



## Welcome to Restoration Eye Care

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, a photo ID, 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.

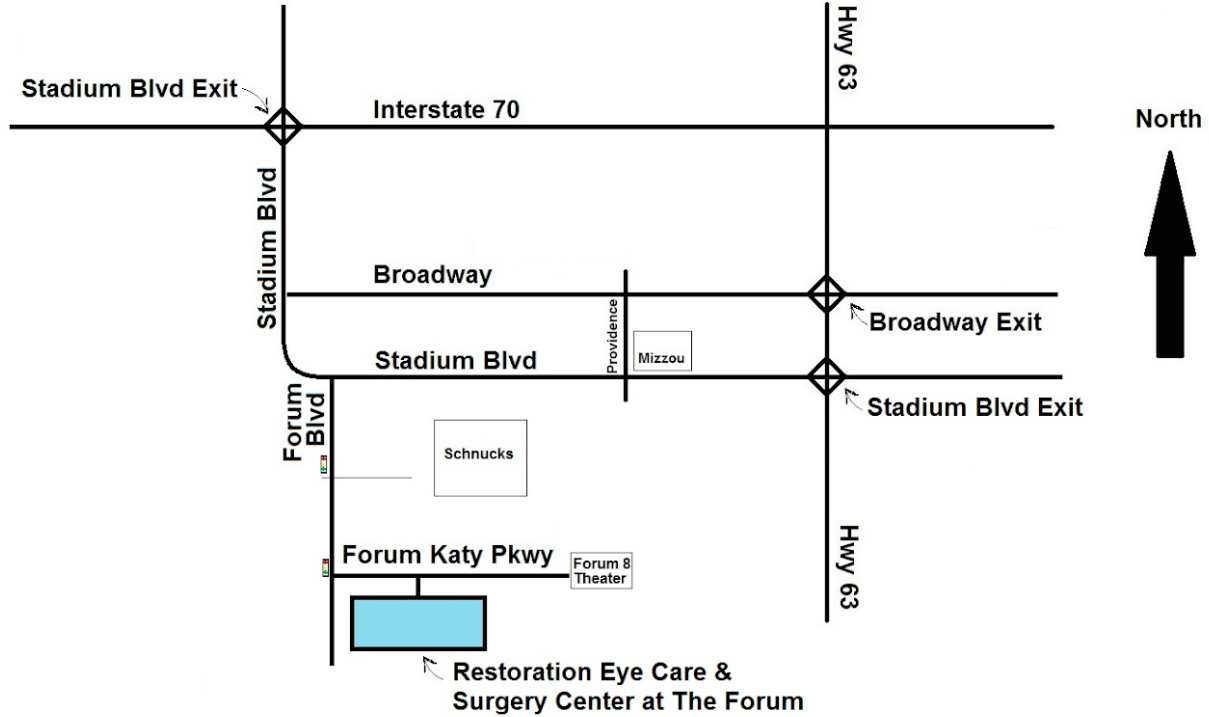
If your health insurance company requires a referral to visit a specialist, then please verify in advance that we have received the referral from your Primary Care Physician, not your eye doctor. We can not see you if you needed a referral that was not sent to us. Please let us know if you need assistance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

New patients will be dilated, so please bring a driver if necessary. If possible, please avoid wearing contact lenses on the day of your appointment. Expect to be with us for at least one hour. For more information we encourage you to visit our website [www.RestorationEyeCare.com](http://www.RestorationEyeCare.com) or give us a call. 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. If your appointment is not cancelled within 24 business hours, then 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 we can be reached by phone at (573) 441-7070.



### 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®.



Lifestyle Questionnaire

Visual Functioning (VF-8)

- Do you have difficulty, even with glasses, with the following activities?
Reading small print, pill bottles, newspaper, books or the telephone book?
Reading traffic signs, street signs, store signs or watching t.v.?
Doing fine handwork like sewing, knitting, carpentry, writing checks, or filling out forms?
Seeing stairs, steps or curbs?
Playing games such as bingo, dominos, card games or mahjong?

Symptoms

- Have you been bothered by:
Poor night vision, color vision or double vision?
Hazy and/or blurry vision?
Seeing in poor or dim light?
Seeing rings or halos around lights at night while driving?
Glare caused by headlights or bright sunlight?
Do you do a lot of night driving?
Do you have dry eyes?
Do your eyes water a lot?

Lifestyle Considerations

- What is/was your occupation?
Do you use the computer frequently?
Do you do a lot of close detailed work?
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?
Do you wear progressive or no-line bifocals?
Do you take your glasses off to read or do near work?
Have you had previous refractive eye surgery (LASIK, PRK, RK)?
Did/Do you wear contact lenses?

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 (pick one option below):
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: \_\_\_\_\_



### 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: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Card No. \_\_\_\_\_

#### 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



### 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: \_\_\_\_\_



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:

Table with 4 columns: Any Past Eye Surgeries?, Date, Explanation, N/A. Rows include: 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, Color Blindness, Double Vision, Eye or Eyelid Cancer, Facial Rosacea, Eye Shingles, Severe Eye Injury, Farsightedness, Tearing/Watering Constantly, Pupil Problems, Cataract, Cloudiness After Cataract Surgery, Nearsightedness, Lazy Eye, Crossed or Turned Eyes, Droopy Eyelid, Eye Allergies, Eye Herpes, Keratoconus, Eye Bone Fracture, Cornea Infection, Dry Eye Syndrome, Iritis/Uveitis, Optic Neuropathy, Myasthenia Gravis.

Patient Name:





**(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 an explanation of any checked in the space below)**

Check here if No Past Medical Problems/History

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

**Explanation-**

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

Check here if No Past Surgeries or Procedures

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**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?**

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**What is/was your occupation?**

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**Patient Name:** \_\_\_\_\_



**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



**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



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

Table with 4 columns and 5 rows of medical categories: Cardiovascular, Blood Pressure Control, Musculoskeletal, Respiratory, General, Ears/Nose/Throat, Diabetes Control, Skin, Allergy, Hematologic, Neurological, Pregnancy, Genitourinary, Metabolic, Psychiatric, Endocrine.

Gastrointestinal section with checkboxes for Liver Disease, GERD, and No Problems. Includes a signature line for the physician with fields for M.D. and Date.

Patient Name: \_\_\_\_\_