigned to the Chu Vision Institute. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to the Chu Vision Institute. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, refractions, and specialized testing used to determine candidacy for refractive surgery. **However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.**

MEDICARE (if applicable): I request that payment of authorized Medicare benefits be made on my behalf to the Chu Vision Institute for services furnished me by the Chu Vision Institute. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. The Chu Vision Institute accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

_____ _____

Patient/POA Signature Date

ChuVision
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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. The doctor can't predict how much your vision will be affected. If you are uncomfortable driving yourself, we recommend making driving arrangements.

Adverse reactions, 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

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INSTITUTE

VISUAL FUNCTION PREOPERATIVE QUESTIONNAIRE

RIGHT EYE

Mark the level of difficulty you have **EVEN WITH GLASSES** performing the following tasks:	No Difficulty	A Little	Moderate Amount	Great Deal	Unable
Reading small print such as labels on medicine bottles, a telephone book, or food labels					
Reading a newspaper or book					
Seeing steps, stairs, or curbs					
Reading traffic signs, street signs or store signs					
Doing fine handwork like sewing, knitting, crocheting or carpentry					
Writing checks or filling out forms					
Playing games such as BINGO, dominos, card games or mahjong					
Watching television					

LEFT EYE

Mark the level of difficulty you have **EVEN WITH GLASSES** performing the following tasks	No Difficulty	A Little	Moderate Amount	Great Deal	Unable
Reading small print such as labels on medicine bottles, a telephone book, or food labels					
Reading a newspaper or book					
Seeing steps, stairs, or curbs					
Reading traffic signs, street signs or store signs					
Doing fine handwork like sewing, knitting, crocheting or carpentry					
Writing checks or filling out forms					
Playing games such as BINGO, dominos, card games or mahjong					
Watching television					

Have you been bothered by:	**RT Yes**	RT No	**LT Yes**	LT No
Poor night vision?				
Seeing rings or halos around lights?				
Glare caused by headlights or bright sunlight?				
Hazy and/or blurry vision?				

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Have you been bothered by:	**RT Yes**	RT No	**LT Yes**	LT No
Seeing well in poor or dim light?				
Poor color vision?				
Double vision (from one eye)?				
Did you fail the vision portion of your driver's license exam?				

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 have 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.

X _____ _____

Signature of Patient Date

Office Use Only
C = total number of Checked boxes in column
F = sum of the Factored amounts
Final Score:(F ____ / C _____) x 25 = V

(C) # checked boxes in column	A Little	Moderate Amt	Great Deal	Unable
(F) factored amounts	X1=	X2=	X3=	X4=0

Lifestyle Vision Questionnaire

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. 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 (Driving, TV, Golf, Tennis)
☐ Mid-Range (Computer, Cooking, Gardening)
☐ Near (Reading, Cell Phone, Sewing, Cards)

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

Please list your favorite hobbies: _____

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

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

Chu Vision INSTITUTE

ROUTINE EYE EXAMS, MEDICAL EYE EXAMS AND REFRACTIONS

Regular eye examinations are important to maintain your vision for your lifetime. It is important that you are aware of your insurance benefits and how they apply to your visit so you know how billing will be handled. Ultimately, it is your responsibility to know what your own medical or vision plan covers. We hope this information will help you understand how your visit is submitted to your insurance for visits with Chu Vision Institute.

Benefits may vary based on the reason for your visit. Your description of your eye condition will help us determine whether your visit to the clinic is defined as "Routine" or "Medical." Your symptoms and eye examination will determine how your visit is coded and billed to your insurance.

To find out what *your* specific costs will be, you will need to call your insurance provider and 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, any other out-of-pocket costs.
- Are there any limits on what my plan will pay for?

Routine Eye Examinations:

A "routine eye exam" takes place when you come for an eye examination without any underlying medical conditions affecting the eye. The doctor screens the eyes for disease and checks your vision. Examples that will necessitate your visit being submitted as a vision exam include **Basic Eye Exam, Routine Eye Check-Up, Yearly Eye Exam, Glasses and Contact Lenses**, **Preventative Care, Wellness Vision Exam.**

Medical Eye Examinations:

Exams for medical care which are for evaluation of a medical related complaint or follow-up of an existing condition are examples of an eye examination that would be billed to your medical insurance. Your provider might order tests or prescribe treatments that may not be covered by your insurance company. Examples that will necessitate your visit being submitted as a medical exam include but are not limited to: **Allergies, Cataracts, Dry or Red Eyes, Eye Irritation, Floaters and/or Flashing Lights, Glaucoma, Macular Degeneration, and Referrals from Outside Physicians.**

Refractions:

A refraction is a diagnostic test used to determine your best corrected vision. During this test, lenses are placed in front of the eye and the patient is asked, "Which is better one or two?" For some medical conditions a refraction is needed even when eyeglasses are not prescribed. Even though this is a vital test to the care of your eyes, the refraction is a non-covered service through Medicare and most other insurance plans. Unfortunately, they do not differentiate between "medical refractions" and refractions performed solely for the purpose of providing glasses. We are required to charge for this service regardless of whether insurance will pay. If your insurance does not cover the cost of this procedure, you will be responsible for the fee.

I understand the difference between routine and medical eye examinations and the potential implications of these differences on which type of insurance gets billed. This includes the potential for fees that may include co-pays, deductibles and/or co-insurance fees, which I will be responsible for. I further understand that a refraction is an important test that I may need, and if so, that I will be responsible to pay the amount of **$117.00** for this test if not covered by my insurance plan.

_____ _____

Patient Signature Date

VIRTUAL VISITS ACKNOWLEDGMENT

1) Nature of Virtual Eye Health Visit

During the virtual visit: a) We will use a HIPAA compliant platform for our visit. b) Details of your medical history, prior tests and examinations will be discussed, as well as a current history and plan using interactive audio and video technology. c) Physical examination will be visual, where feasible. d) Digital photos may be taken to enter into your chart during the virtual visit, but we will not record video or audio with our HIPPA compliant system.

2) Medical Information and Records

All existing laws regarding your access to medical information and copies of your medical records apply to this virtual visit.

3) Confidentiality

Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the virtual visit. All existing confidentiality protections under federal and Minnesota State law apply to information disclosed during this telemedicine consultation.

4) Risks and Consequences

The virtual visit will be similar to a medical office visit, except interactive video technology will allow you to communicate with a doctor at a distance. At first you may find it difficult or uncomfortable to communicate using video. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to physician contact. Following the virtual visit, your physician may recommend a private consultation visit be scheduled in our office for further evaluation or follow up.

5) Rights

You may withhold or withdraw consent to the virtual visit (i.e., end the appointment) at any time without affecting your right of future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

Signed Acknowledgement:

I have been advised of all the potential risks, consequences, and benefits of virtual visits. I have asked the clinic representative any questions that I have about the written information provided above. I understand the written information provided above.

_____ _____

Patient Signature Date