MOBILE EYES OPTOMETRY

♦ In-Home Eye Exams ♦ Senior's Care Homes ♦

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CONSENT FOR EYE EXAMINATION

ALL PAGES OF THE CONSENT FORM MUST BE FILLED OUT and SIGNED FOR AN EYE EXAM TO BE SCHEDULED
Please email form to admin@mobileeyes.ca or fax to 604-263-5595

PATIENT INFORMATION: ☐ Male ☐ Female

Patient Legal Name: First _____ Last _____

Preferred name (if different than first name): _____

MSP/PHN #: _____ Date of Birth (DD/MM/YYYY): _____

Name of Care Home: _____ Room #: _____

GP's Name: _____ GP's Phone #: _____ Fax #: _____

EXAM RESULTS – *please indicate ONE family member or appointed person to contact with exam results*

☐ N/A (patient handles own medical information)

Name: _____ Relationship to the patient: _____

Home #: _____ Cell #: _____ Work #: _____

Email address: _____

CONSENT TO RELEASE INFORMATION:

Has the patient previously been seen by another optometrist and/or ophthalmologist? ☐ Yes ☐ No
If yes, please fill out the below Information to allow us to request previous records for the patient.

I hereby consent for my last Optometrist / Ophthalmologist, Dr. _____ to release the medical information for the patient named above and to fax recent medical reports or chart notes for said patient to Dr. Terynn Chan, OD or her associates at Mobile Eyes Optometry.

Optometrist / Ophthalmologist's Phone: _____ Fax: _____

Date of last eye exam: _____

Please list any previous eye surgeries / treatments: _____

_____

By signing below, I confirm that I have read & completed the information in full and confirm the information provided is accurate to the best of my knowledge. I also agree to pay the fee as outlined in the fee schedule attached on page 3.
Name of person consenting to exam *(print)*: _____

Signature: _____ Date (DD/MM/YYYY): _____

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Patient currently wears glasses: ☐ No ☐ Yes If yes, for: ☐ distance ☐ reading ☐ full-time

Current Eye Problems / Complaint: _____

_____

Patient's Activities *(please check all that apply)*:
☐ watches TV (distance in ft ___) ☐ reads ☐ crafts or bingo ☐ uses computer

Patient Mobility:
☐ can walk (unassisted or with walker) ☐ wheelchair (transferable) ☐ wheelchair (requires a lift to transfer)

☐ in-bed exam required (only check if NECESSARY)

Patient Communication:
☐ Patient speaks English

☐ Patient does not speak English What language does the patient speak? _____
If the patient does not speak English, a family member or other appointed person must attend to translate.

LEGAL POWER OF ATTORNEY (POA) – *In BC, an appointed power of attorney is legally able to make financial and legal decisions for the patient, but not medical ones (see representation agreement below).*
☐ N/A (patient is self-consenting, no POA) ☐ N/A (no POA)

Name: _____ Relationship to the patient: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Home #: _____ Work #: _____ Cell #: _____
Email address: _____

LEGAL REPRESENTATION AGREEMENT - *In BC, a representation agreement allows the appointed person the ability to make personal and healthcare decisions for the patient (this is different than a POA)***.**
☐ N/A (patient is self-consenting, no Representative) ☐ N/A (no Representative) ☐ same as POA above

If the person holding the representation agreement is different than the POA, please fill in their contact information below:

Name: _____ Relationship to the patient: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Home #: _____ Work #: _____ Cell #: _____
Email address: _____

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FEE SCHEDULE:

The schedule below outlines the fees we currently charge over and above MSP to our patients age 65 and over. These fees are billed directly to the patient as per their consent form & are not billed to MSP. Pre-payment information must be provided prior to an eye examination.

In House / Individual / In Bed Eye Exam	$180.00
Care Facility Clinic – New Eye Exam	$115.00 *
Care Facility Clinic – Recall Full Eye Exam	$105.00 *
Care Facility Clinic – Follow-Up/Minor Eye Exam	$80.00 *

** Applies when 5 or more patients are seen for full eye exams at one facility on the same day*

Mobile Eyes Optometry does not directly bill third party insurance providers, unless you are a Ministry patient. Eye exams must be paid for in full and a receipt will be provided to you for you to submit to an insurance provider for reimbursement.

Cost of glasses varies depending on the prescription & will be quoted upon request. No charge for engraving & delivery.

Patients under the age of 65 have no coverage under MSP for an eye exam unless there is a medically related eye problem and therefore may be billed an additional $47.08 for the MSP portion in addition to the fees above.

- *By signing this form, I authorize the Medical Services Plan to pay **Dr. Terynn Chan** (Practitioner) directly for all reimbursement benefits payable to the patient listed below under the Medical & Health Care Services Regulation for care provided to said patient by said Practitioner or her associate. By law, said practitioner must advise me of her full fee & the portion reimbursed by MSP. By agreement, said practitioner may not charge me the portion reimbursable by MSP ($47.08 or $32.96 for a full or follow-up eye exam).*
- *I make this assignment in full knowledge of the amount that I will personally be responsible for, as well as of the amount reimbursable by MSP which will be directed to **Dr. Terynn Chan** (Practitioner).*
- *I am aware the exam fee is **NOT** covered by third party insurance providers, Veterans Affairs Canada (VAC), or Non-Insured Health Benefits (NIHB) program for First Nations and Inuit. In addition, I also note that I will be solely responsible to cover these costs by way of payment to **Dr. Terynn Chan**.*

BILLING INFORMATION – *please indicate the person to bill for the eye exam*

☐ Bill listed POA ☐ Bill listed Representative

☐ Bill patient's comfort fund/trust account at the care home (*note: If you select this option and your care home does not allow trust billing, we will contact you to update your billing information*)

☐ Bill other (*please fill out information below if different than the POA or Representative*)

Name of Person to bill: _____ Relationship to patient: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home #: _____ Work #: _____ Cell #: _____

Email address: _____

☐ I am aware that there will be a fee for the in-home/care home eye examination (see fee schedule above) and I am consenting to an eye examination and recommended follow-up visits by Dr. Chan or her associates.

Signature: _____ Date (DD/MM/YYYY): _____

BRITISH COLUMBIA | Ministry of Health

AUTHORIZATION FOR PAYMENT FROM MEDICAL SERVICES PLAN TO OPTED-OUT PRACTITIONERS

This form allows your practitioner to receive your Medical Services Plan (MSP) reimbursement directly for services that are MSP benefits.
It is only valid if it is signed and dated (including the year) by both the patient and the practitioner.

PATIENT INFORMATION AND AUTHORIZATION (PLEASE USE CAPITAL LETTERS)

Patient Last Name	Patient First Name	Patient Personal Health Number (PHN)

Patient Authorization

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

- If I qualify for supplementary benefits, I am aware that MSP contributes $23 per visit for a combined annual limit of 10 visits each calendar year for the following services: acupuncture, chiropractic, massage therapy, naturopathy, physical therapy and non-surgical podiatry.
- For other services (e.g. dentistry, optometry, surgical podiatry, and midwifery) 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 (dd/mm/yyyy) _____

PRACTITIONER INFORMATION AND DECLARATION (PLEASE USE CAPITAL LETTERS)

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 *Medicare 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 (dd/mm/yyyy) _____

The information contained in this form is collected for the purposes of recordkeeping, claims administration and payment, and to otherwise administer and enforce the *Medicare Protection Act*. If this personal information is being collected by a private practitioner, the collection is occurring with your consent under the *Personal Information Protection Act*. Please speak with your practitioner or contact Health Insurance BC at the address or telephone numbers below if you have questions regarding the collection of your personal information.

Mailing Address: Provider Programs, PO Box 9480 Stn Prov Govt, Victoria BC V8W 9E7
Tel: (Lower Mainland) 604 456-6950, (rest of BC) 1 866 456-6950, Fax: 250 405-3592
Web: www.hibc.gov.bc.ca

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CONSENT TO USE ELECTRONIC COMMUNICATION

Email communication will only be used to send information regarding appointments, exam results, and receipts. NO MARKETING INFORMATION WILL BE SENT.

1. *Risks of using electronic communication*

Mobile Eyes Optometry will use all reasonable means and precautionary measures to protect the security and confidentiality of information sent and received using electronic communications. However due to the risks outlined below, we cannot guarantee the security and confidentiality of electronic communications.

- Use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- Despite reasonable efforts to protect the privacy and security of electronic communication, it is not possible to completely secure the information.
- Employers and online services may have a legal right to inspect and keep electronic communications that pass through their system.
- Electronic communications can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.
- Electronic communications are subject to disruptions beyond the control of the Provider that may prevent the Provider from being able to provide services.
- Electronic communications can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the Provider or the patient.
- Even after the sender and recipient have deleted copies of electronic communications, back-up copies may exist on a computer system.
- Electronic communications may be disclosed in accordance with a duty to report or a court order.
- There may be limitations in the services that can be provided through electronic communications, dependent on the means of electronic communications being utilized.
- Emails, text messages, and instant messages can more easily be misdirected, resulting in increased risk of being received by unintended and unknown recipients.
- Emails, text messages, and instant messages can be easier to falsify than handwritten or signed hard copies. It is not feasible to verify the true identity of the sender, or to ensure that only the recipient can read the message once it has been sent.

2. *Conditions of Using Electronic Communications*

- While the Provider will endeavour to review electronic communications in a timely manner, the Provider cannot provide a timeline as to when communications will be reviewed and responded to. Electronic communications will not and should not be used for medical emergencies or other time-sensitive matters.
- Electronic communications may be copied or recorded in full or in part and made part of your clinic chart. Other individuals authorized to access your clinic chart may have access to those communications.
- The Provider may forward electronic communications to staff to staff and those involved in the delivery and administration of your care.
- The Patient will inform the Provider of any changes in the patient's email address, mobile phone number, or other account information necessary to communicate electronically.
- The Patient will take precautions to preserve the confidentiality of electronic communications.
- If the Patient no longer consents to the use of electronic communications by the Provider, then the Patient will provide notice of the withdrawal of consent by email or other written communication.
- The patient may not video or record videoconference or telephone consults.

3. *Acknowledgement and Agreement*

☐ I acknowledge that I have reviewed and fully understand the risks, limitations, conditions of use, and instructions for use of the communications as described above.

Check one:

☐ **I consent** to the conditions and will follow the instructions outlined above, as well as any other conditions that the Mobile Eyes Optometry may impose regarding electronic communications with patients.

☐ **I do not consent** to the use of electronic communications as outlined above and understand that appointment reminders, receipts, and exam results **will not** be sent to me via electronic communication.

Signature: _____ Date (DD/MM/YYYY): _____