Fee Consent Form

I _____ hereby consent to:

- Providing my insurance company information
- 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
- Being automatically charged a fee of $50.00 if I do not attend my appointment or cancel with less than 24 hours notice.

NOTICE OF COLLECTION OF PERSONAL INFORMATION AND CONSENT TO COLLECT

"We" and "our" mean the following optometric practice: STC Optometry

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@stcoptometry.com.

If you would like to make a comment or complaint regarding the collection, use, disclosure or handling of your personal information you may contact: Dr. Mandeep Bains.

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)

I AM AWARE THAT THE FEE FOR THIS APPOINTMENT IS $_____

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

Signed: _____ Date:_____

Scarborough Town Centre
300 Borough Drive Unit 267 • Scarborough • Ontario • M1P 4P5 •
T: (416) 290-0555 • F: (416) 290-0536 • http://www.stcoptometry.com

1. Patient Information

Last Name:	First Name:	Middle Initial:
Date of Birth:	Home Address:	

Gender: Female ☐ Male ☐	City:	Province:	Postal Code:	Country:
Home Phone:	Cell Phone:	Email Address:		

Preferred method of contact: ☐ Home Phone ☐ Cell Phone ☐ Text ☐ Email

Family Doctor Name:	Family Doctor Phone Number:
Emergency Contact Name:	Emergency Contact Phone Number:

2. Health Card Information:

Health Card Number:	Expiry Date:

3. Insurance Information:

Primary Cardholders Name	Plan Name
Policy/ Group #:	Member ID/ Certificate #:

4. COVID-19 Health History

Do you have fever, new onset of cough, worsening chronic cough, shortness of breath, or difficulty breathing?

☐ Yes ☐ No

Have you had close contact with anyone with acute respiratory illness or travelled outside of Canada in the past 14 days?

☐ Yes ☐ No

Do you have a confirmed case of COVID-19 or have had close contact with a confirmed case of COVID-19?

☐ Yes ☐ No

Have you travelled recently?

☐ Yes ☐ No

If you answered yes to any of these questions, please explain below:

5. Medical History

☐ Please check here if NO medications.

Medications: List all medications/over the counter/vitamins/supplements/eye drops.		
Dose:	Name:	Purpose

☐ Please check here if all of the following is NO.

Social History			
	Yes		Yes
Smoked in the past	☐	Drink alcohol	☐
Currently smoke	☐	Recreational drug use	☐

☐ Please check here if NO allergies.

Allergies:(medication and/or seasonal).	
Allergen:	Reaction:

Medical History

☐ Please check here if all of the following is NO.

Family	Eye History	Self
☐	Cataracts	☐
☐	Glaucoma	☐
☐	Retinal Detachment	☐
☐	Macular Degeneration	☐
☐	Lazy Eye/ Eye Turn	☐
☐	Trauma	☐
☐	Eye Surgery	☐
☐	Other:	☐

☐ Please check here if all of the following is NO.

Family	Medical History	Self
☐	Diabetes	☐
☐	High Blood Pressure	☐
☐	Elevated Cholesterol	☐
☐	Thyroid Disorder	☐
☐	Asthma/ COPD	☐
☐	Sleep Apnea	☐
☐	Stroke	☐
☐	Other:	☐