RESTORATIONEYECARE
TIMOTHY McGARITY, M.D.

Welcome to Restoration Eye Care

We want to thank you for choosing us. Our goal is to provide you with compassionate, timely and accurate care.

Please read and fill out all the enclosed forms, including your signature on the "patient registration" and “medical release information” forms, and bring these completed forms with you on the day of your appointment. Please let us know if we may assist you in completing these forms. We strive to keep your paperwork to a minimum. Allow 15 to 30 minutes to complete the paperwork entirely. Completed paperwork will speed up your check in process. Also, bring all of your insurance cards and a list of any medications which you are taking. We accept most insurance plans and Medicare.

If you have a co-payment it will be collected at the time of service (this does not apply to those who have Medicare and/or supplemental insurance). We accept most forms of payment.

If your health insurance company requires a referral to visit a specialist, then please verify in advance that we have received the referral from your Primary Care Physician, not your eye doctor. We can not see you if you needed a referral that was not sent to us. Please let us know if you need assistance with a referral before the day of your appointment.

Patients coming in for a new evaluation will be dilated, so please bring a driver if necessary. Expect to be with us for at least one hour. If you want more information before your appointment we encourage you to visit our website at www.RestorationEyeCare.com, **call us**, or check us out on ***Facebook***. If you are unable to keep this appointment, please call our office during regular office hours, Monday through Thursday between 8:00 A.M. and 4:00 P.M or Friday between 8:00 A.M. and Noon. Effective May 1, 2012 if your appointment is not cancelled within 24 business hours your account will be charged a **$25 No Show fee**. No Shows are costly to everyone, and we want to fill each appointment slot for patients who need assistance.

We look forward to seeing you in our office at your scheduled appointment time. We are located at 1410 Forum Katy Parkway, Columbia, MO 65203, and can be reached by phone at (573)441-7070.

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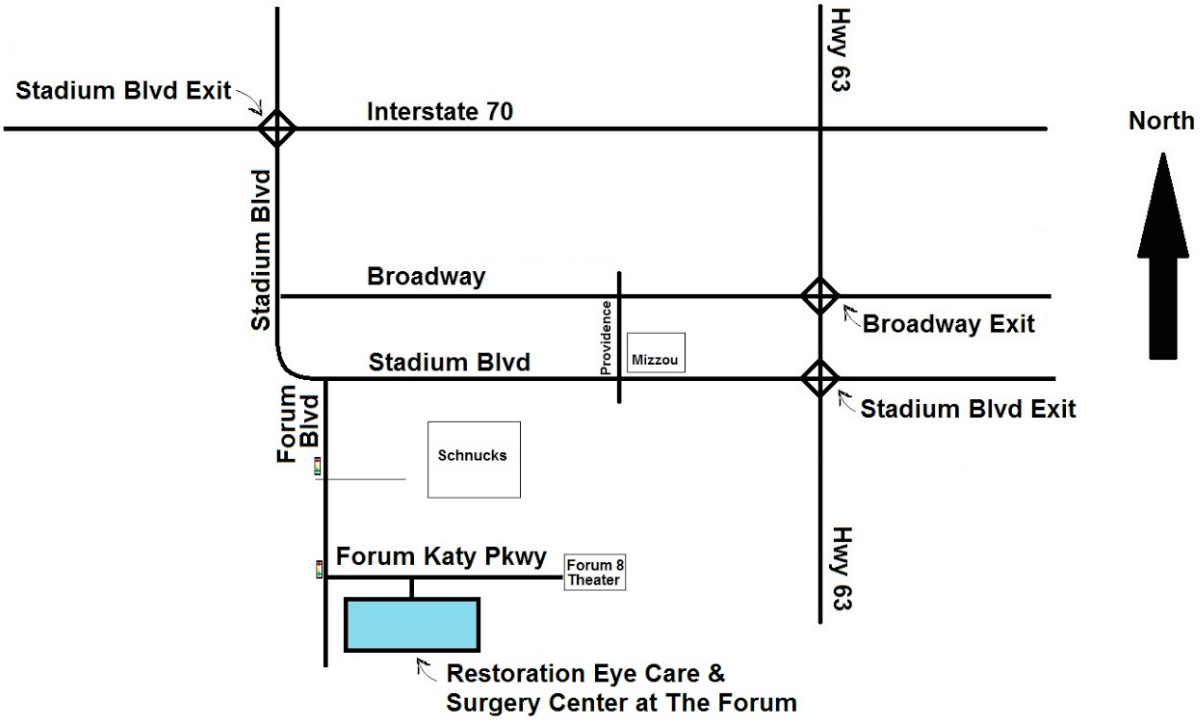
Map to Columbia Location



The Forum Medical Park
Restoration Eye Care, Suite 100
Surgery Center at The Forum, Suite 102
1410 Forum Katy Parkway
Columbia, MO 65203

From Hwy 63

Stadium Exit & Turn West
Stay on Stadium for 3.6 miles (7-10 minutes)
Turn South (Left) to Forum Blvd
Go to 2nd Stoplight & Turn Left
Take next right to parking

From I-70

Stadium Exit & Turn South
Stay on Stadium for 2.7 miles (6-9 minutes)
Turn South (Right) to Forum Blvd
Go to 2nd Stoplight & Turn Left
Take next right to parking

What is a Cataract?

We all have a natural lens inside of our eyes. This natural prescription lens helps to focus our vision. As our eyes age or other diseases affect the eyes, the natural lens becomes cloudy and disturbs good vision. This is called a cataract.

The Initial Cataract Evaluation

An initial evaluation is performed to determine if you have a cataract, and whether it can be safely removed. A full eye exam is performed during this visit, which involves dilating the eyes. Furthermore, we determine if cataract surgery will improve your vision. With cuts to Medicare and health insurance, we are now only allowed to perform the most basic diagnostic testing during this evaluation. In the past, we were able to perform these advanced preoperative tests during the initial cataract evaluation.

The Preoperative Refractive Evaluation (PRE)

After your initial evaluation, a PRE is scheduled on a separate day sometime shortly before your Cataract Surgery. During this refractive surgery evaluation, your eyes are typically not dilated and we perform a multitude of advanced diagnostic tests. The results of these tests are uploaded to the software which objectively plans the surgery.

Cataract Surgery

At our state of the art Surgery Center, Dr. McGarity performs surgery using phacoemulsification. Using ultrasound technology, phacoemulsification gently dissolves and aspirates the cataract from the eye. Then a custom-fit prescription lens, known as an intraocular lens (IOL), is permanently inserted in your eye. The PRE is essential in providing the most accurate measurements to select the best IOL prescription for your eye. The goal is to give you high definition vision, if possible, with cataract surgery.

Vision Options with Cataract Surgery

Medicare and most private insurance companies provide coverage for Standard Cataract Surgery. With new advancements in preoperative testing, surgical techniques and IOL technology, you have some amazing options.

PRE-Lens HD™ Option

Preoperative Refractive Evaluation plus High Definition IOL.

This option includes the **PRE** (not covered by insurance) and a **High Definition Single Focus IOL** (these IOLs are covered by insurance). A variety of HD Single Focus IOL models are available: ***SoftPort AO®***, ***Tecnis®*** and ***AcrySof®*** to name a few. These particular IOL models have been selected because of their proven track record, HD optics and safety. Each of these IOLs have unique optical properties. The results of your PRE™ will be used to custom select which model and power HD Single Focus IOL is best suited for you. The goal is to give you the best vision in the safest manner.

What's the difference between Standard Cataract Surgery and the PRE-Lens HD™ Option?

Standard Cataract Surgery option has a lower cost, less testing and a more economical IOL compared to the PRE-Lens HD Option. It is a safe and effective option for patients who want the least out of pocket expense. Standard Cataract Surgery includes basic preoperative testing (covered by insurance) and a standard IOL (covered by insurance). The Standard IOL is designed to be a clear replacement lens and will typically require glasses full-time to help restore eyesight, although patients will occasionally achieve better distance vision without glasses.

Advanced Technology Cataract Surgery™ Options

Preoperative Refractive Evaluation plus Advanced Technology IOL.

We can now correct Astigmatism with the ***Tecnis Toric®* IOL**. If you have Astigmatism, this IOL will give you the best distance vision possible even if you still need thin prescription glasses after cataract surgery to fine tune your vision. For those patients who want to free themselves of bifocals, the ***Tecnis Multifocal®* IOLs** may be a great option. If you elect to have one of these Advanced Technology IOLs, we provide more extensive postoperative care including laser vision enhancement, if needed, as part of this upgrade.

Value

The gift of vision is priceless. We want patients of all ages and backgrounds to achieve the best vision for life. You are under absolutely no obligation to upgrade to one of the advanced options. If you would like to learn more about these advanced options, then we will provide you with a booklet and a price list following the initial cataract evaluation. To make your procedure more affordable, we offer low monthly payments, including 0% financing through Care Credit®.

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Lifestyle Questionnaire

Visual Functioning

Do you have difficulty, even with glasses, with the following activities?

- Reading small print, pill bottles, newspaper, books or the telephone book? Yes No
- Reading traffic signs, street signs or store signs? Yes No
- Doing fine handwork like sewing, knitting or carpentry? Yes No
- Other specific visual task concerns: _____

Symptoms

Have you been bothered by:

- Poor night vision, color vision or double vision? Yes No
- Hazy and/or blurry vision? Yes No
- Seeing in poor or dim light? Yes No
- Seeing rings or halos around lights at night while driving? Yes No
- Glare caused by headlights or bright sunlight? Yes No

Do you do a lot of night driving? Yes No
Do you have dry eyes? Yes No
Do your eyes water a lot? Yes No

Lifestyle Considerations

What is/was your occupation? _____
Do you use the computer frequently? Yes No
Do you do a lot of close detailed work? Yes No
Do you enjoy any of the following recreational activities?
☐Walking ☐Golf ☐Gardening ☐Swimming
☐Hunting/Fishing ☐Other: _____
Do you like wearing glasses to correct your vision? Yes No
Do you wear progressive or no-line bifocals? Yes No
Do you take your glasses off to read or do near work? Yes No
Have you had previous refractive eye surgery (LASIK, PRK, RK)? Yes No
Did/Do you wear contact lenses? Yes No

If so did/do you wear (check all that apply):
☐ Distance contacts with readers
☐ Multifocal / Bifocal contacts
☐ Hard / Rigid Gas Permeable
☐ Monovision contacts (One Eye Far/Other Near)
☐ Soft contact lenses

Your Goals for surgery

I want to improve my vision and I:
☐ would be happy to wear glasses all the time to fine-tune my vision
☐ would like to have good distance vision without glasses and wear glasses for computer and reading
☐ would like to have good near vision without glasses and wear glasses for driving or distance
☐ would like to have good distance and near vision without glasses and rely on minimal glasses

Patient Name:_____
Patient Signature: _____ Date: _____

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Patient Registration

Patient Name:_____
SSN:_____ Date of Birth:_____
Address:_____
City:_____ State:_____ ZIP:_____
Primary Phone Number:_____ ☐Home ☐Cell ☐Other
Alternate Phone Number:_____ ☐Home ☐Cell ☐Other
E-Mail:_____
Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed
Employer:_____Work Number:_____
Work Address:_____
Spouse or nearest relative:_____ Relationship to patient:_____
Primary Phone Number: _____ ☐ Home ☐ Cell ☐ Work
Alternate Phone Number: _____ ☐ Home ☐ Cell ☐ Work
Referring Physician: _____
Family Physician: _____
Pharmacy Name/Location: _____

Patient's Medicare, Medigap and Supplemental Lifetime Authorization
I request that payment of authorized Medicare benefits be made on my behalf to Restoration Eye Care for any services furnished to me by my provider. 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 request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from this provider.

AUTHORIZATION: I hereby authorize any insurance benefits to be paid directly to RESTORATION EYE CARE and acknowledge that I am financially responsible for any unpaid balance. If my account is sent to a collection agency for non-payment, I will be responsible for any collection fee.

AUTHORIZATION: I authorize RESTORATION EYE CARE to release necessary medical information to insurance carriers and to referring physicians concerning my health care and treatments.

I have read and understand the Health Information Practices of Restoration Eye Care.

_____ _____
Patient's Signature Date

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AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

HIPAA Compliance Privacy Laws of the Federal Government require that we ask you to review and answer the following questions listed below.

Patient's Name: _____

May we leave messages/detailed medical information on voicemail or text message at either of these phone numbers?
□ Yes □ No **Home Phone**: _____
□ Yes □ No **Cell Phone**:_____

May we leave messages/detailed medical information by email?
□ Yes □ No **Email address**: _____

May we contact you at your place of employment? □ Yes □ No
If so, may we leave a message? □ Yes □ No
If yes: **Work Phone**: _____ **Extension**: _____

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)?
□ Yes □ No
If yes, please provide:
Name: _____ Relationship: _____
Phone Number: _____ Alternate Number: _____

Do you have a person who is your Power of Attorney for medical purposes? □ Yes □ No
If yes, please provide:
Name: _____ Relationship: _____
Phone Number: _____ Alternate Number: _____

I hereby authorize Timothy D. McGarity, M.D. P.C. d/b/a Restoration Eye Care, Mid-Missouri Surgery Center, LLC, d/b/a Surgery Center at The Forum and Anesthesia Services of Mid-Missouri, LLC to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked**.

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above. I have reviewed this Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ **Date**: _____

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Medical History Form

Bring this completed form to your appointment, or arrive early to your appointment so that we may assist you in filling out this form.

Current Eye or Eye related problems or complaints (check all that apply)

☐Cataract ☐Decreased Vision ☐Discharge ☐Glare
☐Itching/Burning ☐Redness ☐Dryness ☐Halos
☐Other or explain any concerns:_____

_____

_____

Past Eye Surgery	Date	Explanation	N/A
☐Check here if **No Past Eye Surgeries**			
☐Cataract Surgery			☐
☐Glaucoma Surgery			☐
☐LASIK/PRK/RK			☐
☐Other Eye Surgery			☐

Prior Eye Problems (please mark all that apply)

☐ Check here if **No Past Eye Problems/History**
☐ Astigmatism
☐ Presbyopia (needing bifocals)
☐ Color Blindness
☐ Double Vision (Diplopia)
☐ Eye or Eyelid Cancer
☐ Facial Rosacea
☐ Eye Shingles (Varicella Zoster Ophthalmicus)
☐ Severe Eye Injury (Ruptured Globe)
☐ Farsightedness
☐ Tearing/Watering Constantly (Epiphora)
☐ Pupil Problems (Horner's Syndrome or Tonic Pupil)
☐ Cataract
☐ Cloudiness After Cataract Surgery (Posterior Opacification)
☐ Nearsightedness
☐ Lazy Eye (Amblyopia)
☐ Crossed or Turned Eyes (Strabismus)
☐ Droopy Eyelid (Ptosis)
☐ Eye Allergies (Allergic Conjunctivitis)
☐ Eye Herpes (HSV Keratitis)
☐ Keratoconus
☐ Eye Bone Fracture (Orbital Fracture)
☐ Cornea Infection (Ulcer)
☐ Dry Eye Syndrome
☐ Iritis/Uveitis
☐ Optic Neuropathy (NAION)
☐ Myasthenia Gravis

Patient Name:_____

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(Continued)

☐ Dislocated Lens (Ectopia Lentis)
☐ Retinal Detachment
☐ Retinal Tear without Detachment
☐ Diabetic Retinopathy
☐ Epiretinal Membrane (ERM)
☐ Floaters (Posterior Vitreous Detachment-PVD)
☐ High Eye Pressure (Ocular Hypertension)
☐ Idiopathic Intracranial Hypertension
☐ Sudden or Intermittent Loss of Vision
☐ Blocked Retinal Artery (CRAO, BRAO, Giant Cell Arteritis)
☐ Intraocular Foreign Body
☐ Blind Eye
☐ Macular Degeneration
☐ Blocked Retinal Vein (CRVO, BRVO)
☐ Retinal Swelling (Cystoid Macular Edema)
☐ Glaucoma
☐ Optic Neuritis (from Multiple Sclerosis)
☐ Thyroid Eye Disease (Graves Disease)
☐ Pituitary Tumor (Pituitary Adenoma)

Medical History (please provide explanation of any checked in the space below)

☐ Check here if **No Past Medical Problems/History**

☐ Anesthetic Complications
☐ Cancer
☐ Sleep Apnea (or machine)
☐ Oxygen Requirement at Home
☐ High Blood Pressure
☐ Heart Valve Disease
☐ Rheumatoid Arthritis
☐ Thyroid Disorder
☐ Bleeding Disorder
☐ Diabetes
☐ Asthma
☐ Heart Attack
☐ Irregular Heart Rhythm
☐ Stroke
☐ Migraine
☐ Hepatitis
☐ Brain Tumor
☐ Emphysema (COPD)
☐ Pneumonia in last month
☐ Congestive Heart Failure (CHF)
☐ Heart Stents in last 6 months
☐ Pacemaker/Defibrillator Implant
☐ AIDS/HIV
☐ Dementia

Explanation-_____

_____

_____

_____

Other Surgical History? **Date?** (**Heart Surgery, 2003** for example)

☐ Check here if **No Past Surgeries or Procedures**

_____

_____

_____

_____

Patient Name:_____

Social, Family and Occupational History

Do you smoke?	☐Yes, often	☐Yes, occasionally	☐No, but I used to	☐No, never smoked
What kind of tobacco?		☐Cigarette	☐ Cigar	☐ Pipe
Drink Alcohol?	☐Yes, often	☐Yes, occasionally	☐No, but I used to	☐No, never drank
What type of alcohol?		☐ Beer	☐Wine	☐ Liquor
Illicit drugs?	☐Yes, often	☐Yes, occasionally	☐No, but I used to	☐No, never

Immediate Family History (Please check all that apply). Please note relation to yourself using F-Father, M-Mother, S-Sister, B-Brother (example**: Diabetes-F or Glaucoma-S/B)**

☐ Check here if **No Known Family History**
☐ Cataracts _____
☐ Blindness _____
☐ Crossed/Lazy Eye _____
☐ Corneal Disease_____
☐ Other Eye Problems_____
☐ Other Disease_____
☐ Arthritis_____
☐ Diabetes_____
☐ Macular Degeneration _____
☐ HIV _____
☐ Stroke_____
☐ Glaucoma _____
☐ Heart Disease _____
☐ Rheumatoid Arthritis_____
☐ Lupus_____

What hobbies do you enjoy?

_____

_____

_____

What is/was your occupation?

_____

_____

_____

Patient Name:_____

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Medication & Allergy Reconciliation You may substitute this page by providing us with a neatly printed list of your allergies & medications. **Patient Name:**_____

Allergies (example: **Allergy**: Penicillin. **Reaction**: Rash or stopped breathing) ☐ Check if **No Known Allergies**

Allergy:_____ Reaction:_____

Allergy:_____ Reaction:_____

Allergy:_____ Reaction:_____

Allergy:_____ Reaction:_____

Medication Taken – Include all OTC supplements and vitamins ☐Check only if **Not taking Any Medications**

Medication name and reason taken	**How much? (Dosage)**	**How do you take it?**	**How often? (Frequency)**	**When was your last dose?**	Physician Circle
(example) Albuterol for Asthma	2 puffs	Inhale	2 times	this morning	
1.					Cont. DC New RX
2.					Cont. DC New RX
3.					Cont. DC New RX
4.					Cont. DC New RX
5.					Cont. DC New RX
6.					Cont. DC New RX
7.					Cont. DC New RX
8.					Cont. DC New RX
9.					Cont. DC New RX
10.					Cont. DC New RX
11.					Cont. DC New RX
12.					Cont. DC New RX

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Medication & Allergy Reconciliation continued (fill this page out only if necessary)

Patient Name:_____

Allergies

Allergy:_____ Reaction:_____

Allergy:_____ Reaction:_____

Allergy:_____ Reaction:_____

Allergy:_____ Reaction:_____

Medication Taken – Please include all OTC supplements and vitamins

Medication name and reason taken	How much? (Dosage)	How do you take it?	How often? (Frequency)	When was your last dose?	Physician Circle
13.					Cont. DC New RX
14.					Cont. DC New RX
15.					Cont. DC New RX
16.					Cont. DC New RX
17.					Cont. DC New RX
18.					Cont. DC New RX
19.					Cont. DC New RX
20.					Cont. DC New RX
21.					Cont. DC New RX
22.					Cont. DC New RX
23.					Cont. DC New RX
24.					Cont. DC New RX

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Review of Body Systems – Please check correct box in each category for any current problems or symptoms

Cardiovascular ☐Chest Pain ☐Irregular Heartbeat ☐Shortness of Breath ☐Heart Attack ☐Heart Valve Disease ☐N/A	**General** ☐Fatigue ☐Fever ☐Night Sweats ☐Weakness ☐Weight Loss ☐N/A	**Allergy** ☐Chronic Runny Nose ☐Hives ☐Itching ☐N/A	**Genitourinary** ☐ Discharge ☐ Sores ☐ Painful ☐ Urgency ☐ N/A
Blood Pressure Control ☐ Good BP Control ☐ Borderline BP Control ☐ Poor BP Control ☐ Unknown BP Control ☐ N/A	**Ears/Nose/Throat** ☐Dizziness ☐Ringing in Ears ☐Hearing Loss ☐Hoarseness ☐Sore Throat ☐N/A	**Hematologic** ☐Bleeding ☐Bruising ☐Tender Nodes ☐Clotting ☐Anemia ☐N/A	**Metabolic** ☐Cold Intolerance ☐Excess Hunger ☐Heat Intolerance ☐Excessive Thirst ☐Frequent Urination ☐N/A
Musculoskeletal ☐Back Pain ☐Joint Pain ☐Muscle Aches ☐Stiffness ☐Swelling ☐N/A	**Diabetes Control** ☐Good Control ☐Borderline Control ☐Poor Control ☐Unknown Control ☐N/A	**Neurological** ☐Balance Problems ☐Headache ☐Numbness ☐Tingling ☐Stroke/Seizure ☐N/A	**Psychiatric** ☐Anxiety ☐Depression ☐Insomnia ☐Irritability ☐Nervousness ☐N/A
Respiratory ☐Cough ☐COPD/Emphysema ☐Trouble Breathing ☐Wheezing ☐Asthma ☐Sleep Apnea ☐N/A	**Skin** ☐Hair Loss ☐Rash ☐Skin Lesions ☐N/A	**Pregnancy (are you pregnant?)** ☐First Trimester ☐Second Trimester ☐Third Trimester ☐N/A	**Endocrine** ☐Thyroid ☐Hypoglycemic ☐Hyperglycemic ☐N/A

Gastrointestinal ☐Liver Disease ☐GERD (acid reflux) ☐N/A	**This section is used by the physician for updating purposes only:** For vital signs, see *Physician's Order & Authorization Note* H & P updated date and time of Physician's signature _____ _____**, M.D.** **Date**

Patient Name:_____

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