Pandrama OPTOMETRY

Patient Information

Last Name: _____ First Name: _____
Care Card#: _____ Date of birth: _____
Cell Phone: _____ Home Phone: _____
Email Address: _____
Home Address_____City_____Province_____PostalCode_____
Referred by: _____
Do you have an eyewear benefits program? □Y □N
Insurance Company_____
Plan Name_____
Group Number_____
Insured Full Name_____
Relation to Insured_____
Consent to bill Insurance Company. Please sign_____

How would you prefer to be contacted?

- □ EMAIL
- □ TEXT
- □ CALL

Is it okay to email you to update you on your appointments, newsletters and events? □Y □N

What is the purpose of this visit? _____ _____
Any problems with your current contact lenses or glasses? _____
Date of last eye exam? _____
Have you ever been diagnosed with any eye disease or eye surgeries. If yes, please list_____
Do you have any medical conditions? If yes, please list_____
Do you take any medications? If yes, please list_____
Please list any family ocular or medical history_____

Consent to bill MSP: **Signature x**_____

Authorization for Release of Patient Information (If Applicable)

❑ I agree to have my information, or copies of my records released to all professionals related to my health care.

Name: _____
Email: _____
Fax: _____

Or

❑ Only release my information to _____

Name: _____
Email: _____
Fax: _____

This authorization shall be considered valid throughout the duration of treatment

Signature: _____ **Date: _____**

COVID19 Health Prescreener

1. Are you experiencing ANY of the following emergency symptoms: severe shortness of breath and difficulty breathing, persistent chest pain or pressure, new confusion, bluish lips or face, loss of consciousness, slurred speech, and/or severe, constant dizziness or light-headedness?

_____

2. Are you experiencing any of the following symptoms? Please select all that apply.

- □ **Fever, chills or sweating**
- □ **New or worsening cough**
- □ **Fatigue**
- □ **Body aches**
- □ **Diarrhea**
- □ **Reduced sense of smell and/or taste**
- □ **Mild to moderate difficulty breathing**
- □ **Sore throat**
- □ **Runny nose**
- □ **None of the above**

3. Have you been told by a health official that you may have been exposed to COVID-19 (coronavirus)?

4. Have you been around someone who is known to have COVID-19 (coronavirus)?

---

5. Have you been tested before for COVID-19?

- ☐ **Yes, results negative**
- ☐ **Yes, results positive**
- ☐ **No**

6. In the last 14 days, have you been in an area of high-risk for COVID-19 (coronavirus)?

---

7. In the last 14 days, have you traveled internationally?

---

8. In the last 14 days, have you been around someone who recently traveled to a high-risk area and is also sick?

---

9. Over the last 14 days, have you and the people you live with been practicing social distancing of 6 feet or more?

Authorization for payment from MSP to Opted-Out Practitioners

This form allows your practitioner to receive your medical services plan for reimbursement directly for services that are MSP benefits it is only valid if it is signed and dated including year by both patient and practitioner.

PATIENT INFORMATION AND AUTHORIZATION

Patient First Name	Patient Last Name	Patient Personal Health Number PHN

Patient Authorization

I, the patient named above, authorize MSP to pay the practitioner name below directly for reimbursement for benefits payable to me under the *Medical and Health Care Services Regulation* for care provided tot me. I authorize the

practitioner to collect MSP payment from the date when this form is signed to the end of the calendar year in which this form is signed.

For each service provided, the practitioner will notify me of the full fee and what portion of the fee they will claim directly from MSP.

- For optometric services MSP contributes an amount in accordance with the relevant payment schedule.

I make this authorization in full knowledge that the practitioner will receive the full amount that is reimbursable to me from MSP for this service, and that I will not receive further reimbursement from MSP for any monies I have paid for this service (if applicable).

_____ _____

Patient Signature Date Signed

PRACTITIONER INFORMATION AND DECLARATION

Practitioner Name	MSP Practitioner Number	MSP Payment Number

Practitioner Declaration

I have advised the patient that this form allows me to receive MSP reimbursement directly for services that are MSP benefits, and that the patient will not receive further reimbursement from MSP. I acknowledge that all claims for services provided to this patient comply with the *Medical Protection Act* and the relevant payment schedule. For each service provided, I will notify the patient of the full fee and what portion of the fee I will be claiming directly from MSP.

I understand that this authorization is only valid for the remainder of the calendar year in which it is signed, and that **the patient and I must complete a new Authorization for Payment from Medical Services Plan to Opted-Out Practitioners Form prior to directly billing MSP in future calendar years.** Further, I understand that eligible patients are only eligible for supplementary benefits for 10 claims per year for all supplementary services. As such, if the service relates to a supplementary benefit, I know that I will only receive reimbursement from MSP if the patient has eligible claims remaining for the year on the date of claim submission

_____ _____

Practitioner Signature Date Signed