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INTRODUCTION

The purpose of the College's teaching clinic, the University Eye Institute, is twofold: to educate future optometrists and to provide patients with excellent care. These two activities are mutually dependent. Because the actual practice of primary care is recognized as the best way to train an optometrist, the University Eye Institute is designed to allow the student the opportunity to develop the skills needed to provide exemplary care.

The practice of optometry requires mechanical skills, communicative skills, and integrative and interpretive skills. Mechanical skills, such as using the retinoscope and phoropter or modifying contact lenses, are usually mastered relatively easily by most students. Communicative skills, such as extracting a case history or explaining to a patient the nature of their problems, or those required to integrate data obtained from clinical tests with knowledge of the sciences to arrive at a diagnosis are often more difficult to learn. They can be developed only by examining, communicating and treating large numbers of patients. If a student does not develop the higher-level skills, it is doubtful that s/he will develop them as a practitioner.

Maintaining a high standard of care in the clinic is important for all. University health-care facilities usually have a reputation of providing high-quality care. Patients with unusual or complicated conditions often choose or are referred to such clinics; this enables the hospitals and clinics of the health-care center to have a wide variety of patients and to expose students to conditions that occur only rarely in the population. In a broad sense, the student who provides quality care is enhancing the reputation of the clinic and thereby helping to assure the excellence of their education.

The University Eye Institute at present is comprised of faculty, residents, staff, and students who are providing eye and vision care to thousands of patients each year. In order to prevent chaos and to provide high-quality care to every patient, a number of rules, regulations and procedures are necessary. When viewed in a narrow sense these may seem restrictive; however, these regulations and procedures provide the necessary framework for all components of the program to operate efficiently. This manual explains the rules, regulations and policies of the University Eye Institute.
PATIENT BILL OF RIGHTS

In an institutional setting, it is easy to forget that the patient is an individual with personal needs and expectations. There is often a tendency to consider the patient as a subject or just another of a large number of persons processed through the clinic. Proper health care requires the development of a close doctor-patient relationship based on mutual respect and understanding. In order to reinforce this premise, the University Eye Institute has adopted the following Patient's Bill of Rights. Adherence to these concepts will help to ensure that we are providing competent and considerate care to all of our patients.

1. The patient has the right to the most appropriate optometric, ophthalmological and/or other health care for a particular problem, regardless of race, color, sex, age, religion, national origin, mental/physical handicap or ability to pay.

2. The patient has the right to expect that individuality will be respected and differences in educational and cultural background will be considered in his/her case.

3. The patient has the right to be treated with dignity and respect, to be addressed by his/her proper name and without undue familiarity, to be listened to and to receive an appropriate response.

4. The patient has the right to be treated in a warm, friendly and unhurried manner in an atmosphere of concern and frankness. The patient has the right to comfortable, clean and appealing surroundings while at the University Eye Institute.

5. The patient has the right to know the name of all providers and observers; the student clinician, intern, optometrist or physician rendering patient care.

6. The patient has the right to a full explanation regarding the diagnosis, treatment, prognosis, and treatment alternatives.

7. The patient has the right to information on financial assistance when they are unable to afford appropriate care.

8. The patient has the right to accurate and complete information regarding the extent, cost, and nature of services available to them.

9. The patient has the right to be advised if the University Eye Institute proposes to engage in or perform clinical trials as a component of their care or treatment. The patient has the right to refuse to participate in such research projects and to receive more traditional care.

10. The patient has the right to know when they are participating in research investigations and to give prior, full, valid and informed consent.
11. The patient has the right to privacy and the right to talk with all University Eye Institute personnel without being overheard.

12. The patient has the right to confidentiality of his/her records which will not be released to third parties without signed consent. Records will be made available to the patient upon written request.

13. The patient has the right to know the risks, benefits and obligations associated with the services provided to them.

14. The patient has the right to appropriate referral when indicated.

15. The patient has the right to seek another opinion if desired.

16. The patient has the right to refuse treatment.

17. The patient has the right to the continuity of his/her care.

18. The patient has the right to prompt attention in an emergency situation.

19. When a treatment plan includes optical corrections, the patient will be given the choice of having it filled at the University Eye Institute or elsewhere. The patient has the right to receive a copy of his/her spectacle prescription.

20. The patient has the right to receive an explanation of fees and charges regardless of the source of payment.

Patients should also understand their responsibility to:

1. Respect the rights of other patients and University Eye Institute personnel.
2. Give accurate and complete health information.
3. Make every attempt to carry out the specific plan of care.
4. Accept responsibility for outcomes if instructions are not followed.
5. Promptly meet financial obligations.

No catalog of rights can guarantee for the patient the kind of treatment he/she may justly expect. The University Eye Institute has many functions to perform, including the prevention and treatment of disease, the education of both health professionals and patients, and the conduct of clinical research. All of these activities must be delivered with an overarching concern for the patient, and above all, the recognition of his/her dignity as a human.
Grievance Policy for the University Eye Institute

POLICY

It is the policy of the University Eye Institute (UEI) to ensure that all complaints related to care or services provided, are dealt with as courteously, consistently, and as expeditiously as possible.

If the initial efforts of the Service Director or Department Manager fail to amicably settle complaints, it is the policy of the UEI to utilize this grievance procedure to make reasonable efforts to resolve patient related issues as quickly as possible.

A Patient Complaint is a verbal or written criticism regarding patient care received, which is addressed at the time of the visit by an attending or by a staff member. A complaint is considered resolved when the patient, or the patient’s representative, is satisfied with the actions taken.

A Patient Grievance is a verbal or written complaint by a patient, or patient representative, regarding patient care that is voiced or received after the visit. This concern is submitted to, or received by, a representative of the UEI and requires further action or resolution.

PURPOSE

The purpose of this policy is to provide a system whereby patients, or their representatives, may express concerns and recommend changes freely, without being subject to coercion, discrimination, or unreasonable interruption of care.

PROCEDURE

Notice of Right to File Grievance

A sign is posted in a prominent position in the UEI that notifies patients and their representatives of the UEI’s goal to provide the highest quality patient care possible. Should there be a concern that the patient feels has not been resolved, the patient may request a grievance form from the receptionist or contact the Coordinator of Clinics.
INITIAL RESPONSE TO THE COMPLAINANT

Nonsupervisory personnel who receive a Patient Complaint from a patient, or a patient's family member or representative, either written, by phone, or in person, will refer the complaint to the Associate Director of the UEI.

The Associate Director of the UEI will attempt to gather all salient facts of the encounter. The Associate Director will determine a mutually agreed-upon time to reconvene, either in person or by phone, to report the investigation's findings. This investigational time should not exceed seven (7) working days. All actions and conversations should be documented on the Complainant form.

NOTIFICATION OF INVESTIGATION RESULTS

Upon completion of the investigative process, the Executive Director of the UEI or the Dean of the College will contact the complainant with the results of the investigation. The notification should be in the form of disclosure of actions taken, findings, actions recommended, and any changes made in the practice processes. In instances where the complaint is against a specific employee, the results of actions taken will remain confidential. The complainant will learn only that appropriate steps were taken to remedy the complaint.

RESOLUTION

A patient's grievance is considered resolved when the patient, or patient's representative, is satisfied with the action taken.

There may be times where the UEI has made appropriate and reasonable endeavors to resolve the grievance and the patient or patient's representative remains dissatisfied. In these cases, the UEI will close the file for purposes of this policy.

In some cases, additional action might need to be initiated, such as notifying the University General Council or discharging the patient from the practice.
Patient Complaint Form

Date: ____________

Please describe any problem you experienced:

How can we help resolve it?

Name of Patient: ________________________________

Information Provided/Taken by: __________________________

Referred to: ________________________________

Resolved by: ________________________________

Patient Notified of Action: ________________________________

Date: ____________
GENERAL CLINIC POLICIES / PROCEDURES

Absences

There are few excused absences from assigned clinical rotations. In the event of an emergency, the student must notify the Service Coordinator and/or Service Director prior to the time clinic begins. All absences must be made up at a later time, generally during semester breaks. **Students who fail to make up absences from clinic (including vision screenings, dispensary and Grand Rounds) will receive a grade of I or incomplete.** Students who do not inform their Service Coordinator of a clinic absence, on or before the day the clinic is missed, may be charged with unprofessional conduct, and will be reported to the Associate Dean and Executive Director of the University Eye Institute (see UHCO Policy for Excused Absences from Clinic Assignments, pg. 13).

Students and attendings are expected to be present throughout their scheduled time. Students who need to leave for a short period of time should obtain the faculty's consent, inform the Service Coordinator verbally and sign out on the appropriate sheet in the office. Attendings who must leave for a time should inform the Service Coordinator of their whereabouts.

**Attire**

Students are expected to follow the dress code of the University Eye Institute (see document, pgs. 14-16). There are separate guidelines for patient care and non-patient care activities.

**Grading**

Required clinical activities are graded. Each attending faculty will complete an evaluation form after every patient encounter. A midterm and a final clinic evaluation will be completed by the faculty. For Optometry II students, the final clinic evaluation will determine whether or not the student advances into the third year rotations. For Optometry III students, the faculty will meet at the end of each semester to discuss clinical evaluations and to make decisions on advancement. These decisions will be based on the mid-term and final evaluations as well as a tabulation of the individual patient care performance sheets. A student may fail clinic if he/she does not satisfy the behavioral objectives of that clinic.

**Parking**

Students receive instruction on where to park and are expected to park in the appropriate designated areas. Students must display a current UH parking decal on their car. Students who park in the patient parking lot may be ticketed by UH Police and repeat offenders will be towed. Such disregard of parking regulations will be considered a breach of professional conduct.

**Clinic Hours**

Although hours may vary for specific clinics, in general, the operating hours of The University Eye Institute are 8:00 a.m. to 6:00 p.m. Monday through Friday. Every effort should be made to ensure that all exam services are completed and patients dismissed by 5:30 p.m. If a student is unable to complete the required services, the patient may be rescheduled unless there is an urgent or emergency situation. The attending faculty will determine how a particular patient will be managed.
Supervision

Since students are not licensed to practice optometry, it is imperative that all clinical services be provided under the direct supervision of an appropriate member of the faculty or staff. Such supervision includes those occasions when a student is examining a friend or relative. All appointments should be at regularly scheduled clinic times. All clinical records must be finalized. The dispensary will not accept an Rx that is not signed by an attending.

Student Messages

Important notices such as schedule changes, procedure changes, and special assignments will be distributed to students via UHCO mailboxes, personal email accounts, or class e-mail accounts. Students are expected to check these on a regular basis. The Service Coordinator and Coursemaster should be notified of any email address changes.

Use of Telephones

The telephones in the clinic are not for personal use. Calls to patients or other practitioners, especially long distance calls, may be made with permission of the Service Coordinator. All personal business is to be conducted via the telephones in the student lounge.

Use of Cellular Telephones

The use of cellular telephones in the midst of patient care is intrusive and discourteous. Students are expected to be courteous at all times and to follow these rules:
• cell phones brought into the college should be turned off or set to vibrate;
• patient care should not be interrupted to take an incoming call unless it is thought to be a true emergency.
If such a situation exists, the student’s attending faculty member should be notified in advance.

Food/Smoking

Food consumption is prohibited in rest rooms and all patient care areas of the clinic, including hallways and reception areas. Patients and visitors should be asked to observe these regulations. Food is allowed only in the vending machine area by the elevators and in the student lounge. Patients are limited to the vending machines on the first floor.

The University of Houston is a Smoke Free Environment (see Policy Number: 07.02.02 of the Manual of Administrative Policies and Procedures [MAPP]. Smoking is not permitted anywhere inside the University Eye Institute and the College of Optometry, and only within 25 feet of any entrance to every building on campus.

Personnel Issues

Anytime a student has a question or comment regarding clinic personnel, such matters should be brought to the attention of the Service Director, the Clinic Operations Coordinator, and/or the Executive Director of the University Eye Institute.

 Unscheduled Patient Services

Occasionally, requests are received from patients for copies of prescriptions, to have records transferred, to have driver's license forms completed or wanting their new Rx checked. Whenever possible, these requests will be channeled to the student or to the faculty who
conducted the last examination. If neither is available, a different student may be asked to provide this service. Your cooperation in these cases is appreciated.

A copy of a prescription should be dated with the date of the original examination and not the date that the duplicate copy is printed. Patients should be informed if the date of their request approximates or exceeds the date for recommended follow up. If the patient refuses re-examination, a form should be signed by the patient to signify that he/she is aware that the last prescription has expired.

**Student Responsibilities**

The primary responsibility of a student assigned to clinic is providing competent and considerate patient care. However, due to patient "no-shows", light patient loads, etc.; a student may occasionally be without a patient. During these times, the Service Director or attending may assign other tasks.

**Examination Room Protocols**

For security and continued performance of clinic equipment, students are to complete the following tasks. Before the examination:

1. Begin each examination by inspection of the room. The entire area should be clean and uncluttered. All instrumentation should be sanitized and in proper working order.

2. Ensure that personal instruments are charged and that all of the diagnostic equipment, tests, and or agents to complete the examination in a timely and efficient manner are readily available.

3. In accordance with the new HIPAA compliance regulations, all clinic doors should be slightly ajar during patient examinations. All conversations pertaining to the visit should be held inside the exam lane.

At the end of each clinic session:

1. Clean and cover all instruments with their appropriate dust covers. Report any missing dust covers to the Service Coordinator.

2. Place all trash in the waste containers and make certain that all necessary supplies for the following day are available in the examination room. Obtain any replacements for missing supplies from the Service Coordinator. All stools, chairs, instrument tables, etc. are to be clean and orderly.

3. Any equipment needing repair or maintenance should be reported. In each exam lane, there is an icon on the exam room computer desktop for clinicians to request repairs for all types of equipment. Once the request is submitted, an e-mail will automatically be sent to the equipment room staff & Service Coordinators. The Service Coordinators have the icon on their desktops so they can track the progress of the repair, or if needed, move the student to a different exam room.

4. All electric instrumentation should be turned off upon leaving. All power switches at the door should be in the off position.
5. Make CERTAIN that the examination room door is locked and closed completely after the PM clinic session.

6. If a student fails to adhere to the rules and regulations in this policy manual, it is the responsibility of the attending doctor and Service Coordinator to report violations by completing the Student Performance Insufficiency form. Copies should be distributed as noted and the original document provided to the student.

The Service Coordinator will inspect each examination room to ensure that each student is in compliance with the above policy.

Most equipment failures can be prevented by treating each piece of equipment as if it was one's own. Handle equipment carefully and never force movement when there is resistance. One of the most important aspects of preventive maintenance is the covering of equipment when not in use. The last student clinician to use equipment in a given day is required to cover it with dust covers. Missing dust covers should be reported using an equipment repair form as described above.

Instrument bulbs are frequently a problem. Before turning on the slit lamp, make sure the illumination control is on the lowest setting. This reduces the shock to the bulb filament and increases the life of the bulb. At the end of the day, turning off each instrument manually will increase bulb life overall.

Replacement bulbs for all clinic instrumentation are located in the Equipment Check Out Room, #1219. If a bulb is not available in this room, contact personnel in Room 1232.

Any problem with the building should be called to the attention of the Service Coordinator. Physical plant personnel can then be notified to arrange repair.

In the event the Instrument Service Department is not available and the problem is an emergency, contact the office of the Assistant Dean.
TO: All Clinical Faculty and Students  
FROM: Nicky R. Holdeman, O.D., M.D., Executive Director of UEI  
Ralph Herring, O.D., Third year Coursemaster  
Katrina Parker, O.D., Fourth year Coursemaster  
Amber Gaume Giannini, O.D., Second year Co-Coursemaster  
Julianne Knowles, O.D., Second year Co-Coursemaster  
SUBJECT: UHCO Policy for Excused/Unexcused Absences from Clinic Assignments

The clinic absentee policy was established in April, 1990, and modified in September, 2013

Clinic attendance
You have an obligation to attend all of your assigned clinics according to your group schedules. If circumstances require you to miss a clinic, there are very specific protocols which must be followed. A clinic absence may be considered excused or unexcused.

**Excused absences** are those due to illness and unforeseen events such as car trouble, traffic accidents or family illnesses/deaths. Excused absences will require a 1:1 make-up time. Make-up clinics are scheduled at the end of the semester. Depending on faculty availability, there may be make-up clinics scheduled during the October break for the Academy meeting. You cannot simply be added to a clinic on your unassigned half-day in order to make up an absence.

Regarding illness: If you are sick, you should not be exposing patients, the clinic staff, the clinic faculty, or your fellow classmates. Do not come to clinic sick and ask the coordinators to assign you a patient only if everyone else is busy. Your attendings have the authority to send you home if indeed you are too ill to provide patient care.

Only one type of excused absence does not require clinic time be made up. That excused absence is when you are representing UHCO in an *official capacity* as an officer, trustee or presenter at an optometric meeting or if you are the recipient of a *nationally competitive* travel grant/scholarship. There will be a maximum of three (3) representatives, and a maximum of three (3) clinic days per person. If you miss for a religious holiday, it is a 1:1 make-up time.

- Students should submit a copy of the conference schedule, along with their written forms for an excused absence, and bring documentation or certification supporting their attendance upon their return.
- Each representative must be in good academic standing and passing all of his or her clinical rotations.

For either one of these situations, you must inform the coursemaster *at least one month in advance* of the requested absence and you must complete an absence request form.

**Unexcused absences** are basically everything else, assuming you receive permission to miss your assigned rotation. These include family reunions, weddings, graduations, family trips, etc. Unexcused absences will require a 2:1 make-up time. You also must give *at least one month advance notice* and you must complete an absence request form.

**Clinic Trades:** If you are approved for a clinic trade, it must be a trade for the same clinic (i.e. trading CL clinic days with a classmate and not your taking their CL clinic and they take your Pediatrics clinic.) You will be limited in the number of times allowed to trade clinics. The rule is all clinic trades must be requested in advance and the clinic absence form must be COMPLETED with all required signatures AT LEAST THREE WEEKS in advance. In the Fall and spring semesters when you have a full week of clinics, classes, and labs, the opportunities for any clinic trades is very limited.
UEI STUDENT DRESS CODE

General Concepts

A. Clinic Jackets

1. Clinic jackets will be of an approved style for men and women
2. Clinic jackets will be cleaned and pressed
3. The UEI emblem should be securely sewn over the left breast pocket
4. Each student should have their name monogrammed in consistent red block font (as selected by administration), just above the left breast pocket
5. Only UEI, UH, BSK, or state or national optometric logos (TOA, AOA) should be attached to the jacket, not to exceed 3 pins total
6. Clinic jackets will be worn at all times unless faculty direct otherwise

B. Hygiene

1. All standard hygiene rules apply
   a. No offensive breath or body odors
   b. Minimal use of cologne or perfumes
2. Nails should be clean, short, and well kept (this includes feet for women wearing peep-toe shoes)
3. Hair should be clean and neatly styled
4. Facial hair should be well kept or if no facial hair, should be clean shaven

C. Piercing

1. Only ear piercing is allowed for women
2. Ear pierces should not be above the ear lobe
3. Men are NOT to wear earrings in clinic

D. Tattoos

1. Tattoos MUST be covered at all times

WOMEN

When in clinic, but not seeing patients; women should wear either clinic attire or:

- Khaki or dress slacks
- Button down shirt, polo-like shirt, or sweater
- Casual or dress shoes
- No shorts, jeans, sweatshirts, caps, athletic shoes, or open-toe sandals allowed

When in clinic seeing patients:

Shoes:

- Must be in good repair
- Shoes may be close-toed dress shoes, peep-toe dress shoes, or Closed-toe sandals (as long as they have a strap around the ankle)
- NO open-toe sandals, NO flip-flops, NO shoes with all toes exposed, NO athletic style shoes
Skirts or dresses:
- Skirts or dresses should be no more than an inch above the knee
- Skirts or dresses that are above the knee should not be slit on the side
- Skirts or dresses that are below the knee should not have slits that go above the knee

Shirts:
- Can be long or short sleeved
- Halter-tops, or shirts with spaghetti straps ARE NOT TO BE WORN
- Women must wear a bra
- Shirts must have a modest neckline (i.e., a patient should not be able to see down the front of the top)
- Sleeveless shirts are acceptable, as long as they are non-revealing
- Exposed midriffs are NOT allowed

Pants:
- Pants can be dress slacks or khakis
- Capri pants must be at least MID-Calf in length and NO SHORTER
- NO shorts allowed

Hose:
- Legs must be covered if your skirt is above the knee (i.e., hose are required)
- Leggings and tight pants are NOT allowed
- Hose are not required for pants or for skirts or dresses that are closer to the ankles than to the knees

MEN

When in clinic but not seeing patients; men should wear either clinic attire or:
- Khaki or dress slacks
- Button down shirt, polo-like shirt, or sweater
- Casual or dress shoes
- No shorts, jeans, sweatshirts, caps, athletic shoes, or sandals allowed

When in clinic seeing patients:
- Dress shirt (with long or short sleeves) and a tie
- Dressy sweater may be worn over shirt and tie
- Dress khaki or dress slacks
- Shoes must be dress shoes, in good repair, and polished if applicable

STUDENT PERFORMANCE INSUFFICIENCY

(Receipt of three Student Performance Insufficiency forms constitutes one half day of make-up during the break. Additional violations will be considered a breach of professional conduct and is potential grounds for suspension.)

Date: __________________________
Student: __________________________ Attending Doctor: __________________________
Patient: __________________________ Patient File #: __________________________

INSUFFICIENCIES:

_____ Late Arrival/Early Leave
_____ Making copies of patient information/examination
_____ Leaving the Service area without proper notification
_____ Incomplete patient EMR:
    _____ Fee statement not filled out properly (i.e., faculty/student name, diagnosis, etc.)
_____ Inappropriate Clinic Attire (i.e., not wearing a tie, wearing athletic shoes, skirts that are too short, wearing leggings, not wearing your clinic white coat)
_____ Not covering equipment, cleaning exam room – room # _____
_____ Leaving caps off drugs/drops – room# _____
_____ Not complying with HIPAA regulations (i.e., removing patient information from printers/scanners, closing the door partially during exam process, etc.)

Comments: __________________________________________

__________________________________________________________________________

Other contact lens related duties:

_____ No contact lens Rx data sheet
_____ Improperly completed contact lens order form:
    _____ Incomplete Rx data on order form (i.e., lab, material, perimeters, etc.)
_____ Improperly completed contact lens return form
_____ Assigned modification room clean up

Comments: __________________________________________

__________________________________________________________________________

cc: Attending Doctor
    Service Director
    Executive Clinic Director
    Executive Clinic Director
    Clinic Operations Coordinator
APPOINTMENTS

General Information
Appointments for general comprehensive examinations are scheduled through the Family Practice Service. Progress visits and appointments in the Specialty Clinics may be scheduled through the individual Service Coordinators. Specific appointment schedules and the length of time allotted for each examination varies depending on the level of students involved (i.e.: OPT II, OPT III, or OPT IV) and on the type of examination required.

Attendance
Students are required to report to clinic in time to receive and review the patient's records, prepare their examination rooms, and to acquire and organize the necessary equipment prior to the patient's scheduled appointment. The specific arrival times vary from Service to Service. Some Services require that student clinicians arrive 15 minutes prior to the appointment time; while others require 60 minutes preparation time. This information is available in the individual Services.

If students anticipate that they will be late in arriving for clinic, they should telephone their Service Coordinator immediately to advise them of the expected delay. This call will allow the coordinator to manage the schedule more effectively.

If illness or an emergency prevents a student from attending clinic, that student or a representative of that student must notify the appropriate Service Director or Service Coordinator as soon as possible. This notification will insure that arrangements are made for the patient to be seen by another clinician in a timely manner.

Planned absences from clinic must be arranged 2 - 3 weeks in advance with the appropriate Service Director and are subject to the Service Director's approval. Excused and unexcused absences must be made up at a time and date determined by the Coordinator of the Optometry Clinics.

Unexcused absences and/or failure to notify the clinic of an absence in a timely manner may be considered unprofessional conduct, and, at the discretion of the Director, may be referred to the College Academic Committee, the Executive Director of the UEI, and/or the Associate Dean for Professional Studies for review.

If a student falls behind schedule and anticipates a delay in beginning the next patient's examination, that student must notify the attending and the Service Coordinator of the anticipated delay. In all cases where patients are waiting to be examined, the attending must approve the continuation of the exam. The Service Coordinator will automatically approve all emergency or urgent cases or identify another Service to evaluate the patient.

All non-emergency or non-urgent examinations that cannot be completed within fifteen minutes of the next patient's examination time should be rescheduled for a follow-up appointment or referred to another clinic. Rescheduling the patient in a regular examination slot should be reserved only for difficult cases which cannot be completed within a follow-up visit.

The Service Coordinator or attending should inform waiting patients of the expected beginning time of their examination and the reason for any delay. When necessary, these patients should be transferred to another attending or Service; however, this action should be taken only for delays caused by emergency or urgent cases in progress.
Rescheduling

When scheduling a patient for a return visit that is to occur within a short period of time (within 6 weeks or within that same semester), the student clinician should schedule the patient through the Service Coordinator. If possible, the patient should be scheduled with the original student and attending. The student must give the patient an appointment card indicating the examining student, attending, and the next appointment date and time. If the appointment is to be scheduled for the following semester, the student must inform the Service Coordinator and schedule the patient at the appropriate time.

"No Shows" and Late Arrivals

A "no show" is a patient who does not present on the day of his/her appointment. If a patient is late for an appointment, each situation must be handled individually. Every effort should be made to provide the services needed either in part or in full. If another appointment is necessary to complete the examination, that appointment should be scheduled in the same Service with the same clinician and attending.

"No shows" and cancellations do not relieve an attending or a student clinician from their clinic duties. Students and attendings should inform both the Service Coordinator and the Service Director of their availability for other duties and remain available until the clinic session is over. Other related activities may be assigned by either the attending or the Service Director (i.e.; practicing procedures, seminars, etc.).

Unsupervised Patient Encounters

All patient examinations must be supervised by a member of the Clinical Faculty. Examining patients without faculty supervision and approval is considered unprofessional conduct and will be referred to the College Academic Committee, the Executive Director of the UEI and/or to the Associate Dean of Professional Studies for review.
FEES

General Information

A fee bill created in the MedTrak Practice Management Software will be issued to each patient on every clinical visit. Payment is expected on the day services are rendered.

Services, procedures and/or materials should be identified and coded appropriately within the patient’s Electronic Medical Record (EMR). Completed records must be approved by the faculty and verified by the Service Coordinator. Patients should then be escorted by the student clinician to the cashier for payment. Students should never cut in line or go straight to a cashier if there are people waiting in line. OD/Med patients must have a routing slip accompany them to the cashier to properly identify the patient’s record. For those patients having no fee payment, the charges must still be coded in the patient’s EMR along with the reason charges are being waived. All fee waivers other than prescription re-checks or contact lens adoptions must be approved by the Clinic Service Director or the Executive Director of the UEI.

Credit

It is not the policy of the University Eye Institute to issue or arrange credit to patients. Indigent patients should be interviewed by the designated AlteraMed Business Office staff prior to the patient’s appointment. The Clinic Service Director may make individual arrangements with patients as the need arises.

Charging of Fees

It is the responsibility of the student clinician, staff, attending faculty, opticians and Service Directors to see that UEI professional fees are properly assessed when services or materials are provided. Fee adjustments can be made by authorized individuals only.

PROTOCOLS for USE of the PATIENT ROUTING SLIP
(In OD/Med Only)

As patients present the fee bill in the OD/Med clinic, the OD/Med staff will attach a routing slip to the fee bill and give it to the appropriate doctor/clinician.

When checking out, the fee bill will be reconciled with the charges in Office Mate and the patient will be escorted to the cashier. The OD/Med doctor will instruct the clinician on how to handle the routing slip. When the clinician is ready for the doctor to finalize the chart, they place the routing slip in the doctor’s mail slot along with any testing and make a recall card if needed. When the doctors have finalized the record, they turn the routing slip in to the OD/Med complete box. The staff verifies that the chart has been completed properly and ancillary testing scanned or linked in the EMR. The staff will mail/fax correspondence as needed.

Walk-In Patients
The Receptionist/Cashier will send the patient to the Family Practice Service for a routine eye exam, and if necessary, will request the patient to sign a Financial Policy/Assignment of Benefits form.
Patient Care Services

When the fee bill is received by the Service Coordinator, the student clinician should ensure that the Doctor's and Clinician's name along with the patient ID number is completed before the patient is examined. After the examination, the attending faculty should see that all procedures and diagnosis codes are correct and that any Rx has been entered in the OME ExamWriter before signing. Since the student clinician and attending faculty have the responsibility to see that all patient charges have been entered into the OME ExamWriter before the patient leaves the clinic, the following check list may be of value.

- All professional services and materials must be entered.
- All diagnostic codes must be entered.
- The attending faculty's provider number must be entered. The attending faculty must sign the form.

Material Fees

Optical and/or contact lens materials must be entered into OfficeMate in the appropriate area. Contact lens charges post to fee bill when the student clinician creates a lab order in the EMR. The student clinician must also submit a written order form to the Cornea & Contact Lens staff. All charges are verified in OfficeMate by clinic staff prior to the student clinician escorting the patient to the cashier.

Medicare/Medicaid

If the patient simply wanted an eye examination or new glasses and pathology is discovered, Medicare will not pay. Medicare will pay for medically necessary visits only. If an eligible patient expresses that the reason for the eye exam was eye pain, sudden blurred vision, to see if they had cataracts, was a diabetic patient, etc., (pathology symptoms) then all diagnostic procedures, except refraction, are covered by Medicare.

The AlteraMed Business Office will process all Medicare/Medicaid claims according to the information entered into MedTrak. To protect yourself and the College from liability, be sure all charges have been entered correctly into OfficeMate/ExamWriter.
Determine the extent of \textit{HISTORY} obtained:
The levels of E/M services recognize four types of history that are defined as follows:
- \textit{Problem Focused} -- chief complaint; brief history of present illness or problem.
- \textit{Expanded Problem Focused} -- chief complaint; brief history of present illness; problem pertinent system review.
- \textit{Detailed} -- chief complaint; extended history of present illness; extended system review; \textit{pertinent} past, family and/or social history.
- \textit{Comprehensive} -- chief complaint; extended history of present illness; complete system review; \textit{complete} past, family, and social history.

Determine the extent of \textit{EXAMINATION} performed:
The levels of E/M services recognize four types of examination that are defined as follows:
- \textit{Problem Focused} -- an examination that is limited to the affected body area or organ system.
- \textit{Expanded Problem Focused} -- an examination of the affected body area or organ system and other symptomatic or related organ systems.
- \textit{Detailed} -- an extended examination of the affected body area(s) and other symptomatic or related organ system(s).
- \textit{Comprehensive} -- a complete single system specialty examination or a complete multi-system examination.

Determine the \textit{Nature of the Presenting Problem}:
A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. There are five levels of presenting problems:
- \textit{Minimal} - a problem that may not require the presence of a physician, but service is provided under the physician's supervision.
- \textit{Self-Limited or Minor} - the problem runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status or has a good prognosis with management and compliance.
- \textit{Low Severity} - risk of morbidity without treatment is low; little to no risk of mortality without treatment; full recovery without functional impairment is expected.
- \textit{Moderate Severity} - risk of morbidity and mortality without treatment is moderate; uncertain prognosis or increased probability of prolonged functional impairment.
- \textit{High Severity} - risk of morbidity without treatment is high to extreme; moderate to high risk of mortality without treatment or high probability of severe prolonged functional impairment.

Also, remember that special ophthalmological services such as refraction (92015) and procedure codes 92020 through 92499 are now billed bilaterally. \textit{If only one eye is performed, a 52 modifier must be inserted after the code and the patient billed only 60\% of the regular fee.}

Determine the complexity of \textit{MEDICAL DECISION MAKING}:
Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option. Four types of medical decision making are recognized: \textit{straightforward, low complexity, moderate complexity}, and \textit{high complexity}. To qualify for a given type of decision making, two of the three elements in the following table must be met or exceeded.

<table>
<thead>
<tr>
<th>Number of diagnoses or management options</th>
<th>Amount and/or complexity of data to be reviewed</th>
<th>Risk of complications and/or morbidity or mortality</th>
<th>Type of decision making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
<td>\textit{Straightforward}</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td>\textit{Low Complexity}</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td>\textit{Moderate Complexity}</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td>\textit{High Complexity}</td>
</tr>
</tbody>
</table>
LEVELS OF SERVICE

New Patient

A new patient is one who has not received any medical services from the physician within the past three years. Each code requires that the specified level of all three of the key components history, exam, and decision-making must be met. Remember that the time expended is only a guideline unless counseling and/or coordination of care dominates more than 50% of the face-to-face time, then it becomes the controlling factor for selection of E/M services.

99202 - requires an expanded problem focused history and exam and straightforward medical decision-making. Usually the presenting problems are of low to moderate severity. Doctors typically spend 20 minutes face-to-face with the patient and/or family.

99203 - requires a detailed history and exam, and medical decision-making of low complexity. Usually the presenting problems are of moderate severity. Doctors typically spend 30 minutes face-to-face with the patient and/or family.

99204 - requires a comprehensive history and exam and medical decision-making of moderate complexity. Usually the presenting problems are of moderate to high severity. Doctors typically spend 45 minutes face-to-face with the patient and/or family.

99205 - requires a comprehensive history and exam and medical decision-making of high complexity. Usually the presenting problems are of moderate to high severity. Doctors typically spend 60 minutes face-to-face with a patient and/or family.

Established Patient

A patient who has received medical services from the doctor within the past three years. A major difference for an established patient is that they require at least two of the three key components of history, exam, and decision-making.

99212 - requires at least two of these three key components: problem-focused history, problem-focused exam, and straightforward medical decision-making. Usually the presenting problems are self-limited or minor. Doctors typically spend 10 minutes face-to-face with a patient and/or family.

99213 - requires at least two of these three key components: expanded problem-focused history, expanded problem-focused exam, and decision-making of low complexity. Usually the presenting problems are of low to moderate severity. Doctors typically spend 15 minutes face-to-face with the patient and/or family.

99214 - requires at least two of the three components: detailed history, detailed exam, and decision-making of moderate complexity. Usually the presenting problems are of moderate to high severity. Doctors typically spend 25 minutes face-to-face with a patient and/or family.

99215 - requires at least two of the three components: comprehensive history, comprehensive exam, and medical decision-making of high complexity. Usually the presenting problems are of moderate to high severity. Doctors typically spend 40 minutes face-to-face with a patient and/or family.
FEE ADJUSTMENTS

EYE CARE ADJUSTMENT PROGRAM (ECAP)

The University Eye Institute is committed to provide optimal vision services whenever possible regardless of the ability to pay. Patients who cannot afford the fee for examination services or spectacles should be referred to the Clinic Business Office before the exam for information on our ECAP program.

Patients are screened for a fee adjustment on the basis of income and family dependents. The scale used is the Poverty Income Guidelines as set by the Department of Health and Human Services and is similar to the scale employed by the Harris County Hospital District.

Patients are asked to provide information on income and verification is required. Patients may speak to the designated staff in the AlteraMed Business Office prior to an appointment. The patient will be advised regarding the specific information requested for fee adjustments. Unless specifically noted, ECAP qualifies the patient for reduced fees for one year, after which the patient will need to requalify. Patients can be referred to the AlteraMed Business Office for a fee adjustment screening prior to the day of their appointment. Designated employees in the AlteraMed Business Office have the authority to verify the patient’s income and complete the fee adjustment forms. If there are specific questions that need to be addressed you may request to speak to the UEI AlteraMed Business Office Manager.

There are established prescription guidelines for spectacle lenses available through the ECAP program. For powers outside these limits, all efforts will be made to provide lenses at a reduced cost. Should the patient choose to add extras, that cost will be paid by the patient.

Patients, who are prescribed contact lenses because their vision cannot be corrected with a spectacle Rx and they cannot afford contact lenses, should be referred to the Director of the Cornea and Contact Lens Service before the lenses are fitted. Individual arrangements may be made for reduction of professional service fees. However, payment must be received for all materials at the usual and customary rate unless otherwise approved.

Educational Purposes

Service Directors may make individual arrangements with a patient who qualifies for a reduction in fees for educational purposes. Only the Executive Director of the UEI and/or Service Directors has the authority to approve the educational fee adjustments.

Other Resources

The following resources are available for patients 13 years and under who have completed the ECAP application form and meet the Poverty Income Guidelines. For example:

1. Doric Shrine: We have a limited amount of funds donated from this organization to pay for glasses and frames of children who meet the guidelines.

Details are available in the UEI AlteraMed Business office.
No Charge - No Payment Due

All patients seen without incurring additional charges should be managed in the same manner as paying patients when they exit the clinic. The clinician should first escort the patient to the clinic office to have the staff review the fee bill. Then patients should be escorted to the reception area by the student clinician and thanked for coming. The cashier should promptly review for accuracy then process according to the AlteraMed Business Office policy.

Gratis/Professional Courtesy

Professional courtesy may only be approved through the Dean, Executive Director of the UEI or Service Directors. This may be in the form of total or partial fee waiving. The University Eye Institute extends professional courtesy to its faculty, staff, students, and members of their immediate family, if third party payment is not available or does not apply.

Immediate family is defined as spouse, children, parents, and siblings. Professional courtesy will be extended for services only. In no instance will material costs be waived.

Research Subjects

Occasionally, research subjects will be compensated for participation in approved projects. Investigators must acquire and fill out proper fee waiver forms and present them to the appointment clerk or Service Coordinator when making the subject's appointment.

Sponsored Program Fees

Occasionally, organizations will sponsor screenings and/or vision examinations for specific patient groups. Fee arrangements will be made in advance and will not follow normal billing procedures.
PROFESSIONAL COURTESY FOR SERVICES AND MATERIALS
January, 2013

The following is the policy for courtesy fee reductions provided to UHCO/UH Faculty, Staff, Current Students, UHCO Retirees and their Spouses and UH Retirees by the University Eye Institute.

In all cases, if the patient has insurance, it will be billed but the patient may be eligible for a fee waiver or a refund to cover the expense.

In all cases, the patient will be responsible for any deductibles that might apply.
<table>
<thead>
<tr>
<th>Courtesy Group</th>
<th>Professional Fee Reduction</th>
<th>Materials Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>CURRENT: UHCO Benefits Eligible Faculty UHCO Benefits Eligible Staff UHCO Students AlteraMed Staff ASC Staff UnitedHealthcare Healthselect: referral required for medical.</td>
<td><strong>Well Vision Exam</strong> (367.XX only) University insurance, UnitedHealthcare HealthSelect Issue a co-pay waiver Non University Insurance: Collect co-pay, refund thru the FERV office <strong>Medical Exams/ Procedures:</strong> Referral (if necessary), Collect co-pay. Refund may be requested thru the FERV office <strong>Non-covered services:</strong> 100% reduction. <strong>Contact lens fitting (if not covered by insurance):</strong> 100% reduction</td>
<td>Optical materials for personal use only: Invoice cost + dispensing fee (Includes plano sunwear) (for AlteraMed Staff: this is in lieu of utilizing Eyemed) Contact lens materials for personal use only: Complimentary lens program + dispensing fee.</td>
</tr>
<tr>
<td>UHCO Retirees + Spouse Only Typically will have Medicare and UnitedHealthcare Healthselect, but may also have additional coverage (ie: AARP or other secondary policy)</td>
<td><strong>Well Vision Exam</strong> (367.XX only) Collect co-pay/ co-insurance. Bill secondary if applicable Refund thru the FERV office. <strong>Medical Exams/ or Procedures:</strong> may need referral Collect co-pay/ co-insurance if applicable. Refund may be requested thru the FERV office. <strong>If:</strong> UEI does not participate in plan/ Patient needs a non-covered procedure/Un-insured: 100% reduction <strong>Contact lens fitting (if non covered, Except Ortho-K):</strong> 100% reduction</td>
<td>Optical materials for personal use only: Invoice cost + dispensing fee (Includes plano sunwear) <strong>Limit to 2-pairs/ year. 30% reduction on additional pairs</strong> Contact Lens Materials for personal use only: 10% reduction Provided the patient obtained RX or CL RX thru exam at the UEI.</td>
</tr>
<tr>
<td>Courtesy Group</td>
<td>Professional Fee Reduction</td>
<td>Materials Reduction</td>
</tr>
<tr>
<td>----------------</td>
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<td>---------------------</td>
</tr>
</tbody>
</table>
| **IMMEDIATE Family of Current Benefits Eligible UHCO Faculty/Staff/ Students**  
  **spouse, children, step-children, parents, step-parents, siblings only**  
  **Well Vision Exams for dependent children covered by University Insurance (UnitedHealthCare)**  
  **The patient is responsible for any un-met deductible**  | **Well Vision Exam (367.XX only)**  
  Collect co-pay/ co-insurance.  
  Bill secondary if applicable  
  Refund thru the FERV office.  
  **Medical exam/ Procedures:**  
  May need referral  
  Collect co-pay/ co-insurance if applicable.  
  Refund may be requested thru the FERV office.  
  **If UEI does not participate in plan/ Patient needs a non-covered procedure/Un-insured:**  
  100% reduction  
  (Except NOVA/Development)  
  **Contact lens fitting if not covered:**  
  100%  | **Optical materials for personal use only:**  
  Invoice cost + dispensing fee  
  (includes plano sunwear)  
  **Limit to 2-pairs/ year.  30% reduction on additional pairs**  
  **Contact Lens Materials for personal use only:**  
  Invoice cost + dispensing fee  
  Provided the patient obtained RX or CL RX thru exam at the UEI. |
| **EXTENDED Family of Current Benefits Eligible UHCO Faculty/Staff and Students**  
  **grandparents, grandchildren, aunts, uncles, nieces, nephews, cousins and in-laws only**  
  **The patient is responsible for any un-met deductible**  | **Well Vision Exam (367.XX only)**  
  Collect co-pay/ co-insurance.  
  Bill secondary if applicable  
  **Medical exam/ Procedures:**  
  May need referral  
  Collect co-pay/ co-insurance if applicable.  
  **If UEI does not participate in plan/ Patient needs a non-covered procedure/Un-insured:**  
  50% reduction  
  (Except NOVA/Development)  
  **Contact lens fitting (if not covered, Except Ortho-K):**  
  50% reduction  | **Optical materials for personal use only:**  
  30% reduction  
  (Includes plano sunwear)  
  **Contact Lens Materials for personal use only:**  
  15% reduction  
  Provided the patient obtained RX or CL RX thru exam at the UEI. |
<table>
<thead>
<tr>
<th><strong>Courtesy Group</strong></th>
<th><strong>Professional Fee Reduction</strong></th>
<th><strong>Materials Reduction</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Optometry 2 “Required” Patients (those they solicit and bring in for an exam in Opt 2)</td>
<td>Comprehensive Exam: 100% reduction on exam given during Opt 2 clinic only.</td>
<td>Optical Materials for personal use only: 30% reduction provided patient obtained RX thru Opt 2 exam at UEI</td>
</tr>
<tr>
<td>The students may bring as many patients as they wish <strong>BUT</strong> are only counted as “required” if they are seen by an OPT 2 Student.</td>
<td>If additional exams or procedures required, patient will need to pay or use insurance.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Optometry 2 “Required” Patients</strong> (those they solicit and bring in for an exam in Opt 2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The students may bring as many patients as they wish <strong>BUT</strong> are only counted as “required” if they are seen by an OPT 2 Student.</td>
<td><strong>Well Vision Exam (367.XX only)</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Collect co-pay</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Medical Exams/ Procedures:</strong> Get referral (if necessary), Collect co-pay.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>If:</strong> UEI does not participate in plan/ Patient needs a non-covered procedure/Un-insured:</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Issue Student Voucher:</strong> Well Vision Exam: $32 Medical/ Emergency visit: $35/ visit 25% reduction on additional services and procedures (Except NOVA/ Development)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Contact lens fitting</strong> (if not covered, Except Ortho-K): 25% reduction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Optical materials for personal use only: 30% reduction (Includes plano sunwear)</td>
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<td><strong>Contact Lens Materials for personal use only:</strong> 15% reduction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provided the patient obtained RX or CL RX thru exam at the UEI.</td>
</tr>
<tr>
<td></td>
<td><strong>Full Time University and College Students from ANY TEXAS SCHOOL with a valid student ID</strong></td>
<td><strong>Patient is responsible for any un-met deductible</strong></td>
</tr>
<tr>
<td></td>
<td><strong>No courtesy for family members</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Patient is responsible for any un-met deductible</strong></td>
<td></td>
</tr>
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<td>Courtesy Group</td>
<td>Professional Fee Reduction</td>
<td>Materials Reduction</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>UH Benefits Eligible Faculty</td>
<td>Well Vision Exam (367.XX only) University insurance, UnitedHealthcare HealthSelect: Issue a co-pay waiver</td>
<td>Optical materials for personal use only: 30% reduction (Includes plano sunwear)</td>
</tr>
<tr>
<td>UH Benefits Eligible Staff</td>
<td>Non University Insurance: Collect co-pay, NO waiver</td>
<td>Contact Lens Materials for personal use only: 15% reduction</td>
</tr>
<tr>
<td><strong>No courtesy for family members</strong></td>
<td>Medical Exams/ Procedures: Get referral (if necessary), Collect co-pay.</td>
<td>Provided the patient obtained RX or CL RX thru exam at the UEI.</td>
</tr>
<tr>
<td><strong>Medical exams for patients covered thru University Insurance (UnitedHealthcare HealthSelect)</strong></td>
<td>If: UEI does not participate in plan/ Patient needs a non-covered procedure/Un-insured: 25% reduction (Except NOVA/ Development)</td>
<td></td>
</tr>
<tr>
<td><strong>Need referral for medical</strong></td>
<td>Contact lens fitting (if not covered, Except Ortho-K): 25% reduction</td>
<td></td>
</tr>
<tr>
<td><strong>The patient is responsible for any un-met deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UH Retirees</td>
<td>No special reductions apply to services or procedures</td>
<td>Optical materials for personal use only: 30% reduction (Includes plano sunwear)</td>
</tr>
<tr>
<td><strong>No courtesy for family members</strong></td>
<td></td>
<td>Contact Lens Materials for personal use only: 10% reduction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provided the patient obtained RX or CL RX thru exam at the UEI.</td>
</tr>
</tbody>
</table>
UNIVERSITY EYE INSTITUTE
FEE ADJUSTMENT FORM
REQUEST FOR UHCO IMMEDIATE FAMILY / RELATIVE
FEE REDUCTION

Patient Name: ____________________________________________

Patient Account #: _______________________________________

Related To: _______________________________________________

Relation to Patient: _________________________________________

Immediate Family: _________________________________________
(Spouse, children, parents, siblings, step-children, and step parents)

Relative: _________________________________________________
(In-laws, nieces, nephews, aunts, uncles, grandchildren, grandparents)

Professional Courtesy for Services and Materials for UHCO Current Students, Employees, Retirees and Immediate Family and Relatives

A professional courtesy for services and materials is available for current UHCO students, benefits eligible UHCO employees, UHCO retirees and immediate family members (i.e. spouse, children, parents, siblings, step-children and step-parents) after all insurance benefits, if applicable, have been applied. UHCO will reimburse this group of individuals for their co-pay and file a third party claim for the remainder of the charges. Co-pays will be paid at the time of service by the patient. Receipts for the co-pay amounts can be submitted to the FERV office for reimbursement.

Relatives of UHCO faculty, staff, UHCO retirees, and current students who are not immediate family members, (i.e., in-laws, nieces, nephews, aunts, uncles, cousins, grandparents, and grandchildren) are eligible for a 50% courtesy reduction on fees for professional services if no insurance is available.

Services not paid by insurance or not covered by insurance will be waived for immediate family members only. Fee waivers do not apply to individuals who are not immediate family members. Non immediate family members will receive a 50% reduction on services not covered by insurance.

Current UHCO students, UHCO employees, UHCO retirees and immediate family (i.e. spouse, children, parents, siblings, step-children and step-parents) are eligible to purchase spectacles and contact lenses for personal use at the College invoice cost plus a dispensing fee, with 50% down when the order is placed and paid in full at the time of dispensing. Non immediate family members will receive a 20% reduction on spectacles and contact lenses.

The University Optical Service requests that UHCO students assist family members with frame selection and to make selections during non-peak times in order not to detract from other UEI patients.

Fee reductions only apply if no insurance is available.

Acknowledgement:

I acknowledge that I have read the University Eye Institute’s Professional Courtesy for Services and Materials Policy for UHCO Immediate Family and Relatives. I understand that violations, including misrepresenting relations, will result in disciplinary action up to and including termination. I understand that I maybe requested to provide proof of relationship (i.e. birth certificate, marriage certificate, etc.). Failure to provide proof of relation when requested will result in the denial of any waiver or reduction of fees.

__________________________________________  _______________________
UHCO Faculty/Staff/Student Signature       Date

__________________________________________
UHCO Faculty/Staff/Student Name (printed)
EQUIPMENT ROOM PROTOCOLS

Equipment checked out to a student for clinic use remains the responsibility of the student until it is returned and inspected by both the student and equipment room clerk.

Equipment checked out to a faculty member remains the responsibility of the faculty member until it is returned and inspected by both the faculty member and equipment clerk.

Equipment that leaves the equipment room should be inspected by the person who is checking the equipment out to make sure that it is intact. If equipment is not intact, it should be brought to the equipment room clerk's attention at the time of check-out.

Students will be charged the full cost for replacement of lost equipment.

Equipment for screenings will be released only with written permission from the Associate Dean of Professional Studies or the External Program's office.

Equipment for labs will be checked out to faculty members only. The faculty member will be responsible for the equipment and the equipment must be returned to the equipment room on the next working day unless other arrangements have been made with the Equipment Clerk.

Equipment Maintenance and Repair

When equipment malfunctions, and an emergency repair is needed, the request can be made by clicking the equipment repair icon on the exam room computer desktop. Once the request is submitted, an e-mail will automatically be sent to the equipment room staff & the Service Coordinators. The Instrument Service Department will schedule the repair as soon as possible.

<table>
<thead>
<tr>
<th>Clinic Equipment Repair Form</th>
</tr>
</thead>
</table>
| **Send Request To**
| Instrument * |
| Clinic * |
| Room/Location * |
| **Description of the Repair needed** * |
| **Urgency** * |
| **Requester's E-mail** * |
| Submit |
Required Clinical Equipment

The student clinician is responsible for obtaining and maintaining their clinical equipment. It is expected that the clinician will have the following equipment available for patient care encounters:

First Year (Fall & Spring Semesters)

BIO
Clinic Kit
1 Maddox Rod Occluder
1 Pin Hole Occluder
1 Polaroid Analyzer
1 tape measure
1 M Card/Amsler
1 Near point card
1 Penlight
1 Eye patch
1 Name Tag
1 Parrot Stick
1 PD stick
Reichert Adult Slide (#11180)
Ishihara Color Plates
Optical Tool Kit
Sphygmomanometer
Trial Lens Kit [Must include stenopaic slit]
Trial Frame
Loose Prisms
Welch Allen Diagnostic Kit
Welch Allen Rechargeable handle
Welch Allen Transilluminator
Trial Lens Well Holder (8 Well)
0.50 x-Cyl flipper

Fall Second Year

Contact Lens Loupe 7X
Suction Cups (2)
Contact Lens Plastic Tweezers
Lighthouse Cards
TVAS Cards
Randot Stereo Test
IOP Kit
1 Lacrimal Probe
1 Golf Club shaped Foreign Body Spud
1 Kimura Type Platinum tip Spatula
1 Desmarres Type Lid Retractor (11mm)
1 Jewelers Forceps
1 Cilia Forceps  
1 Irrigating Cannula  
1 Scleral Depressor  
1 Adult Barraquer Type wire Speculum  
1 Metal Eye Shield  
Alger Brush  
Goldmann Type 3-Mirror Lens  
Volk +78D (clear only)  
Wesson Fixation Disparity Card

**Supplemental Useful Equipment (Optional)**

Reichert Vectograph Slide (#11423)  
Amsler Grid with Keeler Manual  
Posner and/or Sussman Gonio Lens  
Random dot E  
Lang Pediatric Stereo Test  
Worth 4 Dot  
Frisby Stereo Test  
HOTV - UNCROWDED  
Wratten Filters w/ Color Vision Test
PRIMARY CARE SERVICES

Infection Control Recommendations

The following guidelines are approved by the Clinic Faculty Executive Committee for the prevention of infectious diseases within the University Eye Institute. These guidelines are effective against all infectious agents likely to be encountered in the optometric practice, regardless of virility. While much concern has been raised about the virus that causes Acquired Immunodeficiency Syndrome (AIDS), the viral agents of epidemic keratoconjunctivitis, though not life threatening, are much more contagious. Therefore, proper controls for the latter will be adequate for the former. The known presence of an infectious agent always encourages precaution. It is the unknown presence of an infectious agent that brings the greatest risk; therefore, the recommended guidelines should be followed at all times.

1. Hand washing is an absolute must before and after any patient care procedure. Hand washing in front of the patient lets your patient know that you practice good hygiene.

2. Latex examination gloves should be worn to protect chapped hands or breaks in your skin from contact with body fluids such as blood, tears, mucous membranes or saliva. Examination gloves should also be worn anytime you or your patient has any infectious agent which may be transmitted as a result of the skin of your hands being compromised. Gloves do not replace hand washing. If the gloves are powdered, hand (glove) washing should be done before touching the patient about the eyes or handling contact lenses. DO NOT move around or leave the examination room while still wearing gloves. Wash your hands after removing examination gloves.

3. In performing blood glucose testing or venipuncture always wear latex examination gloves. The lancet or needle and syringe should be disposed of immediately into sharps boxes, without recapping.

4. All non-invasive instruments with which the patient has come into contact must be cleaned and disinfected with 70% isopropyl alcohol, zephiran (benzalkonium chloride), or other disinfectant as indicated. These instruments include, but are not limited to:

   a. The chin and forehead rests of all instruments.
   b. Phoropter/refractor face shields and forehead rests.
   c. Examination chair armrests and headrests.
   d. Visual field eye patches (place a tissue underneath the patch).
   e. P.D. rulers.
   f. Occluders.
   g. Trial frame.
   h. Counter and table tops.
   i. Gonio lenses should be wiped with 70% isopropyl alcohol or zephiran, rinsed with water, cleaned with disinfecting soap, rinsed again with water, and dried with non-abrasive tissue or lens cloth.
   j. PMMA and RGP diagnostic contact lenses should be cleaned, rinsed with saline solution, disinfected in fresh 3% hydrogen peroxide for ten minutes, rinsed again in saline solution and dried for storage.
   k. Soft diagnostic contact lenses should be cleaned, rinsed with saline solution, disinfected in fresh 3% hydrogen peroxide, neutralized, and stored in sterile saline solution. Standard heat disinfection should be used for those lenses able to tolerate this procedure.

5. Instruments used for invasive procedures and minor surgery should be cleaned well with a disinfectant and prepared for autoclaving by placing them in autoclave bags.
6. Masks and gowns are generally not needed nor are they indicated for routine optometric procedures. If the patient is known to have an infection which may be transmitted by airborne routes, such as tuberculosis, etc., masks should be worn. The immunocompromised patient should be asked to wear a mask for their own protection. If the examiner has an infection transmitted by airborne routes, then he/she should be excused from the clinic until non infectious.

7. Any material contaminated with body fluids or blood, such as dirty gauze dressings and patches, should be properly disposed of in biohazard containers.

8. Clinic coats or clothing contaminated with blood or body fluids must be decontaminated by soaking in a solution of 1:10 chlorine bleach for 30 minutes prior to laundering.

9. Refer to the Infectious Control Program and Standard Operating Procedures document for other policies and procedures pertaining to control of biohazards.

10. Report all accidental exposures to the Chief of Medical Services. In addition, an accident report must be completed.

**TONOMETER STERILIZATION**

**Background**

1. Hepatitis C virus is the most common chronic bloodborne infection in the US.
2. 20-40% of chronically infected Hepatitis C patients have no known risk factors for Hepatitis C infection.
3. 50% of Hepatitis C seropositive patients are currently ambulatory and asymptomatic.
4. Hepatitis C virus has been isolated from tear fluid and the concentration in the tears may be higher compared to plasma and is independent of the severity of Hepatitis C infection.
5. There is a potential and real possibility of transfer of Hepatitis C virus during the course of an eye examination.
6. An isopropyl alcohol wipe leaves 88.91% of Hepatitis C RNA remaining on tonometer tips.
7. Povidone iodine wipes kill over 99% of Hepatitis C virus.

**Procedure**

**Before each measurement:**

1. Get 2 tissues, one 10% povidone iodine packet, and one isopropyl alcohol packet.
2. Carefully open the iodine packet (they are pretty moist) being aware that iodine may stain anything (lab coats, shirts, chairs, instruments, carpets, etc.) it touches. Save the foil pack, placing it on top of one of the tissues. Gently wipe the tonometer tip for 5 seconds, then place the pad on the foil, wrapping all components in the tissue and then discard it in a trash receptacle.
3. Quickly wipe off any residue of iodine from the tonometer tip with the alcohol pad and gently dry with the other tissue. The probe is now ready for use.
4. Wash your hands before touching anything.

Please be careful not to bend the tonometer arm, as essentially little or no pressure is required.

Do not irrigate the tips with saline or contact lens solutions. Moisture will enter the tonometer housing and cause permanent damage.
FAMILY PRACTICE SERVICE – GENERAL INFORMATION

The Family Practice Service operates most days of the week and sees patients ranging from age 6 through geriatrics.

Students are required to bring to clinic all handheld equipment used in previous Primary Care laboratories (near point cards, occluder, penlight, etc.), as well as their retinoscope, direct ophthalmoscope, fundus lens, and binocular indirect ophthalmoscope, stethoscope, sphygmomanometer, vectographic slide, analyzer or Polaroid glasses, and a condensing lens. As a rule, the student is expected to bring all the equipment he/she will need, and should not rely on the availability of equipment from the equipment check-out room.

Students are expected to complete primary care examinations with increasing efficiency as they move through the clinical program (see specific rotations for a detailed description of behavioral objectives). Students who are not near completion of the examination after the allotted time can expect their supervising faculty member to take over and complete the examination. All electronic medical records and forms must be completed by the student within 24 hours of the completion of the exam.

The Service Coordinator and/or the clinical faculty will assign a patient to each student. The student will receive a paper fee statement; which needs to be signed by their attending faculty at the end of the examination. It is the students’ responsibility to log into the correct location (Family Practice Service in this instance) and create a new examination using the correct template from the provided list.

The student should greet the patient in the reception area and escort them to the examination room. After the examination and consultation are completed, the student will escort the patient to Optical Services or to the cashier for payment.

Examinations should be performed in a problem oriented fashion, but should conform to the minimum data base established by the College and by the Texas Optometry Board for all primary care exams. Thus, tests such as retinoscopy, tonometry, blood pressure and dilated fundus examination should be completed on all patients, and tests such as keratometry, and color vision examinations should be performed on any patient who is coming to our clinic for the first time. Students must never administer pharmaceutical agents to a patient without prior permission from their attending faculty member. Drugs for dilation or tonometry include, but are not limited to the following:

- Tetracaine 0.5%
- Phenylephrine 2.5%
- Tropicamide 1.0%
- Proparacaine 0.5%
- Benoxinate/Flur. (Fluress)
FAMILY PRACTICE SERVICE:  
ADULT CLINIC –  
OPTOMETRY II

Students must pass each station of the Pre-Clinic Competency Examination with a minimum grade of 70% prior to entering OPT II Clinic. If a student fails one station of the Pre-Clinic Competency Exam, they will have one re-take opportunity to pass the failed station. If 2 or more stations of the exam are failed, the student will be required to re-take the entire examination. The student will have a single opportunity to earn a passing grade of 70% or higher on all stations. Failure of any station on the re-take will result in a failing grade overall and the student will not be permitted to enter OPT II clinic in the spring. The student will then be assigned to a remediation program designed by the OPT II Coursemasters and the Dean of Professional Studies. At the end of remediation, the student will be required to re-take the entire Pre-Clinic Competency examination and must pass all stations with a 70% or higher. Failure to pass the retest after remediation will result in suspension from the program.

The Family Practice Service Clinic for OPT II students operates four clinic sessions in the Spring semester, providing primary care examinations. In the OPT II Clinic, a faculty member supervises approximately 3 students. Students will spend one half day in clinic per week, and will rotate out of the Service periodically to observe specialty clinics within the UEI. Students are expected to arrive early to check the equipment and supplies in their assigned exam room, disinfect all countertops, chairs and equipment, and prepare their own equipment for use PRIOR to seminar with their attending. Seminar begins at 8:00am for morning sessions and at 1:00pm for afternoon sessions. OPT II students will usually see one patient per clinic session.

FAMILY PRACTICE SERVICE:  
ADULT AND PEDIATRIC CLINIC –  
OPTOMETRY III

Both the Primary Care Pediatric and the Adult clinic are located in the Family Practice Service. The patients in this clinic range in age from 6 to 17 years for pediatrics and over 18 for adult.

The students are assigned to the Adult and Pediatrics Clinic one half day each per week. During this time they see initial examinations as well as follow-up visits. Third year student’s work with supervising faculty in approximately a 4:1 ratio. Each student is scheduled for 2 examinations per half day.

Examinations are to be performed in the “problem oriented” approach to patient care and record keeping. However, all primary care evaluations must satisfy the minimum data base for the Adult/Pediatric Clinic and the minimum as required by the Texas Optometry Board. Routine procedures, such as retinoscopy, tonometry, blood pressure, pupil dilation, etc., must be performed on all patients. Exceptions must be approved by the attending faculty.

Appointments

Examination appointments are available in the early and mid-morning or early and mid-afternoon depending on the particular day of the week. Patients should ideally be scheduled for progress visits with the same student and attending. If the same student is unavailable the patient should be scheduled for their attentings next available time slot. Exceptions can be made with the approval of both the attending and the Service Coordinator.
All appointments are scheduled through the Family Practice Service.

Recalls

Before leaving the clinic, all patients should be informed of the approximate date of their next examination:

a. Any follow-up appointment should be documented in the EMR under patient management as an Order for a scheduled exam as well as through the Family Practice Service (FPS) Clinic Coordinator before the patient leaves.

b. Next year’s exam should be documented under patient management as an Order for a recall. The FPS staff will automatically recall the patient next year through the practice management software but the order should still be documented in the EMR.

Medical Records

All electronic medical records should be completed by the student on the day of the examination, if possible. In the event the student cannot finish a record by the end of the clinic day, they have 24 hours to complete the record or an insufficiency will be documented by the attending and reflected in the evaluation of the patient encounter. Any three (3) clinical insufficiencies will result in having to make up a clinic session during the semester break and will be reported as Unprofessional Conduct to the Academic Committee.

Students are responsible for correcting any data not consistent with the examination as well as the language of the normative statements. No new documents should be added to any existing paper record. All paper, correspondence and reports need to be scanned into the patient’s electronic medical record by the student. It is the students’ responsibility to scan and link the paperwork into the correct patient chart and to shred all paperwork after it has been scanned and verified.

Attending faculty are responsible for checking their records in the Open and Closed charts area of the EMR on a regular basis. All outstanding files are to be “Finalized” and electronically signed as soon as possible.

Referrals

The Service Coordinator should be informed of all patients to be referred (internal and external referral). When referring internally, the examination must be reviewed by the student and clinical faculty and “Finalized” prior to the next scheduled appointment.

Reports

Reports should be written by the student or attending (at the faculty's discretion). All reports must be approved by the attending who supervised that particular student and patient.
CORNEA AND CONTACT LENS SERVICE

The Cornea and Contact Lens Service (CCLS) provides both Primary Care and Specialty Care Services related to contact lenses and/or corneal disorders. Although this unit directs most of its emphasis to contact lens care, all aspects of Primary Care Optometry will be provided for patients examined within this unit.

Scheduling

All appointments are to be made by the Cornea and Contact Lens Service staff.

Each session in the Cornea and Contact Lens Service will consist of three one hour appointment slots. Comprehensive vision examinations or lengthy contact lens fitting procedures are scheduled for two hours. Routine fittings, progress evaluations, DFE/progress appointments, and/or dispensing visits are scheduled for one hour. Students are expected to see one comprehensive exam and one progress evaluation or three progress evaluation patients per session. Students are responsible for all appointments within their time slots, and must complete appropriate care within that period.

Seminars

Seminars are scheduled one-half hour before patient care begins. Students are expected to be in the clinic with all equipment set up, their examination room in order, and their patient records reviewed before the beginning of the seminar session.

Patient Recall

Before leaving the clinic, all patients should be informed of the approximate date of their next examination:
  a. Any follow-up appointment should be documented in the EMR under patient management as an Order for a scheduled exam as well as through the Cornea and Contact Lens Service (CCLS) Clinic Coordinator before the patient leaves.
  b. Next year’s exam should be documented under patient management as an Order for a recall. The CCLS staff will automatically recall the patient next year through the practice management software but the order should still be documented in the EMR.

Lens Pickup/Return Counter (1400)

All equipment, disposable diagnostic lenses, care kits, and inventory lenses as well as other contact lens supplies and equipment are located at the contact lens pickup/return counter. Any lens kits and solution that is being loaned to students such as diagnostic lens sets, Unisol 4 etc., must be signed out. Students are responsible for the safe return of all diagnostic kits and solution borrowed by the end of the clinic session.

Contact lens care kits are for our patients.

Return all empty vials for dispensed lenses, with the patient’s name, to a staff member in room 1400.

Contact Lens Lab (1421)
The GP modification and lens inspection equipment is located in room 1421. All GP diagnostic lenses are to be cleaned and dried before being returned to Room 1400.

**Contact Lens Consultation (1411)**

Room 1411 is the consultation area. It also contains forms used in the clinic, computers, a projector, and a telephone.

**Contact Lens Clean-Up Duty**

A clean-up duty roster is posted on the bulletin board next to room 1411. "Clean-up" consists of turning off and covering of the instruments in the hallways and in room 1421 along with cleaning of the modification units and general straightening up of the room.

**Fees**

The CCLS offers two methods of payment. For new patients being fit with contact lenses for the first time, only a global or package fee is available. This global fee provides contact lens services for 45-120 days from the initial fitting date. After this adaptation period, additional fees will be required. Former patients needing extended follow-up care may pay the global fee or they may simply pay for each office visit. All fees must be paid at the time services are provided. Patients who are fitted with lenses to be ordered must pay the cost of the materials in full before the lenses can be ordered. Exceptions can only be approved by the Service Director.

Fees for materials and services are posted on the inside of all cabinet doors (above the sink) within each exam room as well as in room 1411.

**Ordering Procedure**

A lab order must be created in the Electronic Medical Record of the patient. Both the electronic lab order and a written order form are required.

The University Eye Institute CCLS "Contact Lens Order/Reorder", hereafter referred to as "order form" will be used for all contact lens orders and returns. This form must be filled out completely to aid ancillary staff and clinicians in prompt and efficient processing. The date, patient demographics including the patient number and telephone number, student clinician, and faculty signature must be entered. **No order will be processed without a faculty signature.** The appropriate box in the upper right corner must be checked depending on the order status. Only **original and re-fit will be processed as warranted lenses unless otherwise specified**

The completed order form is to be placed in the order bin located at the lens pickup/return counter. Lenses will be ordered within 24 hours. When lenses are received, the contact lens clinic staff will assure that the lens ordered was indeed the lens received and the patient will be scheduled for a dispensing appointment, if possible, with the student listed on the order form.

When dispensing lenses, record the date on the order form. The order form should be placed in the order bin to be filed for contact lens Rx tracing.
Returning Lenses for Exchange or Credit

All lenses being returned must be in their original vials/cases. A lens return form and a new order form, if reordering, must accompany the lenses being returned.

Electronic Medical Records (EMR)

EMR must be finalized by the end of the day. However, CL orders should be signed and turned in for processing by the end of the clinic session. It is the responsibility of faculty to finalize all records of all patient visits.

Contact Lens Prescription/Records Release

According to the “Fairness to Contact Lens Consumers Act” (H.R. 3140) contact lens prescriptions must be released to the patient once you have “completed a contact lens fitting” without the patient asking for it. An exception to this requirement exists if you determine that because of a medical indication further monitoring is required, and you give the patient a verbal explanation of the reason the prescription is not released and document in the patient’s medical record a written explanation of the reason.

A “contact lens fitting” is defined as the process that begins after the initial eye examination and ends when a successful fit has been achieved. This “process” may include:

a. an examination to determine lens specifications
b. an initial evaluation of the fit of the lens on the eye
c. medically necessary follow-up examinations

The expiration date must be one year from the issue date” (the date the patient receives the prescription) UNLESS you can document in the patient’s medical record that a risk to ocular health exists. In this case, the patient must be informed of the reason for your decision. The expiration date cannot be less than the period of time you recommend the patient be re-examined. If a prescription has expired, upon request from the patient, you must provide “a one time extension of the contact lens prescription”.

When filling a prescription, record on the prescription the number of boxes dispensed and return the prescription to the patient.

Once the fitting process is completed, ask the patient, “Would you like to order your annual supply of lenses today?” If they elect to order less than an annual supply from us, you must reduce the number of boxes authorized on the contact lens Rx by the amount ordered.

No contact lens prescription will be released to the patient before or during the adaptation period. Once the patient has successfully adapted to their lenses, a complete prescription must be released with an appropriate expiration date. Patient information will be released to another doctor at any time. However, patients must sign a release form before a contact lens prescription or patient information can be released.

Referrals

All primary ophthalmological referrals will be made to the University Eye Institute Medical Service. Acute situations will be handled at the discretion of the attending faculty.
Telephones

Telephones located in the CCLS business office are not to be used by students or faculty. Faculty and students may use the telephone located in the consultation room (1411), however, calls should be limited to CCLS business. In most instances, patients should be asked to use the courtesy phone located in the hall next to the Family Practice Service.
Clinicians in the OD Service will see a variety of patients and perform a number of procedures.

**Patient Care**

Patients often enter the Service from either in-house referrals or a private practitioner. Some patients will have follow-up visits after having been previously seen in the OD Clinic.

A. Determine why the patient was referred. In-house referrals are usually accompanied by a referral form summarizing the pertinent facts.

   If the patient was not an in-house referral, pertinent information should be obtained, organized, and presented to the attending.

   B. Based on the record review, a plan of action should be developed including additional history tests to be performed, and their order of completion.

   C. Once the testing is complete, the student should document the data, formulate an assessment, and communicate with the attending faculty. The attending will review the data and recommendations and accept or modify them before communicating with the patient or the referring source.

   D. Electronic Medical Records should involve complete and accurate recording of all data, diagnosis, and treatment on the examination form as well as writing a letter to the referring source.

The referral letters should be written by the student following consultation with the attending faculty and signed by the student and the attending faculty.

E. In order to simplify record-keeping, a set of common abbreviations that appear in the appendix of this manual should be used.

**Examination Procedures**

Each examination should begin with a comprehensive history. The questions asked should cover the obligatory eight and verify information previously obtained in other examinations.

Best corrected acuities must be taken before performing other procedures. If new spectacles have been ordered but not delivered, it is necessary to place the Rx in a trial frame or phoropter. If the best corrected acuity is not 20/20, pinhole acuities should be obtained.

Most patients in this clinic will be dilated. Before dilation the student must:

a) check pupillary responses.

b) evaluate the angle with the slit lamp and with gonioscopy if indicated.

c) check the IOP's with Goldmann tonometry.

d) consult with the faculty member before administration of pharmaceuticals to obtain "go or no go" instructions.
HOW PATIENTS ROTATE THROUGH THE SERVICE

I. Appointments
   A. The Service Coordinator schedules patients.
   
   B. Patient Base
      1. In-house referrals
      2. Outside referrals
      3. Recalls
      4. Emergencies
      5. Special problems or requests by patients

II. Students assigned to patients
    A. Assignments are made prior to the scheduled appointment and medical records are made available.
    B. Students/patients are assigned to specific attendings several days before the scheduled appointment.

III. Patient check-in
     A. Check in at the front desk
     B. Directed to the OD/Med Service
     C. Service Coordinator collects the fee statement and puts it in the holding bin
     D. Service Coordinator checks off patient on the schedule
     E. Students are responsible for checking to see when the patient arrives and collecting the fee statement.

IV. Exam
    A. Student examines patient with faculty overseeing the exam

V. Fee Statement/payment
    A. Students complete the fee statement with patient file folder number - faculty, student name, diagnosis, procedures performed
    B. Faculty signs the fee statement and verifies accuracy of completion
    C. Student escorts patient to cashier
BEHAVIORAL OBJECTIVES

FAMILY PRACTICE SERVICE - OPTOMETRY II

The behavioral objectives of the OPT II spring semester clinic are based upon the basic optometric examination procedures taught in the OPT I year and fall semester OPT II. The student should meet minimum competency levels on the following objectives at the beginning of the semester, and is expected to progress rapidly in the development of proficient skills and expanded knowledge base and application.

In the beginning of the Spring Semester, the student is expected to:

1. Take an accurate and complete case history. This includes determining and recording:
   A. chief complaint(s) and history of present illness
   B. present and past visual/ocular status
   C. present and past medical status
   D. family history of ocular/systemic disease
   E. current medications
   F. allergies
   G. social history, including specific visual needs

2. Perform preliminary tests and record results appropriately:
   A. visual acuities (unaided and habitual, distance and near)
   B. confrontation fields
   C. versions
   D. pupillary reflexes
   E. cover test (distance and near)
   F. near point of convergence
   G. near point of accommodation (push-up method)
   H. blood pressure

3. Perform an accurate refraction. This includes:
   A. a complete neutralization of the patient's Rx
   B. keratometric readings accurate to 0.50 D. and 10 degrees
   C. retinoscopy accurate to 0.50 D. and 20 degrees
   D. subjective accurate to 0.25 D. and 5 degrees
   E. determine the appropriate presbyopic bifocal correction (including range of clear vision)

4. Assess binocularity and accommodative status. This includes:
   A. distinguishing tropia/phoria, eso/exo, hyper/hypo with the cover test
   B. recording phorometric findings accurate to 1 prism diopter
   C. Von Graefe phoria (lateral and vertical)
   D. vergence ranges (lateral and vertical)
   E. associated phoria findings when indicated
   F. stereopsis, suppression, and vergence ranges when indicated
   G. accommodative amplitude accurate to 1 diopter
   H. accommodative lag, range, or flexibility when indicated
5. Perform an accurate health assessment. This includes:
   A. anterior segment status (gross examination and biomicroscopy)
   B. intraocular pressure (applanation tonometry)
   C. Posterior segment status with dilation (binocular indirect ophthalmoscopy, direct
      ophthalmoscopy, and non-contact fundus lens ophthalmoscopy)
   D. gonioscopy, if appropriate

6. Complete the data base (see minimum data base). This includes:
   A. keratometry, color vision on all new patients
   B. BP, DFE, IOP, etc., on all patients

7. Make an accurate assessment and plan, including return to clinic

8. Interact appropriately with the patient. This includes:
   A. wearing proper attire and practicing proper personal and clinic hygiene
   B. communicating effectively, using appropriate language
   C. displaying concern and respect for the patient

9. Perform an examination within time limits. This means no longer than:
   A. exam time prior to dilation = 105 minutes (1 hr/45 minutes)
   B. total patient chair time = 150 minutes (2 hrs/30 minutes)

10. Complete the exam record properly. This includes:
    A. entering all data on the exam sheet
    B. completing assessment, plan, Rx, and signature
    C. completing the clinic fee slip properly
    D. completing the patient encounter form

By the end of the Spring semester, the student should be able to make reasonable assessment of
the patient's status and formulate an appropriate treatment plan.

In addition to the above basic vision examination skills, the student will be able to perform the
following contact lens related skills/procedures by the end of the Spring semester:

Modify rigid contact lenses (decrease overall diameter and optical zone, apply secondary and
peripheral curves, change power, polish concave and convex surfaces, and apply a finished
edge).

Apply and remove rigid and soft contact lenses on a patient's eye.

Teach patients to apply and remove rigid or soft contact lenses and how to care for
them.

Conduct a diagnostic fitting session for rigid and soft contact lenses (selection of lenses,
evaluation of fit, determination of power, and ordering of lenses).

Record all clinical activities in SOAP format.
PEDIATRIC SERVICE – OPTOMETRY III

During the OPT III clinical year, the student should be able to perform an examination of children. In addition to basic procedures (see Adult Service), the student should be able to perform the following tests, evaluate the results and develop an appropriate treatment plan for the patient.

1. Obtain an appropriate case history including school performance and developmental history.

2. Assess the visual acuity of a child, and document accurately, adjusting for actual test distance when different from standard testing distances. The student should be able to perform the following tests:
   - Snellen
   - HOTV
   - Lea Cards
   - Bailey Lovie
   - Pinhole test for decreased acuity

3. Determine an appropriate refraction of a child, using objective and subjective techniques.

4. Tolerance chart for retinoscopy (in phoropter or loose lens retinoscopy):

<table>
<thead>
<tr>
<th>Semester</th>
<th>Power</th>
<th>Axis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cylinder power 0.75 to 1.75D</td>
<td>Cylinder power 2.00D &amp; up</td>
</tr>
<tr>
<td>OPT III</td>
<td>Both meridians within +/-0.75D</td>
<td>20 degrees</td>
</tr>
<tr>
<td>Fall &amp; Spring</td>
<td>Both meridians within +/-0.50D</td>
<td>15 degrees</td>
</tr>
</tbody>
</table>

5. Perform alternate forms of retinoscopy:
   - Dynamic – MEM (within +/-0.50D)
   - Static – loose lens retinoscopy

6. Determine the magnitude and direction of a phoria or intermittent tropia using:
   - Unilateral and alternating cover tests with prism bar or loose prism.
   - Maddox rod.

Tolerance chart for measurement of deviation:

<table>
<thead>
<tr>
<th></th>
<th>Deviations from 0 – 20 Δ</th>
<th>Deviations &gt; 20 Δ</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPT III Summer</td>
<td>5 Δ</td>
<td>8 Δ</td>
</tr>
<tr>
<td>OPT III Fall &amp; Spring</td>
<td>3 Δ</td>
<td>5 Δ</td>
</tr>
</tbody>
</table>
7. Assess sensory fusion (stereoacuity, suppression) using:
   - Random Dot E
   - A.O. Vectographic slide
   - Titmus Fly stereo test
   - Randot stereo test
   - Worth 4 Dot
   - 4 p.d. base out test for suppression
   - Wesson card (fixation disparity and associated phoria)
   - Forced vergence fixation disparity curve w/ Wesson Card

8. Assess motor fusion (vergence ranges and facility) using prism bars, loose prisms and/or prism flippers.

9. Perform accommodative tests:
   - Accommodative facility with plus and minus lenses
   - Accommodative amplitudes with push-up or pull-away method

10. Administer home therapy for phoria or intermittent tropia:
    - Pencil push ups
    - Near-far jump vergences
    - Brock string
    - Various vectograms and tranaglyphs
    - Free-space rings
    - Aperture rule
    - Lens and prism flippers
    - TV trainer
    - Computer orthoptics
    - Other therapy deemed appropriate

11. Administer the following perceptual skills screening tests:
    - SAPS
    - PASP
    - VMI
    - Rutgers Drawing test A or B

12. Dispense perceptual skills training program:
    - SAPS
    - PASP

13. Assess intraocular pressure using the tonopen.

14. By the end of the Summer semester, the student should be able to complete an entire examination in 2 hours or less, and can be expected to complete 2 patient encounters per clinic session.
    By the end of the Fall semester, the student should be able to complete an examination in 1 hour 15 minutes or less, and can be expected to complete 2 patient encounters per clinic session.
    By the end of the Spring semester, the student should be able to complete an examination up to the dilation in less than 1 hour and can be expected to complete 2 patient encounters per clinic session.
Perform a strabismic exam including:

7. Measure subjective and objective angles of strabismus using:
   - Unilateral and alternate cover tests with prism
   - Maddox rod
   - Major amblyoscope
   - Hirschberg and angle Kappa
   - Krimsky

8. Assess comitance:
   - Objectively:
     a. Hirschberg
     b. Alternate cover test in cardinal positions of gaze
     c. Park’s three step test
   - Subjectively
     a. Red lens or Maddox rod in cardinal positions of gaze
     b. Hess Lancaster

9. Assess monocular fixation using:
   - Visuoscopy
   - Foveal entoptic phenomena (Haidinger’s brush)

10. Assess retinal correspondence using:
    - Cover test and Maddox rod
    - Herring-Beilschowsky After-image test
    - Bagolini lens
    - Worth 4 Dot

11. Properly document all the findings in the patient’s record.

12. Give a case presentation in which relevant data and information are discussed and organized to support a recommended plan.

13. Write a proper referral letter or report regarding the patient’s visual status and/or developmental status.
PEDiatric Service – OPTOMETRY IV

During the OPT IV clinical year, the student should be able to perform an examination of children of all ages. In addition to the objectives listed for Pediatric Service Optometry III, the student should also be able to perform the following tests, evaluate the results and develop an appropriate treatment plan for the patient.

1. Obtain an appropriate case history including developmental history.

2. Assess the visual acuity of a young child using:
   • Cardiff Cards
   • Teller acuity cards
   • Resistance to occlusion
   • Fix-and-follow
   • Vertical prism test

3. Perform alternate forms of retinoscopy:
   • Dynamic retinoscopy
   • Mohindra technique

4. Assess sensory fusion for the young child using:
   • Lang I and II stereotest
   • Frisby stereotest
   • Randot Preschool stereoacuity test
   • KBBT #4

5. Assess motor (reflex) fusion objectively using loose prisms.

6. Make appropriate modifications for the patient’s age, including, but not limited to:
   • Confrontation visual fields
   • Amplitude of accommodation using dynamic retinoscopy method
   • Objective determination of NPC

7. Assess development using the Denver II developmental test, interpret findings and document appropriately.

8. Properly document all the findings in the patient’s EMR record.

9. Give a case presentation in which relevant data and information are discussed and organized to support a recommended plan.

10. Properly complete the “Assessment”, “Patient Education” and “Plan” sections of the patient chart.

11. Write a proper referral letter or report regarding the patient’s visual status and/or developmental status.
ADULT SERVICE – OPTOMETRY III

During the OPT III clinical year, the student should be able to perform all the OPT II behavioral objectives and the following in the Adult Service:

1. Test for and appropriately prescribe for the visual needs of patients over 40.

2. Manifest refraction should fall within the following tolerance chart:

<table>
<thead>
<tr>
<th>Semester</th>
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<th>Axis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
<tr>
<td>OPT III Fall &amp; Spring</td>
<td>Both meridians within +/- 0.50 D</td>
<td>15 degrees</td>
</tr>
</tbody>
</table>

3. Test accommodative status including accommodative lag, range, and flexibility and determine appropriate add if needed.

4. Perform tests for, diagnose, and manage patients with:
   - Primary open angle glaucoma
   - Cataracts (prior to surgical referral)
   - Age-related macular degeneration
   - Common peripheral retinal degenerations
   - Corneal, tear layer, and vitreal changes associated with aging
   - Common ocular urgencies/emergencies

5. Screen for and properly manage patients with common systemic disorders (e.g. hypertension, diabetes mellitus, thyroid disease)

6. Perform the following diagnostic tests when appropriate: three- and four-mirror gonioscopy, scleral depression, pachymetry, etc.

7. Perform various visual field procedures when appropriate: FDT, Humphrey, Amsler grid.

8. Give an oral case presentation to your attending in which relevant data and information are discussed and organized to support a recommended plan.

9. Properly record and summarize all the above on the patient’s EMR record in an organized manner.

10. Make appropriate recommendations for referral to internal clinics or outside health care practitioners and social service agencies.

11. Write a referral letter in a timely manner (either in-house or external)
12. Properly complete the fee bill and other appropriate forms by the end of the Summer semester, the student should be able to complete an entire examination up to the dilation in 2 hours or less.

By the end of the Fall semester, the student should be able to complete an entire examination in 1 hour 30 minutes or less, and can be expected to complete 2 patient encounters per clinic session.

By the end of the Spring semester, the student should be able to complete an entire examination up to the dilation in under 1 hour and can be expected to complete 2 patient encounters per clinic session.
CORNEA AND CONTACT LENS SERVICE- OPTOMETRY III

During the OPT III clinical year, the student should be able to perform ALL of the behavioral objectives from Family Practice Service Optometry II and III in addition to the following:

I. Routine Annual Examination
   1. Take a thorough contact lens history.
   2. Be familiar with how systemic or topical drugs affect contact lens wear.
   3. Perform an appropriate spherical and spherocylindrical over-refraction and document visual acuities with each.
   4. Perform a slit lamp examination to assess both the fit and the condition of the contact lenses.
   5. Perform a slit lamp examination of the eyes without contact lenses, looking for any complications from lens wear such as corneal neovascularization, microcysts, etc.
   6. If the contact lenses need to be refit, be able to suggest to the instructor what type of lenses to refit and why.
   7. Proper completion of fee bill including contact lens professional fees and orders.

II. Contact Lens Progress Visit
   1. Record the patient’s subjective contact lens history.
   2. Perform and record measurements of visual acuity, over-refraction, lens fit, and corneal integrity.
   3. Determine and carry out additional procedures needed to understand subjective or objective symptoms and signs.
   4. Be familiar with how systemic or topical drugs affect contact lens wear.
   5. Present the instructor with a summary of relevant information and recommend a plan.
   6. Properly record and summarize the above on the patient’s record in an organized manner.
   7. Proper completion of fee bill and other appropriate forms.

III. New patient lens fit
   1. Take a thorough contact lens history.
   2. Identify general and ocular health problems related to contact lens wear.
   3. Carry out examination procedures and evaluate the following:
      - blink reflexes
      - tear film, including tear break up time
      - meibomian glands
      - tarsal conjunctivae
      - pre-lens wear staining
   4. Be familiar with how systemic or topical drugs affect contact lens wear.
   5. Compute optical relationships between spectacle refraction, K-readings, base curves, tear lens, contact lens power, and over-refraction.
   6. Discuss with the instructor the rationale for the fitting philosophy to be attempted.
   7. Apprise the patient on contact lens options specific to that patient and explain details of cost.
   8. Be able to discuss the risks and benefits of contact lens wear with the patient.
   9. Determine specifications for initial lens prescription.
   10. Be aware of contact lens warranties.
   11. Verify lenses before delivery.
12. Be able to insert and remove lenses for the patient.
13. If ordering trial lenses, write up the order form, have the instructor sign it, and turn it in the appropriate area.
14. If delivering lenses to a first time contact lens wearer, be able to teach the patient lens insertion, removal and appropriate lens care methods.
15. Discuss the need for continuing and/or follow up care.
16. Prescribe a wearing schedule that is rational and takes into account the daily life of the individual.
17. Properly record and summarize all the above on the patient’s record in an organized manner.

IV. Other procedures
   If indicated, the student should be proficient in the following procedures:
   1. Corneal topography- both acquisition and interpretation
   2. Verification of GP lens parameters including base curve, power, overall diameter, optic zone diameter, and center thickness
   3. Modification of GP lenses including polishing surfaces and edges, changing power, and altering peripheral curves

The following recommendations for releasing contact lens prescriptions are taken from the federal “Fairness to Contact Lens Consumers Act” (H.R. 3140) and the Texas Optometry Board proposed amendments to Rule 279.2 Contact Lens Prescriptions.

1. You must release the prescription once you have “completed a contact lens fitting” without the patient asking for it. An exception to this requirement exists if you determine that, because of a medical indication, further monitoring is required, you give the patient a verbal explanation of the reason the prescription is not released, and document in the patient’s medical record a written explanation of the reason.

2. A “contact lens fitting” is defined as the process that begins after the initial eye examination and ends when a successful fit has been achieved. This “process” may include:
   a. an examination to determine lens specifications
   b. an initial evaluation of the fit of the lens on the eye
   c. medically necessary follow-up examinations

3. You may charge a fitting fee that includes fees for lenses required to be used in the fitting process. Unless medically necessary, you may not require the patient to purchase a quantity of lenses in excess of the lenses needed to complete the fitting process.

4. The expiration date must be 1 year from the “issue date” (the date the patient receives the prescription) UNLESS you can document in the patient’s medical record that a risk to ocular health exists. In this case, the patient must be informed of the reason for your decision. The expiration date cannot be less than the period of time you recommend the patient be reexamined.

5. If a prescription has expired, upon request from the patient, you must provide “a one time, two month extension of the contact lens prescription”.

6. When faxing a prescription, write “By Fax” or similar wording on the original prescription prior to faxing.

7. When filling a prescription, record on the prescription the number of lenses dispensed and return the prescription to the patient. If all the contact lenses authorized by the prescription are dispensed, write on the prescription “All Lenses Dispensed,” make a copy of the prescription to retain in the patient’s record, and return the original to the person presenting the prescription.

In order to reduce time and amount of paper generated, I recommend that, once the fitting process is completed, as the patient, “Would you like to order your lenses today or would you like to have a written prescription?” If they elect to order from us, note in the record “patient declined LC Rx”. If a patient orders a one year supply of lenses from us and also wants a copy of the Rx, complete the prescription and then write on it “ALL LENSES DISPENSED”.
During the OPT III clinical year, the student should be able to perform the following procedures in the Ocular Diagnostic Service:

1. Review the electronic medical record and properly complete the chart review form.

2. Give a concise case presentation covering the reason for the current visit, what is planned for the patient’s exam and in what order the tests will be performed. Be knowledgeable of past treatments including, photographs, lab tests, VF, OCT, HRT, any other tests, and the patient’s current medications.

3. Properly administer a visual field test including analyzing the results.

4. Properly measure IOP using Goldmann tonometry.

5. Properly perform pachymetry and know what the results mean.

6. Evaluate the anterior chamber by 3 and 4 mirror gonioscopy.

7. Examine the vitreous, retina, optic nerve and choroid using appropriate procedures and hand held lenses.

8. Assist in an electro-diagnostic evaluation.

9. Properly complete all pertinent forms including the fee bill.

10. Properly record the history and examination findings in the patient’s electronic medical record. Properly complete the assessment, plan and patient education sections of the patient EMR.

11. Write an appropriate referral letter or consultation letter.
CLINICAL PROCEDURES CHECKLIST

Each semester of the 2nd and 3rd year that the student attends clinic, a Procedure Proficiency Sheet must be completed. The Procedure Proficiency Sheet consists of a series of procedures that should be within the scope of the student's abilities. The purpose of the Sheet is to ensure that every student is proficient in each procedure by demonstrating the procedure on a patient. The procedures should NOT be performed on a fellow student, but on a patient. Exceptions must be approved by the appropriate Coursemaster.

The student should alert the attending faculty in advance that he/she intends to perform one or more of these procedures on the patient. The attending may then enter the exam room at the appropriate time, observe the student, and sign and date the checklist, verifying the student's skill.

The checklist is distributed during the first week of clinic. During midterm grading all Opt III students must have their Adult Unit Clinical Faculty review and sign the sheet to attest that they have indeed been working to complete the form. The sheet must be completed and returned to the appropriate Coursemaster by the date noted on the form. Failure to complete the Clinical Procedures Checklist on time results in an incomplete grade of I for that semester.

CLINICAL GRADING

Students will be evaluated on individual patient encounters, as well as midterm and final overall performance. Detailed information about clinical grading categories, the determination of clinical course grades, the identification of recipients of clinical letters of excellence, and the possible consequences of below expected clinical performance are published in the University of Houston College of Optometry Academic Policy and Procedures Manual which can be viewed in its entirety at: http://www.opt.uh.edu/current-students/academic-resources/academic-policy-and-procedures/. In addition, the manual describes the college’s academic honesty and professional conduct code which applies to all students at the College of Optometry.
OPTICAL SERVICES

Hours of operation are Monday through Friday 8:00 a.m. to 6:00 p.m. Students scheduled for the morning rotation are expected to arrive by 8:00 a.m. and assist patients until 12:30 p.m. Students scheduled for the afternoon rotation are expected to arrive by 12:30 p.m. and assist patients until 6:00 p.m. or until all clinic patients have been assisted. Upon arrival, students should record their name and the time they arrived in the attendance record book on the receptionist's desktop. Students should bring their dispensary tool kit, marker, penlight, ruler and a pen to be prepared to assist patients.

At the beginning of each semester, procedure lists will be given to the students to work on while they are not assisting patients. These lists are a series of tasks designed to enhance the educational experience of the optometry students while in the optical service rotation. These lists are due at the end of each semester and should be returned to the manager's mailbox in the faculty/staff mailroom. Students should make a copy of their completed lists before submitting to the manager.

Optical Service is a component of the student’s clinic rotation. Students are expected to wear proper clinic attire and a clean pressed lab coat when assigned to the Optical Service Department. The consumption of food is strictly prohibited in this area.

Optical Service Duties

1. Assisting patients in proper frame selection and discussing appropriate lens options for the patients individual Rx needs
2. Completing an order form for patients desiring to order spectacles or materials
3. Verifying orders from the fabricating laboratory
4. Dispensing spectacles, properly adjusting spectacles and explaining to the patients how the spectacles are to be used and cared for
5. Performing adjustments and minor repairs on eyewear as requested by the patients
6. Answering inquiries from patients about their eyewear or visual concerns.
7. Assisting the staff of the Optical Service as needed for other miscellaneous duties

The patient's name and arrival time will be recorded on the sign in sheet at the reception desk in Optical Service. Also noted on the sign in sheet is the type of service that the patient needs, (i.e.) frame selection, pick up order, and other service. A staff optician will indicate by their initials that they are responsible for the patient. The optician may assign a student clinician to a patient once information has been gathered about the patient. The optician will share information with the student attending the patient so as to ensure quality care is provided.

Depending on a student’s skill level and the complexity of the service needed, they may need the assistance of a staff optician at the beginning of the patient encounter or may be able to meet most of the patient’s needs on their own. In either scenario, all patients must be seen by a staff optician before they leave the area. Under no circumstance should a student dismiss a patient from the Optical Service area without first asking an optician to review the work performed.

Often patients may need to be directed toward a special group of frames due to their insurance plan or referring organization. The top of the patient’s fee bill usually reflects information
critical in directing the patient to the correct frame selection. When in doubt, students should ask the opticians what frames the patients are allowed to select and what the plan covers. Once the patient has chosen a particular frame and the student is satisfied that the frame is aesthetically and optically suitable, the student should complete the upper portion of the Optical Service Order Form. Complete demographic data as well as specific information pertinent to the patient’s visual needs should be indicted on this form. Treatments and benefits of different lens options should be discussed with each patient.

The fee for lenses is determined by the lens options such as Transition or Anti-Reflection coating. The prices for all lenses and options are listed on the price schedules in the dispensing tables. The student should record and explain to the patient the amount for both frame and lenses on the pricing information area of the order form. The student should then review the patient’s selection and completed order with an optician. The optician will enter the Rx information in the computer system and verify the measurements the student has taken and ensure the frames fit the patient properly. The order is placed in an envelope and tracking numbers assigned.

Criteria for New orders

♦ All pertinent information recorded on the order form
♦ Accurate measurements have been checked carefully (frame size, temple length, seg height, PD, etc.)
♦ Review of occupational and avocational needs including lens materials and coatings with demonstration when appropriate have been discussed with the patient
♦ Calculation and recording of fees have been checked by an optician and the order has been entered in the computer system

The student will assist the patient to the cashier for payment. It is required that the patient pay 100% full payment on orders before glasses can be processed. After payment is made, the student returns the order in the area marked “new orders”. If for any reason the patient does not pay while at the cashier the student needs to alert the attending optician.

Patients with Eye Care Assistance Program (ECAP), Medicaid eligibility and other patients referred by an affiliated organization are directed to the “ECAP” frames that are located in trays, and not on the frame boards or rotators. The trays are in the rear of the Optical Service area. All styles for “ECAP” are marked by a green dot. A special green price schedule is used for calculating charges. These special price schedules are in the dispensing tables.

Dispensing

Eyeglass orders that are ready for dispensing will have a printout enclosed which includes all the pertinent information about the Rx. The student should ensure that the lenses are clean and that the eyewear is in basic alignment before presenting the spectacles to the patient. Final adjustments should be performed to the satisfaction of the patient. If the patient has had a significant change in their Rx, they may feel uncomfortable initially. Some patients may need to be reminded that a new Rx often requires an adjustment period and patients should be encouraged to try the Rx for a few days before we schedule a follow up visit. Students should inform patients on the proper care of their spectacles. Once the student clinician has completed dispensing the order, an optician will review the student’s work using the following criteria:

♦ Alignment of spectacles
♦ Nose pad adjustment (if any)
♦ Temple adjustment
♦ Counseling the patient regarding Rx and/or lens design changes
♦ Counseling the patient regarding the proper care of spectacles
♦ Explanation of coatings, and other product performance expectations

The optician will assist the student during the delivery of eyewear when needed. Once the optician has seen the patient and the eyewear has been properly adjusted, the student assists the patient to the cashier if there is a balance due and then returns the order form to the receptionist’s desk.

**Adjustments**

The student should ascertain the nature of the patient's concern and perform the needed adjustments to the patient's satisfaction. If the adjustment appears to be complicated, the student may seek the assistance of an optician. **An optician should check any adjustment before the patient departs.**

**Repairs**

The student should determine the nature of the repair. The student should complete the repair or ask an optician for assistance. **An optician should check any repair before the patient departs.**

**Inquiries**

The most common inquiry is some form of visual difficulty with a new prescription. The student should secure the patient's file from the Medical Record's department, ascertain the nature of the difficulty, and verify the prescription. If there is an error in the Rx, the student should inform an optician. In most cases, the patient will need a progress visit to assess the extent of the problem. The student may consult with the clinic staff to arrange an immediate appointment. Occasionally, patients will return expressing dissatisfaction with spectacles they have purchased. The student should listen carefully to the patient and seek the assistance of one of the opticians.
Benefits eligible faculty, staff, and students of the University of Houston College of Optometry (UHCO) are entitled to purchase eyewear at invoice cost plus a $10.00 clinical development fee. The University Optical Service also extends this professional courtesy to the AlteraMed Group and UHCO immediate family members (i.e., spouse, children, parents, and siblings). Work-study students employed by the UHCO are also eligible to purchase their personal (not their family members) eyewear at invoice cost plus the $10.00 clinical development fee, one time only. All individuals receiving invoice cost pricing must personally cover the invoice cost of modifications or remakes if they are required for any reason.

Guidelines for handling invoice cost orders are as follows:

1. Patients of the University Optical Service will be given priority service over orders the college does at invoice cost. (If a student or staff member of the Optical Service department is serving college personnel and a UEI patient arrives, the student or staff member may be called to assist that patient.)

2. College personnel and qualified family members should avoid selecting and/or receiving personal orders during peak patient hours. The University Optical Service staff will suggest opportune times for personal and family selection and dispensing.

3. Professional students will assist the Optical Service staff with frame selection, ordering, and dispensing of spectacles for their own family members whenever possible.

4. All ordering, dispensing, and calculating of invoice cost must be approved by the opticians on duty. It is advisable to ask the attending opticians for information regarding professional courtesies offered by various vendors to optometry students, faculty, and staff on their personal Rx purchases.

5. Individuals receiving invoice pricing must personally cover the cost of remakes.

6. UHCO personnel and their immediate families are required to make full payment 100% on orders before glasses can be processed.

7. UHCO personnel will be allowed to purchase a maximum of one pair of spectacles per family member per calendar year at invoice cost.
MEDICAL RECORDS

A medical record is a legal document that should be sufficiently detailed and contain all significant clinical information pertaining to the patient. Clinic records of patients treated at the College of Optometry are the property of the University Eye Institute and are not to be reproduced without proper authorization or in accordance with a subpoena, court order, or statute. The majority of patient records are electronic. There are a few paper documents of a patient’s medical record, and they must be secured in the Medical Record Department.

Unauthorized removal of patient medical records from the Clinic/College is grounds for suspension.

A Medical Record shall be maintained for every individual who is evaluated or treated at the University Eye Institute, the University Eye Institutes External Clinics, or by a University Eye Institute doctor, technician, or optician.

Documentation comprising the Medical Record may be maintained in either paper (hardcopy) or electronic formats, including digital images, and can include patient identifiable source information, such as photographs, films, digital images, and/or a written or dictated summary or interpretation of the findings.

The clinic record serves several purposes. It is used to:

1. Document the course of the patient's treatment,
2. Communicate between the doctors and other professionals contributing to patient care,
3. Provide continuity of care on subsequent visits by the patient,
4. Review, study, and evaluate patient care by clinic or faculty/staff committees,
5. Provide data for: third parties concerned with the patients; other doctors and health care facilities; insurance companies; compensation carriers; attorneys; government agencies,
6. Provide data to assist in protecting the legal interest of the patient, the University Eye Institute, faculty/staff,
7. Provide data for research, study, and education.

Record Retrieval from the Medical Records Department

Paper medical records are pulled on an as needed basis for scheduled clinic appointments. Records may be requested by telephone or in person in the Medical Record Department. Some paper records are stored off site and may take several business days to obtain. The following information must be provided, in order for a record to be pulled accurately:

1. The patient's full name.
2. The clinic record number, if known.
3. Date of birth.
4. Approximate date of last visit.
5. Address
6. Name of person and/or Clinic responsible for the record.

Note: Items 3, 4, and 5 are not required, if the folder number is known.
Record Transfer

The procedure that must be followed whenever a record is transferred from the original requester to another professional is to take the record to the Service Coordinator who will transfer the record to the correct Service. Records may remain outside the Medical Record Department for a maximum of seven days for purposes other than immediate patient care. The requester will be held responsible for the record until its return to the Medical Record Department. If the record is needed at any time by the Record Department, the requester must return the record immediately.

Processing a Clinical Record

Students should attempt to complete the EMR the day of the patient’s visit. However, the deadline for completion is no later than 24 hours of the patient’s scheduled examination. The Electronic Medical Records (EMR) must be finalized within seven (7) calendar days. If, after seven days the incomplete records have not been completed, the Service Director will inform the Executive Director of the UEI.

Failure to comply within this period will constitute a breach of policy as set forth by the Credentialing and Privileging Committee.

Quality Review of Record Documentation

In order to maintain consistent, comprehensive record documentation, a system of Peer Review is utilized. Following procedures and criteria established by the Clinic Faculty, records are reviewed routinely for content and completeness. Deficiencies are monitored and corrective measures are implemented at the discretion of the Executive Director of the UEI.

Release of Information

The patient is entitled to the protection of his/her personal and medical information. All patient care information is regarded as confidential and is available only to authorized users.

Due to the varied nature of the requests and the desire to provide the best continuation of care for the patient, all requests received by the Medical Record Department for patient information will be referred to the appropriate doctor or Service Coordinator for processing. A written request must accompany patient record.

Requests made by telephone will also be referred to the appropriate Service with available information to aid in making the return call.

Authorization for Release of Information (see page 79)

A valid authorization for release of information should contain:

1. Name of the institution that is to release the information.
2. Name of the individual/institution to receive the information.
3. Patient identification to include full name, address, and date of birth.
4. Purpose or need for the information.
5. Extent or nature of the information to be released (inclusive date of treatment).
6. Date that consent is signed.
7. Signature of patient or the patient's legal representative.
A legible photocopy of an authorization is considered valid.

**Parental Rights**

Did you know that a parent does not automatically have the right to a minor child’s medical records? The HIPAA Privacy Rule generally allows parents to have access to their children’s medical records. However, there are four situations that you should be aware of when this is not the case:

- If the minor is the one who consented to care and the State or other applicable law does not require parental consent. Texas requires parental/guardian consent for the medical and eye care services that the UEI provides to minors;
- If the minor obtains care at the direction of a court or a person appointed by the court;
- If the minor child has been emancipated (released from parental control and supervision) in a court of law; or,
- If the parent agreed prior to the care that the minor and the health care provider would have a confidential relationship.

Even if a particular situation does not fall into one of the four exceptions, a treating physician may use professional judgment on whether to allow a parent access to a minor’s medical information. Refusing a parent access usually only happens when the physician believes that the minor has been or may be subjected to domestic violence, abuse, or neglect. In other words, the physician believes that treating the parent as the minor child’s personal representative could endanger the child.

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**Record Retention Policy**

Clinical records are retained in hard copy (original form) for five (5) years past the date of the last exam or visit, at which time they are considered inactive. Annually, all inactive records are purged from the active files and scanned to CD’s. The hard copy files will then be destroyed. This is in full compliance with the Statute of Limitations of the State of Texas.
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

EFFECTIVE September 23, 2013

This Notice of Privacy Practices (the “Notice”) tells you about the ways we may use and disclose your protected health information (“medical information”) and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to the University Eye Institute, including its providers and employees (the “Practice”).

I. OUR OBLIGATIONS.

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;
- Notify affected individuals following a breach of unsecured medical information under federal law; and
- Follow the terms of the version of this Notice that is currently in effect.

II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

A. For Treatment. We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.

B. For Payment. We may use and disclose medical information about you so that we or may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to
your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. If, however, you pay for an item or service in full, out of pocket and request that we not disclose to your health plan the medical information solely relating to that item or service, as described more fully in Section IV of this Notice, we will follow that restriction on disclosure unless otherwise required by law.

C. **For Health Care Operations.** We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers.

D. **Quality Assurance.** We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.

E. **Utilization Review.** We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether the appropriate level of services is received, depending on condition and diagnosis.

F. **Credentialing and Peer Review.** We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.

H. **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

I. **Appointment Reminders and Health Related Benefits and Services.** We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone, leaving a message on an answering machine, leaving a message with the person answering the phone or contacting you by automated text / e-mail ) to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you.

J. **Business Associates.** There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

K. **Individuals Involved in Your Care or Payment for Your Care.** We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

L. **As Required by Law.** We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

M. **To Avert an Imminent Threat of Injury to Health or Safety.** We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

N. **Organ and Tissue Donation.** If you are an organ donor, we may use and disclose medical information to organizations that handle organ procurement or organ, eye or tissue
transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

O. **Research.** We may use or disclose your medical information for research purposes in certain situations. Texas law permits us to disclose your medical information without your written authorization to qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by state or federal law. For example, we may use or disclose your information to an Institutional Review Board or other authorized privacy board to obtain a waiver of authorization under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is “de-identified.”

P. **Military and Veterans.** If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.

Q. **Workers’ Compensation.** We may disclose medical information about you for your workers’ compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers’ compensation insurance or a state workers’ compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

R. **Public Health Risks.** We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

- To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).
- To report births and deaths.
- To report suspected child abuse or neglect.
- To report reactions to medications or problems with medical devices and supplies.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- To provide information about certain medical devices.
- To assist in public health investigations, surveillance, or interventions.

S. **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

T. **Legal Matters.** If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your medical information, such as investigations of
health care providers, competency hearings on individuals, or claims over the payment of fees for medical
services.

U. **Law Enforcement, National Security and Intelligence Activities.** In certain
circumstances, we may disclose your medical information if we are asked to do so by law enforcement
officials, or if we are required by law to do so. We may disclose your medical information to law
enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your
physical, mental or emotional health or safety or the physical safety of another person. We may disclose
medical information about you to authorized federal officials for intelligence, counterintelligence, and
other national security activities authorized by law.

V. **Coroners, Medical Examiners and Funeral Home Directors.** We may disclose your
medical information to a coroner or medical examiner. This may be necessary, for example, to identify a
deceased person or determine the cause of death. We may also release medical information about our
patients to funeral home directors as necessary to carry out their duties.

W. **Inmates.** If you are an inmate of a correctional institution or under custody of a law
enforcement official, we may disclose medical information about you to the health care personnel of a
rectional institution as necessary for the institution to provide you with health care treatment.

X. **Marketing of Related Health Services.** We may use or disclose your medical
information to send you treatment or healthcare operations communications concerning treatment
alternatives or other health-related products or services. We may provide such communications to you in
instances where we receive financial remuneration from a third party in exchange for making the
communication only with your specific authorization unless the communication: (i) is made face-to-face
by the Practice to you, (ii) consists of a promotional gift of nominal value provided by the Practice, or (iii)
is otherwise permitted by law. If the marketing communication involves financial remuneration and an
authorization is required, the authorization must state that such remuneration is involved. Additionally, if
we use or disclose information to send a written marketing communication (as defined by Texas law)
through the mail, the communication must be sent in an envelope showing only the name and addresses
of sender and recipient and must (i) state the name and toll-free number of the entity sending the market
communication; and (ii) explain the recipient’s right to have the recipient’s name removed from the
sender’s mailing list.

Y. **Fundraising.** We may use or disclose certain limited amounts of your medical
information to send you fundraising materials. You have a right to opt out of receiving such fundraising
communications. Any such fundraising materials sent to you will have clear and conspicuous instructions
on how you may opt out of receiving such communications in the future.

Z. **Electronic Disclosures of Medical Information.** Under Texas law, we are required to
provide notice to you if your medical information is subject to electronic disclosure. This Notice serves
as general notice that we may disclose your medical information electronically for treatment, payment, or
health care operations or as otherwise authorized or required by state or federal law.

AA. **Sign in Sheet.** We may use or disclose medical information about you by having you
sign in when you arrive at one of our Services. We may also call out your name when we are ready to see
you.
III. OTHER USES OF MEDICAL INFORMATION

A. Authorization. There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

B. Psychotherapy Notes, Marketing and Sale of Medical Information. Most uses and disclosures of “psychotherapy notes,” uses and disclosures of medical information for marketing purposes, and disclosures that constitute a “sale of medical information” under HIPAA require your authorization.

C. Right to Revoke Authorization. If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

A. Right to Inspect and Copy. Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice’s HIPAA Officer at the address listed in Section VI below.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law.

If your requested medical information is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

B. Right to Amend. If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.
We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

C. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures.

If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice’s HIPAA Officer at the address set forth in Section VI below for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations.

To request a list of accounting, you must submit your request in writing to the Practice’s HIPAA Officer at the address set forth in Section VI below.

Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won’t be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice’s HIPAA Officer at the address listed in Section VI of this Notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a
prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan’s decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

E. **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice’s HIPAA Officer at the address listed in Section VI below.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

F. **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, you must make your request in writing to the Practice’s HIPAA Officer at the address set forth in Section VI below.

G. **Right to Breach Notification.** In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a “breach” as defined in and/or required by HIPAA and applicable state law.

V. **CHANGES TO THIS NOTICE.**

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice’s HIPAA Officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

VI. **COMPLAINTS.**

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

University Eye Institute  
Attn: HIPAA Public Information Officer  
4901 Calhoun Rd., Houston, TX 77204-2020  
713-743-1886

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice’s HIPAA Officer at the address or phone number listed above.
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received the University Eye Institute *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

___________________________________________________

___________________________________________________

___________________________________________________

Patient Name: _____________________________

(Please Print Name)

Patient Date of Birth: _____________________________

SIGNATURES:

Patient/Legal Representative: _____________________________ Date: __________

If Legal Representative, relationship to Patient: _____________________________

Witness (optional) : _____________________________ Date: __________
NOTICE: This sample Notice of Privacy Practices was prepared by the Texas-based law firm of Jackson Walker, L.L.P. Any questions regarding this material are subject to the following paragraph and should be directed to your own legal counsel or to Jeffery Drummond at (214) 953-5781. The Texas Medical Association (TMA) has no responsibility for the content of this material and makes no representation regarding the accuracy, currency, or completeness of this information.

Jackson Walker, L.L.P. and TMA provide this information as a commentary on legal issues with the understanding that it is not intended to provide advice on any specific legal matter. Due to the specific circumstances of a particular medical practice, some providers may be subject to other requirements not covered by the provisions of this document (for example, certain covered entities dealing with substance abuse treatment services will also be subject to the requirements of 42 CFR Part 2 disclosure restrictions), and should consult their own attorney. This information should NOT be considered legal advice and receipt of it does not create an attorney-client relationship. This is not a substitute for the advice of an attorney.

Although Jackson Walker, L.L.P. and TMA have attempted to present materials that are accurate and useful, some materials may be outdated, and Jackson Walker, L.L.P. and TMA shall not be liable to anyone for any inaccuracy, error or omission, regardless of cause, or for any damages resulting there from. Any legal forms are only provided for the use of physicians in consultation with their attorneys. You should not rely on this information when dealing with personal legal matters; rather, legal advice from retained legal counsel should be sought.
## AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

This authorization permits the University Eye Institute to use or disclose an individual’s protected health information. Individuals completing this form should read the form in its entirety before signing and complete all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

### Information regarding patient for whom authorization is made:

| Full Name: | __________________________________________________________________________ |
| Other Name(s) Used: | ___________ |
| Date of Birth: | ______ |
| Address: | ___________________ |
| City: | ___________ |
| State: | ______ |
| Zip Code: | ______ |
| Phone: | (_____)__________________________ |
| Email (Optional): | __________________________________________________________________________ |

### Information regarding health care provider or health care entity authorized to disclose this information:

| Name: | ____________________________________ |
| Address: | ___________________ |
| City: | ___________ |
| State: | ______ |
| Zip Code: | ______ |
| Phone: | (_____)__________________________ |
| Fax: | (_____)__________________________ |

### Information regarding person or entity who can receive and use this information:

| Name: | __________________________________________________________________________ |
| Address: | ___________________ |
| City: | ___________ |
| State: | ______ |
| Zip Code: | ______ |
| Phone: | (_____)_______________________ |
| Fax: | (_____)_______________________ |

### Specific information to be disclosed:

- [ ] Medical Record from (insert date) ______ to (insert date) ______
- [ ] Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other health care providers.
- [ ] Other: __________________________________________________________________________

### Include: (Indicate by Initialing)

- Drug, Alcohol or Substance Abuse Records
- Mental Health Records (Except Psychotherapy Notes)
- HIV/AIDS-Related Information (Including HIV/AIDS Test Results)
- Genetic Information (Including Genetic Test Results)

### Reason for release of information: (Choose all that Apply)

- Treatment/Continuing Medical Care
- Personal Use
- Billing or Claims
- Insurance
- Legal Purposes
- Disability Determination
- School
- Employment
- Other (Specify): ________________

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The individual signing this form agrees and acknowledges as follows:
(i) **Voluntary Authorization:** This authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) **Effective Time Period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made or the following specified date: Month: ______  
Day: _______ Year: ________.

(iii) **Right to Revoke:** I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) **Special Information:** This authorization may include disclosure of information relating to **DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION**, except psychotherapy notes, **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines above. In the event the health information described above includes any of these types of information, and I initial the corresponding lines in the box above, I specifically authorize release of such information to the person or entity indicated herein.

(v) **Signature Authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

**SIGNATURES:**

Patient/Legal Representative: ______________________________________ Date: ______________

If Legal Representative, relationship to Patient: ____________________________________________

Witness (optional): ______________________________________ Date: ______________

A minor individual’s signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

Signature of Minor (if applicable): ______________________________________ Date: ______________
Authorization for Release of Prescription Only
UNIVERSITY of HOUSTON, COLLEGE OF OPTOMETRY
4901 Calhoun Rd. (505 J. Davis Armistead Building)
Houston, TX 77204-2020
Medical Records Department 713-743-1922, Medical Records Facsimile 713-743-0963

I hereby request and authorize the University of Houston, College of Optometry to release my prescription.

__________________________________________  __________________________
Patient’s Name                                Patient’s Date of Birth

__________________________  __________________________
Patient’s Record Number (if known)             Patient’s Social Security Number (if known)

__________________________  __________________________
Patient’s Phone Number                           Patient’s Facsimile Number

I understand that this authorization includes permission to release information related to the history, diagnosis and/or treatment of any condition.
The requested information is to be sent to (name of doctor, hospital, person, or organization where prescription should be sent):

Name: __________________________________________

Address: _________________________________________

City: __________________ State: __________ Zip Code: __________

Phone: ___________________ Fax Number: __________

Purpose/reason for release of Prescription (circle): Medicare Ins  Legal Matters  Research  Other

Circle One:  Glasses Prescription       Contact Lens Prescription

I understand the nature of the authorization and that this authorization can be revoked at any time by the person giving authorization, with a written and dated notice, except to the extent that disclosure made in good faith has already been made prior to receipt of revocation.
I understand that my treatment is not conditioned on obtaining this authorization.
I understand that this authorization is specific for release only to the above party and expires (90) days following the date of signature.
I understand that information used or disclosed may no longer be protected by federal privacy laws.
I understand that I can be charged for obtaining a copy of my prescription according to the fee schedule established in the Texas Administrative Code.

Printed Name of Patient: ____________________________ Date: __________________

Signature of Patient: __________________________________________

Printed Name of Patient’s Representative: ____________________________

Signature of Patient’s Representative: ____________________________

Relationship to Patient: ____________________________________________
MEDICAL RECORDS GUIDELINES

The Harris County Medical Society has prepared for physicians the following guidelines on patient medical records. The information has been taken from several publications in an attempt to provide physicians with a simple and condensed reference on the subject.

Specific questions or legal advice should be obtained from the physician's attorney, the Office of the General Counsel of the Texas Medical Association 1-800-880-1300, X1340, or X1341, or the attorney for the carrier of your professional liability insurance.

(This document was updated in July, 1996)

1. **Is a physician obligated to forward to another physician the medical records of a former patient?** A physician who formerly treated a patient should not refuse, for any reason, to make his records of that patient promptly available on request to another physician presently treating the patient. Proper authorization for the use of records must be granted by the patient.

2. **Should a physician obtain a written release from a patient before releasing medical records?** Proper authorization for the use of records must be granted by the patient. Before releasing medical records, the physician must receive from the patient a signed, written authorization which states (1) the records which are to be covered by the release, (2) the reasons or purposes for the release, and (3) the person to whom records are to be released.

   The record is a confidential document involving the physician-patient relationship and should not be communicated to a third party without the patient's prior written consent, unless required by law or to protect the welfare of the individual or the community.

3. **What is included by the term "medical records"?** Medical records mean any records pertaining to the identity, diagnosis, evaluation, or treatment of a patient by a physician that are created or maintained by a physician.

4. **Who owns a patient's medical records?** Notes made in treating a patient are primarily for the physician's own use and constitute his/her personal property. However, a physician shall furnish (1) copies of medical records, (2) a summary or (3) a narrative report of the medical records, pursuant to a written consent for release of the information.

5. **May the physician charge a fee for the time and expense involved in forwarding this information?** The physician shall furnish the information within a reasonable period of time and may charge reasonable fees for furnishing the information to be paid by the patient or someone on his behalf.

6. **Is a physician obligated to forward medical records to an attorney -- or anyone other than the patient -- without a subpoena?** On proper written authorization from the patient, a physician should provide a copy or a summary of the record to the patient or to another physician, an attorney, or other person designated by the patient.

7. **Are there situations when it would be appropriate for a physician to legally refuse release of records?** Texas law provides that a physician may refuse to release medical records if the physician determines that access to the information would be harmful to the physical, mental, or emotional health of the patient. Please note that a physician may delete confidential information about another person who has not consented to the release.

8. **What should a physician do with patients' records upon retirement or relocation?** If the physician is leaving his practice for any reason (retirement, relocation, etc.) patients should
be notified that copies of their records will be made available to them or to another physician if they provide the signed, written authorization described above.

9. **Is it legal for a physician to sell his practice?** It is both legal and ethical to sell a medical practice. However, the purchaser must agree to make records of any patient treated by the selling physician available to subsequent physicians, or to other persons the patient's designate. If a physician is selling his medical practice, he may wish to duplicate all files to be maintained in his possession to provide information in the future and to aid in his defense should he be sued. If such duplication is prohibitive in terms of expense, then he may wish to enter into an agreement with the physician purchasing his practice to maintain the records.

Patients may designate the recipient of their records -- even if it is the patient himself. In any event, the physician should send a copy of the records to the physician or patient and maintain the original records in his possession.

10. **How long should a physician keep patient records?** The statute of limitations of liability suits is two years for adults; however, the courts have created various exceptions. Therefore, it is suggested that the physician maintain the records for a greater length of time -- perhaps 10 years. This provides additional time for those injuries which may not be discoverable (injuries as a result of foreign objects left in the body, vasectomies, fraudulent concealment, radiation treatment, etc.) within the two year limitations period. The medical records for care provided to minors should be retained at least until the minor's 20th birthday, i.e., age 18 plus two years. A physician may wish to check with his/her professional liability insurance carrier to determine if the carrier has recommendations regarding a retention period for medical records.

11. **May a physician refuse to forward medical records if a patient has an outstanding bill?** It is unethical for a physician to refuse or to delay improperly in responding to a valid request for transfer of a former patient's medical records because of an unpaid bill.

12. **Is a physician obligated to forward the information if an attorney calls and requests medical records on a patient who is suing that physician or that physician's colleague(s)?** A patient is entitled to obtain complete and unaltered copies of his medical records from the physician he/she is suing. Therefore, if a patient's attorney who is suing a physician requests records, that physician should comply with the request with proper written authorization from the patient and after notifying his professional liability insurance company. If a patient's attorney who is suing a colleague requests medical records, the physician should comply with the request after being provided with a written authorization from the patient.

13. **Do the same general rules apply to retention of records on a deceased patient?** It is suggested that all adult records be kept 10 years whether the patient is deceased or not.

14. **What should a physician do if his office is served with a subpoena for medical records?** The physician should call the patient or patient's attorney and state that he has been served with a subpoena for that patient's records. The physician should then ask for the attorney or the patient to supply him with a written authorization releasing those records. Following this procedure assures that the patient will not later claim that the subpoena was defective and that the physician released confidential information. If a patient's attorney does not want the records released, he/she should move the court to quash the subpoena so that the physician will not have to reveal the medical records.

A brochure on this subject is available through the Texas Medical Association. Titled "Code for Physician and Attorneys of Texas, “the brochure was developed by the TMA
Committee on Liaison with the State Bar of Texas and the State Bar Committee on Coordination with other professional groups and is designed to achieve a better understanding between the medical and legal professions.

This condensed information contains quotations from the Medical Practice Act of Texas, the Current Opinions of the Texas Medical Association Board of Councilors (November 1986), and Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association (1986).

Also referenced in the preparation of this publication were "Medicine and the Law" articles in Texas Medicine, "Medical Records--Retention and Release" (October 1983) and "Is there a statute of limitations in a medical professional liability lawsuit?" (April 1987).

(Update: July, 1996)

The Texas State Board of Medical Examiners (TSBME) has approved fees that physicians may charge for providing patients with copies of their medical records. The fees are $25 for the first 20 pages and 15 cents per page thereafter, plus the cost of mailing, shipping, or delivery.

Amendments to the Medical Practice Act of Texas adopted by the Texas Legislature last year define medical records as “any records pertaining to the history, diagnosis, treatment or prognosis of the patient, including copies of medical records of other health-care practitioners contained in the records of the physician to whom a request for release of records has been made.” The amendments provide that:

1. Physicians shall furnish copies or a summary of the records within 30 days after receiving a written request unless he or she determines that access to the information would be harmful to the patient’s physical, mental, or emotional health. The physician may delete confidential information about another person who has not consented to the release.

2. If the request is denied, either in whole or in part, the physician must give the patient a signed and dated written statement giving the reason for the denial and place a copy of it in the patient’s medical records.

3. Physicians may not charge for copies of records if the request comes from a licensed Texas health-care provider or physician licensed by any US state or territory or Canada for the purpose of emergency or acute medical care.

4. If a proper request is received for purposes other than emergency or acute care, the physician may withhold the records until payment is received. If payment is not made at the time of the request, the physician has 10 calendar days to notify the requesting party in writing of the need for payment, and a copy of the letter must be part of the patient’s file. Records cannot be withheld because of past-due accounts for medical care.

5. Physicians are not required to provide copies of billing records pertaining to a patient’s care unless specifically requested as part of the request for the release of medical records.

For more information, physicians may call TSBME at (512) 305-7065.
APPENDIX

Emergency Procedures

An emergency is an unexpected, serious event demanding immediate attention. Fortunately, in our facility, true emergencies are a rare occasion; however, one must be prepared to act quickly if an emergency should arise. An emergency may be of ocular origin (i.e., central retinal artery occlusion, chemical burns of the cornea, bilateral papilledema swelling) or systemic in nature (i.e., chest pain, loss of consciousness).

In general, if an emergency occurs, the Chief of Medical Services should be summoned immediately. If feasible, the patient should be transported to the minor surgery/emergency room in the Medical Services area. If the patient cannot be safely moved, medical treatment must be provided at the original site.

Seizures

Seizures can result from a primary central nervous system disorder or may be a manifestation of a serious underlying metabolic or systemic disorder. Management of a seizure, whatever the etiology, is primarily limited to preventing bodily injury. Vital functions, such as respiration, must be monitored and supported. Attempts to protect the tongue should not generally be undertaken unless a padded tongue depressor or plastic airway can be inserted between the teeth easily. It is counterproductive to damage teeth, gums or tongue while trying to force an object between tightly clenched jaws. A finger should never be inserted into the patient’s mouth to straighten the tongue. This action is both dangerous and unnecessary. Clothing about the neck should be loosened and a pillow placed under the head. The patient should be rolled onto his side to prevent aspiration of vomitus. The patient should be monitored and CPR initiated if indicated. Once the patient is stable, he/she should be referred for a neurologic examination.

Syncope

Syncope is a sudden, brief, loss of consciousness and may result from a variety of cardiovascular and noncardiovascular causes. In the clinical setting, the most common type of syncope is the vasovagal disorder that is seen in all age groups and affects men and women equally. The common precipitating factors are emotional upset, sight of blood, painful medical procedures, injury, application of a contact lens, etc.

Physiological decreases in both arterial pressure and heart rate, mediated by the vagus nerve, combine to produce central nervous system hypoperfusion and subsequent syncope. Serious cerebral hypoxia with resultant tonic-clonic movements is more likely to occur if the patient remains upright. The patient may experience a prodrome lasting from 10 seconds to a few minutes and includes weakness, light-headedness, nausea, sweating, salivation, blurred vision, and tachycardia. Examination reveals an individual who is pale, sweating, has dilated pupils and a slow, weak pulse. With loss of consciousness, bradycardia replaces tachycardia. Abnormal movements may be noted during the period of unconsciousness. These movements are mainly tonic or opisthotonic but tonic-clonic activity is occasionally manifested. Urinary incontinence may occur, but tongue biting is rare.
Treatment of these patients includes recumbence, monitoring, reassurance and a recommendation to avoid precipitating factors. These measures are usually all that is necessary. Adequate nutrition and hydration should be encouraged. After a period of observation, the patient should be referred to their private physician to exclude cardiogenic syncope.

**Chest Pain**

There are many causes of chest pain that may be attributable to the heart, lung, esophagus, pancreas, gall bladder, and musculoskeletal systems. Clinically, it is often difficult to ascertain exactly what the problem may be. The clinical diagnosis of a typical myocardial infarction is based on a history of crushing chest pain or discomfort that lasts longer than 30 minutes, is not relieved by rest and has no other clear explanation. The pain often radiates to the neck or either arm. Other symptoms such as nausea, dyspnea, and profuse sweating are often present. Painless infarcts and atypical pain (e.g., pain in the jaw or either arm without chest pain) occur occasionally, especially in diabetic patients.

If you are with someone who is experiencing any of these symptoms, the first step is to have the victim rest quietly and calmly. Since both angina pectoris and heart attack are caused by too little oxygen to the heart muscle, the victim's activity must be kept to a minimum. The victim should be allowed to assume the position that gives him or her the most comfort and easiest breathing.

If prescribed by a physician, nitroglycerin placed under the tongue or an ointment placed on the skin may relieve the pain of angina pectoris. Since nitroglycerin lowers the blood pressure it should be given with the victim lying or sitting. It usually produces a stinging sensation under the tongue and may cause a headache. If cardiac symptoms persist for more than 5 to 7 minutes following rest and nitroglycerin, EMS should be activated. If a patient begins to experience cardiac arrest or failure, CPR should be initiated until emergency personnel arrive. When you telephone for help, tell the dispatcher:

1. You have a patient who needs immediate emergency care and give explicit instructions for reaching the front door of the Optometry building through U of H entrance #2.
2. The telephone number from which you are calling.
3. How many persons need help?
4. What the apparent problem seems to be.
5. The condition of the patient.
6. What is being done for the patient?

Always hang up last, allowing the dispatcher to hang up first. After summoning an ambulance, notify campus police (713-743-3333) of the occurrence at the Optometry building.

Someone should be appointed to meet emergency personnel curbside and direct them immediately to the appropriate area of the building.

The minor surgery room is equipped to handle emergencies of all types. A complete resuscitation kit, oxygen, EKG monitor, surgical gurney, etc., are all available. This equipment may be carefully moved to another area in the clinic if the patient cannot be safely transported to the minor surgery room.

All emergency cases should be documented by filing an incident report to the Executive Director of the UEI.
Management of Acute Angle Closure Glaucoma

Acute angle closure glaucoma should be regarded as a medical emergency. Therapy should be directed at rapidly reducing the intraocular pressure and in opening the angle. Both medical and laser treatment play a role in opening the angle and in eliminating pupillary block.

Dilation in eyes with shallow anterior chambers and narrow angles is a calculated risk. Before instilling mydriatic drops, the patient's medical history should be critically reviewed. Special note should be made of any underlying systemic diseases that would contraindicate the use of oral and/or topical medications employed to break the attack. The patient's habitual medications must be researched to exclude potential drug interactions. The patient’s cardiovascular, volume, and pulmonary status must be evaluated and their electrolyte balance and renal function considered before dilation.

High risk patients should be dilated early in the day as angle closure is most likely to occur as the pupil slowly returns from the maximally dilated position. A rise in intraocular pressure typically occurs in one to three hours after installation of mydriatic drops. Forewarn the patient of the possibility of angle closure, dilate one eye only, and observe the patient until the pupil has returned to its near normal state. Adrenergic agents, especially 10% phenylephrine, carry a greater risk than mydriatics that paralyze the sphincter. Tropicamide is weakly cycloplegic, of short duration, and can usually be reversed with low concentration of pilocarpine. Thus tropicamide (preferably 0.5%) should be the drug selected in dilating this at risk patient population.

Symptoms of Angle Closure

In a complete angle closure, the eye is red and painful. The patient will often complain of hazy vision and see colored haloes around lights. The cornea will appear cloudy due to edema and the pupil will typically be mid-dilated and fixed. Some patients will experience significant nausea and abdominal distress due to autonomic stimulation.

Signs of Angle Closure

The critical signs of an angle closure attack are an occluded angle in the involved eye, acutely elevated intraocular pressure and corneal micro cystic edema. A rise of 2-4 mm Hg from the intraocular pressures taken before dilation is highly suspicious of early angle closure. Gonioscopic confirmation of angle closure is essential, since cycloplegics can cause an intraocular pressure rise in eyes with open angles, even in the absence of pigment liberation.

When Angles Close

There is no absolute "cookbook" method for managing every angle closure attack. Each case should be evaluated and handled on an individual basis. Listed below are guidelines for an angle closure attack.

1. Examine the affected eye and the fellow eye.
2. Gonioscope both anterior chamber angles (gonioscopy of an edematous cornea may predispose to a corneal abrasion). Gonioscopy of the involved eye after the IOP is lowered is essential in determining whether the angle has indeed opened.

3. Instill 1 drop of a topical beta-blocker (levobunolol 0.5% or timolol 0.5% x 1) and 1 drop of topical alpha-adrenergic agonist (e.g. apraclonidine 0.5%). Beta-blockers may cause bradycardia, hypotension, and/or exacerbate congestive heart failure. They are also known to produce increased airway resistance and may be contraindicated in severe diabetics.

4. Administer an oral carbonic anhydrase inhibitor. Acetazolamide (250-500mg p.o.) is highly effective and can open some closed angles even in the presence of ischemic iris atrophy and paralysis of the pupil. Because acetazolamide is a sulfonamide, there is a chance of sensitivity with sulfa allergies. CAI's can produce a metabolic acidosis and may also induce a sickle cell crisis in patients with sickle cell anemia.

5. After these measures, reassess the ocular findings in one hour. The intraocular pressure is usually decreased but the angle may remain appositionally closed. One drop of 1%-2% pilocarpine is given and the patient re-examined 30 minutes later.

   a. If the intraocular pressure is reduced and the angle is open, the patient may be treated medically with topical low dose pilocarpine (1%-2%), beta-blockers, topical steroids, and oral acetazolamide if necessary until the eye is quiet and laser iridectomy can be performed.
   b. If the intraocular pressure is unchanged or elevated and the angle remains closed, lens related angle closure should be suspected, further pilocarpine withheld, and the attack broken by laser therapy.

Other Treatment

Physical methods have been reported to be successful in treating acute angle closure. Indentation of the central cornea with a Zeiss four mirror lens, cotton tip applicator, or muscle hook will force aqueous humor peripherally and may open the angle temporarily. This procedure may be quite uncomfortable for the patient.

Angle-closure glaucoma is associated with a marked inflammatory reaction. The instillation of 1% prednisolone or 0.1% dexamethesone is desirable to reduce inflammation before laser surgery. Severe pain may be treated with analgesics and vomiting may be controlled with anti-emetics. If vomiting is severe, hyperosmotic agents and carbonic anhydrase inhibitors must be given intravenously.

Follow Up

If the IOP drops significantly and the angle is determined to be opened by gonioscopy, definitive iridectomy is performed once the cornea is clear and the anterior chamber is quiet.
Guidelines for Use of Ophthalmic Drug Samples

- **Glaucoma**
  - Sample and dispense one bottle initially to evaluate the drug’s effect of intraocular pressure.
  - Write and issue a prescription after a successful follow up visit.
  - Write and issue a refill prescription on future follow up visits – **do not provide additional samples.**

- **Allergy**
  - Sample and dispense one bottle and a written prescription for new medications
  - Supply written refill prescriptions on subsequent visits
  - Do not sample returning allergy patients unless it is a new medication.

- **Anti-Infectives**
  - Sample one drop while the patient is in the chair to initiate therapy.
  - Write and issue the prescription.
  - Advise the patient to fill the script immediately.
  - Only provide a sample in extreme situations in which a patient cannot get to a pharmacy on the same day to fill the prescription.
  - **Never provide a sample without a prescription.**

- **Dry Eye OTC**
  - Sample and dispense one bottle of product during the eye examination and consider providing a written prescription for the product to enhance compliance.

- **Contact Lens Solutions**
  - Sample only one starter kit per patient each year and provide your written recommendation for the product your patient should purchase to increase compliance.
  - Do not give the patient multiple sample bottles.
  - Do not give the patient different sample starter kits or rewetting drops on the same visit.

- **New Pharmaceutical Products**
  - When an OTC or prescription pharmaceutical product is introduced, a sample might be used by a practitioner or achieve a level of clinical comfort with the product.
  - Dispensing of a sample should still generally be accompanied by a written prescription for the pharmaceutical, in the case of both OTC and prescription products.

Use your discretion in sampling in situations when it may be difficult for a patient to get to the pharmacy in a timely manner (weekends, late evening). To aid in compliance, consider calling in the prescription to the pharmacy on behalf of the patient.

### COMMON OPTOMETRIC ABBREVIATIONS

**History, Evaluation and Management**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMA</td>
<td>against medical advice</td>
</tr>
<tr>
<td>Hx</td>
<td>history</td>
</tr>
<tr>
<td>OHx</td>
<td>ocular history</td>
</tr>
<tr>
<td>FHx</td>
<td>family history</td>
</tr>
<tr>
<td>c/o</td>
<td>complains of</td>
</tr>
<tr>
<td>f/u</td>
<td>follow-up</td>
</tr>
<tr>
<td>cc, cve</td>
<td>chief visual complaint</td>
</tr>
<tr>
<td>LPE</td>
<td>last physical examination</td>
</tr>
<tr>
<td>HA</td>
<td>headaches</td>
</tr>
<tr>
<td>Dx</td>
<td>diagnosis</td>
</tr>
<tr>
<td>Fx</td>
<td>findings</td>
</tr>
<tr>
<td>Mx</td>
<td>management</td>
</tr>
<tr>
<td>Px</td>
<td>prognosis</td>
</tr>
<tr>
<td>Sx</td>
<td>symptoms</td>
</tr>
<tr>
<td>Tx</td>
<td>treatment</td>
</tr>
<tr>
<td>Rx</td>
<td>prescription</td>
</tr>
<tr>
<td>c, cc</td>
<td>with</td>
</tr>
<tr>
<td>s, sc</td>
<td>without</td>
</tr>
<tr>
<td>+</td>
<td>positive or present</td>
</tr>
<tr>
<td>-</td>
<td>negative or absent</td>
</tr>
<tr>
<td>WNL</td>
<td>within normal limits</td>
</tr>
<tr>
<td>r/o</td>
<td>rule out</td>
</tr>
<tr>
<td>WD</td>
<td>working distance</td>
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<tr>
<td>LV</td>
<td>low vision</td>
</tr>
<tr>
<td>LVA</td>
<td>low vision aid</td>
</tr>
<tr>
<td>RTC</td>
<td>return to clinic</td>
</tr>
<tr>
<td>CV</td>
<td>color vision</td>
</tr>
<tr>
<td>BP</td>
<td>blood pressure</td>
</tr>
<tr>
<td>S</td>
<td>subjective</td>
</tr>
<tr>
<td>O</td>
<td>objective</td>
</tr>
<tr>
<td>A</td>
<td>assessment</td>
</tr>
<tr>
<td>P</td>
<td>plan</td>
</tr>
<tr>
<td>IMP</td>
<td>impression</td>
</tr>
<tr>
<td>IOP</td>
<td>intraocular pressure</td>
</tr>
<tr>
<td>T</td>
<td>tonometry</td>
</tr>
<tr>
<td>TAP</td>
<td>tension by applanation (Goldmann)</td>
</tr>
<tr>
<td>NCT</td>
<td>noncontact tonometry</td>
</tr>
<tr>
<td>SLE</td>
<td>slit-lamp examination</td>
</tr>
<tr>
<td>DFE</td>
<td>dilated fundus examination</td>
</tr>
<tr>
<td>MIO</td>
<td>monocular indirect ophthalmoscopy</td>
</tr>
<tr>
<td>BIO</td>
<td>binocular indirect ophthalmoscopy</td>
</tr>
<tr>
<td>DO</td>
<td>direct ophthalmoscopy</td>
</tr>
<tr>
<td>VF</td>
<td>visual fields</td>
</tr>
<tr>
<td>ERG</td>
<td>electroretinogram</td>
</tr>
<tr>
<td>EOG</td>
<td>electro-oculogram</td>
</tr>
<tr>
<td>VEP</td>
<td>visually evoked potential</td>
</tr>
<tr>
<td>ODM</td>
<td>ophthalmodynamometry</td>
</tr>
<tr>
<td>OKN</td>
<td>optokinetic nystagmus</td>
</tr>
<tr>
<td>PST</td>
<td>photostress test</td>
</tr>
<tr>
<td>W4D</td>
<td>Worth 4 Dot</td>
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### Acuity

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>VA</td>
<td>visual acuity</td>
</tr>
<tr>
<td>PH</td>
<td>pinhole</td>
</tr>
<tr>
<td>NLP</td>
<td>no light perception</td>
</tr>
<tr>
<td>CF</td>
<td>counting fingers</td>
</tr>
<tr>
<td>HM</td>
<td>hand motion</td>
</tr>
<tr>
<td>LP</td>
<td>light perception</td>
</tr>
<tr>
<td>LPR, LP'</td>
<td>light projection</td>
</tr>
<tr>
<td>ND</td>
<td>neutral density</td>
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### Refraction

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>W, Hab</td>
<td>current (habitual) spectacle prescription</td>
</tr>
<tr>
<td>R</td>
<td>retinoscopy</td>
</tr>
<tr>
<td>M</td>
<td>manifest refraction</td>
</tr>
<tr>
<td>BVA</td>
<td>best visual acuity</td>
</tr>
<tr>
<td>PH</td>
<td>pin hole</td>
</tr>
<tr>
<td>PHNI</td>
<td>pin hole - no improvement</td>
</tr>
<tr>
<td>SM</td>
<td>simple myopia</td>
</tr>
<tr>
<td>SMA</td>
<td>simple myopic astigmatism</td>
</tr>
<tr>
<td>CMA</td>
<td>compound myopic astigmatism</td>
</tr>
<tr>
<td>SH</td>
<td>simple hyperopia</td>
</tr>
<tr>
<td>SHA</td>
<td>simple hyperopic astigmatism</td>
</tr>
<tr>
<td>CHA</td>
<td>compound hyperopic astigmatism</td>
</tr>
<tr>
<td>MA</td>
<td>mixed astigmatism</td>
</tr>
<tr>
<td>WRA</td>
<td>with-the-rule astigmatism</td>
</tr>
<tr>
<td>ARA</td>
<td>against-the-rule astigmatism</td>
</tr>
<tr>
<td>D</td>
<td>dioptrian</td>
</tr>
<tr>
<td>DS</td>
<td>dioptrian sphere</td>
</tr>
<tr>
<td>X, CX</td>
<td>axis of cylinder</td>
</tr>
<tr>
<td>K</td>
<td>keratometry</td>
</tr>
<tr>
<td>JCC</td>
<td>Jackson cross cylinder</td>
</tr>
<tr>
<td>FCC</td>
<td>fused cross cylinder (14B)</td>
</tr>
<tr>
<td>R-G</td>
<td>red-green</td>
</tr>
<tr>
<td>PL</td>
<td>plano</td>
</tr>
<tr>
<td>LIP</td>
<td>lens in phoropter</td>
</tr>
<tr>
<td>N</td>
<td>near</td>
</tr>
<tr>
<td>ACC</td>
<td>accommodation</td>
</tr>
<tr>
<td>AMP</td>
<td>amplitude of accommodation</td>
</tr>
<tr>
<td>PRA</td>
<td>positive relative accommodation</td>
</tr>
<tr>
<td>NRA</td>
<td>negative relative accommodation</td>
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### Binocular Vision

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>O</td>
<td>vertical orthophoria</td>
</tr>
<tr>
<td>CT</td>
<td>cover test</td>
</tr>
<tr>
<td>EP</td>
<td>esophoria at distance</td>
</tr>
<tr>
<td>EP'</td>
<td>esophoria at near</td>
</tr>
<tr>
<td>ET</td>
<td>esotropia at distance</td>
</tr>
<tr>
<td>ET'</td>
<td>esotropia at near</td>
</tr>
<tr>
<td>E (T)</td>
<td>intermittent esotropia at distance</td>
</tr>
<tr>
<td>E (T')</td>
<td>intermittent esotropia at near</td>
</tr>
<tr>
<td>XP</td>
<td>exophoria at distance</td>
</tr>
<tr>
<td>XP'</td>
<td>exophoria at near</td>
</tr>
<tr>
<td>XT</td>
<td>exotropia at distance</td>
</tr>
</tbody>
</table>
XT'  exotropia at distance
X (T)  intermittent exotropia at distance
X (T') intermittent exotropia at near hypotropia
HT    near point of convergence
NPC   interpupillary distance
PD, IPD accommodative convergence/accommodation ratio
VT    vision training or therapy
FD    fixation disparity
EF    eccentric fixation
NRC   normal retinal correspondence
ARC   anomalous retinal correspondence
AMBL  amblyopia
CON   constant
COM   comitant
NON-COM non-comitant

Anatomy

Conj  conjunctiva
AC    anterior chamber
PPM   persistent pupillary membrane
MG    Marcus-Gunn pupil
APD   afferent pupillary defect
A/V   arteriole to venule ratio
CRA   central retinal artery
CRV   central retinal vein
SVP   spontaneous venous pulsation
MR    macular reflex
/P, /A, /B, /D light reflexes graded as present, absent, bright, dim
RPE   retinal pigment epithelium
NFL   nerve fiber layer
ONH   optic nerve head
C/D   cup to disc ratio
DD    disc diameter
LCN   long ciliary nerve
EOM   extraocular muscles
SR    superior rectus
SO    superior oblique
IR    inferior rectus
IO    inferior oblique
LR    lateral rectus
MR    medial rectus

Contact Lenses

HCL    hard contact lens
SCL    soft contact lens
GPH    gas permeable hard
DW     daily wear
EW     extended wear
OAD    over all diameter
OZD    optical zone diameter
BC     base curve radius
SC     secondary curve radius
PC/W peripheral curve radius/width
K’s keratometry readings
HVID horizontal visible iris diameter
FLP fluorescein pattern
MVMT movement
WT wearing time
MWT maximum wearing time
RA residual astigmatism
TBUT tear break-up time
OR over-refraction
SA service agreement
NC no charge

Pathology
MERD meridional
DB diabetes
HTN hypertension (systemic)
CVD cardiovascular disorder
DR background diabetic retinopathy
PPDR preproliferative diabetic retinopathy
PDR proliferative diabetic retinopathy
NVM neovascular membrane
PRP panretinal photocoagulation
GTT glucose tolerance test
HTN hypertension
HR hypertensive retinopathy
RD retinal detachment
WWOP white without pressure
WWP white with pressure
ARMD age related macular degeneration
    /D, /W dry, wet
CNVM choroidal neovascular membrane
CSR central serous retinopathy
CME cystoid macular edema
ROP retinopathy of prematurity
AS arteriolar sclerosis
CRAO central retinal artery occlusion
CRVO central retinal vein occlusion
TIA transient ischemic attack
CVA cerebral vascular accident
IRMA intraretinal microangiopathy
CSME clinically significant macular edema
NVD neovascularization of the disc
NVE neovascularization elsewhere
SRNM subretinal neovascular membrane
HEM hemorrhage
TA temporal arteritis
GLC glaucoma
COAG chronic open angle glaucoma
CAG closed angle glaucoma
OHT ocular hypertension
LPI laser peripheral iridotomy
LTP laser trabeculoplasty
PAS peripheral anterior synechiae
PS posterior synechiae
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>CAT</td>
<td>cataract</td>
</tr>
<tr>
<td>PSC</td>
<td>posterior subcapsular cataract</td>
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<tr>
<td>ASC</td>
<td>anterior subcapsular cataract</td>
</tr>
<tr>
<td>NS</td>
<td>nuclear sclerosis</td>
</tr>
<tr>
<td>IOL</td>
<td>intraocular lens</td>
</tr>
<tr>
<td>ICCE</td>
<td>intracapsular cataract extraction</td>
</tr>
<tr>
<td>ECCE</td>
<td>extracapsular cataract extraction</td>
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<tr>
<td>KP</td>
<td>keratic precipitates</td>
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<tr>
<td>KCS</td>
<td>keratoconjunctivitis sicca</td>
</tr>
<tr>
<td>EE</td>
<td>epithelial erosion</td>
</tr>
<tr>
<td>SPK</td>
<td>superficial punctate keratitis</td>
</tr>
<tr>
<td>PEK</td>
<td>punctate epithelial keratitis</td>
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<tr>
<td>CCC</td>
<td>central corneal clouding (0 to 4+)</td>
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<tr>
<td>SEI</td>
<td>subepithelial infiltrates</td>
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<tr>
<td>FB</td>
<td>foreign body</td>
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<tr>
<td>EKC</td>
<td>epidemic keratoconjunctivitis</td>
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<tr>
<td>GPC</td>
<td>giant pupillary conjunctivitis</td>
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<tr>
<td>PVD</td>
<td>posterior vitreous detachment</td>
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<tr>
<td>AVD</td>
<td>anterior vitreous detachment</td>
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<tr>
<td>PHPV</td>
<td>persistent hyperplastic primary vitreous</td>
</tr>
<tr>
<td>RP</td>
<td>retinitis pigmentosa</td>
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</table>

**Pharmaceutical**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>DPA</td>
<td>diagnostic pharmaceutical agent</td>
</tr>
<tr>
<td>TPA</td>
<td>therapeutic pharmaceutical agent</td>
</tr>
<tr>
<td>OTC</td>
<td>over the counter</td>
</tr>
<tr>
<td>BAK</td>
<td>benzalkonium chloride</td>
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<tr>
<td>STAT</td>
<td>immediately</td>
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<tr>
<td>c</td>
<td>with</td>
</tr>
<tr>
<td>s</td>
<td>without</td>
</tr>
<tr>
<td>prn</td>
<td>as needed</td>
</tr>
<tr>
<td>ut. disct.</td>
<td>as directed</td>
</tr>
<tr>
<td>h</td>
<td>hour</td>
</tr>
<tr>
<td>hs</td>
<td>hour before sleep/at bedtime</td>
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<tr>
<td>d</td>
<td>day</td>
</tr>
<tr>
<td>q</td>
<td>every</td>
</tr>
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<tr>
<td>qd</td>
<td>every day</td>
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<tr>
<td>qod</td>
<td>every other day</td>
</tr>
<tr>
<td>bid</td>
<td>twice a day</td>
</tr>
<tr>
<td>tid</td>
<td>three times a day</td>
</tr>
<tr>
<td>qid</td>
<td>four times a day</td>
</tr>
<tr>
<td>ac</td>
<td>before eating</td>
</tr>
<tr>
<td>po</td>
<td>by mouth</td>
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<td>sol</td>
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</tr>
<tr>
<td>ung</td>
<td>ointment</td>
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