Due to COVID-19, our office procedures have been enhanced for your safety. To ensure a safe and efficient visit for you, **we require that you complete and submit this form along with your Medical Questionnaire (link below and also on our website) no less then 48 hours before your appointment. Unfortunately, if we do not receive these forms within that time, your appointment will be removed from our schedule.**

1. Fee consent form (once downloaded, this is an electronically fillable form). **Please fill out all fields** and email this form back to us.

2. Medical History Form Click to access online portal. Use “Existing Patient” login and fill out the form “Medical History”

OHIP covers the basic elements of an eye examination. Spectrum Eye Care uses advance diagnostic testing not covered by OHIP to detect and manage eye disease earlier and more precisely, resulting in better health outcomes. These tests do not replace traditional examination measures but they allow us to vastly minimize the amount of face to face examination time behind the microscope.

Optical Coherence Tomography (OCT) testing is a non-invasive imaging technology used to obtain high resolution images of the deeper parts of the retina that are not visible during routine examination.

OCT allows the individual layers of the retina to be visualized and retinal thickness can be measured to aid in the early detection and diagnosis of retinal diseases and conditions such as Glaucoma, Macular Degeneration, Diabetic retinopathy and disorders associated with High Blood Pressure, Cholesterol and numerous other conditions.

I wish to have OCT as a part of my exam for $56 ☐ Y ☐N

FEE CONSENT FORM:

I ______________________________ hereby consent to:

- Providing my insurance company information (if applicable)
- Accepting payment receipts and optical prescriptions via email
- Providing my personal health information to ensure the time I spend in the office is efficient and focused on my medical care
- Incurring a fee of $75 if I do not attend my appointment or cancel with less than 24 hours notice.

I, ______________________________________ have read the information on this form and **DO** consent to the above.

Signed: _______________________________ Date: _________________________________

NOTICE OF COLLECTION OF PERSONAL INFORMATION AND CONSENT TO COLLECT
"We" and "our" mean the following optometric practice: Spectrum Eye Care
READ CAREFULLY BEFORE SIGNING: By signing this form, you consent to our collection of the information above.
We collect, use and share your personal information for the following purposes: your ongoing eye care; to provide services to you; to understand your eligibility for benefits and/or services;to arrange payment for services; and as required by law.
The collection of this information is authorized by the *Health Insurance Act, Optometry Act, Regulated Health Professions Act* and *Health Protection and Promotion Act*.
We will take all reasonable steps to ensure that your personal information is treated confidentially and is only used for the purposes it was collected. We will take all reasonable steps to prevent unauthorized access, use or disclosure of your personal information.
You may obtain access to your personal information stored by us in accordance with the *Personal Health Information Protection Act* by making a written request to: info@spectrumfamilyeyecare.ca
More information about our collection, handling and protection of personal information is available in our privacy policy, posted online at www.spectrumfamilyeyecare.ca
You also have the right to complain to the Information Privacy Commissioner / Ontario, 1400-2 Bloor Street East, Toronto, ON M4W 1A8 (800-387-0073)

Patient Information:

Please fill out the following information:

First Name:	Last Name:	Email:
Date of Birth (M/D/Y):	Address 1:	Address 2:
City:	Province:	Postal Code:
Cell phone:	Home phone:	Preferred Method of Contact: ☐ Email ☐ Text ☐ Phone
Family Doctor:	Family Doctor Phone Number:	
Do you have insurance: ☐ Y ☐ N	Plan Name (ie. Sunlife, Manulife):	Policy Number:
Member ID/Certificate #:	Do you have Dependent Coverage? ☐ Y ☐ N	I consent to Spectrum Eye Care direct billing on my behalf: ☐Y ☐N
If you are not the primary insurance holder, please specify first & last name of primary:		
Health Card Number (in case we need to refer you):	Health Card Expiry:	