WELCOME TO OUR OFFICE

Patient Name: Last_______________ First_______________ MI_______ Salutation__________

Address_______________ City_______________ State______ Zip______________

Home Phone:_______________ Work Phone:_______________ Cell Phone:_______________

Soc.Sec.#_______________ Driver's License #:_______________ Email:_______________

Occupation/Grade: _______________ Date of Birth: _______________ Age: _____ Sex: M F

Employer/School: _______________ Employer's Address:_______________

Medical Doctor's Name and Group:_______________ Last Examination:____________

Spouse/Parent/Guardian Name: _______________ Soc.Sec.#:_______________ DOB:____________

Occupation: _______________ Spouse/Parent/Guardian Employer:_______________

In Case of Emergency, Contact:_______________ Relationship: _______________

Home Phone:_______________ Work Phone:_______________ Cell Phone:_______________

Whom can we thank for referring you to our office?

Please list all insurances, vision and medical.

	Vision Insurance	Primary Medical Insurance	Secondary Medical or Vision Ins.
Ins. Co. Name			
Insured's Name			
Identification No.			
Group No.			
Insured's DOB			
Insured's SS#			
Relation to Insured			

EYEGLASS HISTORY

Do you wear glasses? ☐ Yes ☐ No Full Time Part Time Computer Distance Near (please circle)

Computer Use ☐ Yes ☐ No Hours per day:______________ Distance from computer______________

Glasses owned (please circle) Single Vision Progressive Bifocals Trifocals Safety Glasses Sports Glasses Sunglasses Computer

Any problems with night vision or glare? ☐ Yes ☐ No

Do you wear sunglasses? ☐ Yes ☐ No

Are your sunglasses with your current prescription? ☐ Yes ☐ No

What would you like to do that you can not do with your current prescription? _______________

Would you like to be evaluated for refractive laser correction? ☐ Yes ☐ No

CONTACT LENS HISTORY

Do you currently wear contact lenses? ☐ Yes ☐ No

Have you ever worn contact lenses before? ☐ Yes ☐ No Reason for stopping:__________________

Do you have back up glasses with the correct prescription? ☐ Yes ☐ No

Answer only if you currently wear contact lenses:

What type? Rigid Gas Permeable Soft Ext Wear Color Brand: _______________

How old are your current lenses?______________ How often do you replace them? _______________

What solution do you use? _______________ Are they comfortable? ☐ Yes ☐ No

PLEASE TURN OVER

MEDICAL HISTORY

EYE HISTORY Do you have any of the following?

blurred vision	☐ Yes	☐ No
double vision	☐ Yes	☐ No
headaches	☐ Yes	☐ No
floaters/flashes	☐ Yes	☐ No
excess tearing	☐ Yes	☐ No
loss of side vision	☐ Yes	☐ No
dry eyes	☐ Yes	☐ No
itching	☐ Yes	☐ No

Do you or anyone in your family have?

	Self	Family	None
Cataracts	☐	☐	☐
Glaucoma	☐	☐	☐
Macular Degeneration	☐	☐	☐
Retinal Detachment	☐	☐	☐
Crossed/"lazy" eye	☐	☐	☐
Diabetes	☐	☐	☐
High Blood Pressure	☐	☐	☐
Color Blindness	☐	☐	☐

List any medications / herbals / over the counter drugs you are taking:	

Allergies to Medications: ☐ Yes ☐ No If yes, explain ______________________________

Any surgeries or major injuries? ☐ Yes ☐ No If yes, explain ______________________________

Are you pregnant and/or nursing? ☐ Yes ☐ No

SOCIAL HISTORY *This information is kept strictly confidential, but is required by some insurance plans. You may discuss this with the doctor if you prefer.*

If yes to any, explain type/amount/how long:

Do you use tobacco products? ☐ Yes ☐ No ______________________________

Do you use illegal drugs? ☐ Yes ☐ No ______________________________

Do you drink alcohol? ☐ Yes ☐ No ______________________________

Have you been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

REVIEW OF SYSTEMS Many diseases of the body have eye health consequences. Please answer the following:

Do you currently have any of the following problems?

Chronic fever, unexpected weight loss/gain, fatigue?		☐ Yes	☐ No
Ear/nose/throat	(e.g. hearing loss, sinus problems, sore throat)	☐ Yes	☐ No
Heart	(chest pain, irregular beat, swollen feet, cold hands/feet)	☐ Yes	☐ No
Respiratory	(shortness of breath, wheezing, coughing)	☐ Yes	☐ No
Gastrointestinal	(heartburn, abdominal pain, diarrhea, vomiting)	☐ Yes	☐ No
Genitourinary	(painful urination, blood in urine)	☐ Yes	☐ No
Musculoskeletal	(muscle aches, joint pain, swollen joints)	☐ Yes	☐ No
Skin	(rashes, excessive dryness, growths or lumps)	☐ Yes	☐ No
Neurological	(numbness, weakness, headaches, "blackouts")	☐ Yes	☐ No
Psychiatric	(depression, anxiety)	☐ Yes	☐ No
Endocrine	(frequent urination, thirst, feeling hot or cold all the time)	☐ Yes	☐ No
Blood/Lymph	(bruising, weakness, unusual paleness, swollen glands)	☐ Yes	☐ No
Allergy/Immune	(frequent infections, allergic reaction to food, dust, pollen)	☐ Yes	☐ No

Authorization release: I hereby authorize my insurance benefits to be paid directly to Eye Care West Optometry. **I realize I am financially responsible for all charges whether or not paid by insurance.** I authorize the use of this signature on all insurance submissions. I grant permission to contact my physicians and/or school to assist in my care.

Date	Initials

______________________________ ______________________

Patient/Parent/Guardian Signature Date

Carleton S. Fong, O.D. ● Anthony J. Huang, O.D.

Financial Policy and Privacy Policy Acknowledgement

We are committed to providing you with the best possible eye care. If you have medical insurance that covers eye care or other vision insurance, we will be glad to complete any forms you may have and assist you in obtaining your maximum allowable benefits.

Payment for services is due at the time the services are rendered. If services are provided to a minor, the presenting parent is responsible for any charges. When buying glasses or contacts, we require at least 50% of the purchase price to start the order. The remaining balance will be due within 30 days or upon dispensing of eyewear. We accept cash, check, Visa or MasterCard.

We are providers and accept assignment on several vision and medical plans as well as Medicare. This means that at the time of the examination, you will be responsible for any co-payments, deductibles or fees for non-covered services. We will bill and receive payment directly from your insurance company for covered services. You will be responsible for any remaining balance not paid by the insurance company. Please ask a staff member to verify if we are panel providers for your insurance plan prior to services.

If a referral is required to see us, it is your responsibility to obtain that referral prior to your examination. A referral with an authorization number is not a guarantee for payment by the insurance company. If you were not eligible for services at the time of the examination, your HMO, PPO or IPA may deny payment and you will be responsible.

Please realize that:

1. Your insurance is a contract between you, your employer and the insurance company.
2. Our fees normally fall within the acceptable ranges set by most insurance companies and are usually covered up to the maximum allowance set by each carrier. If this is not the case, you are still liable for any remaining balance.
3. Some select procedures are not considered covered services by some insurance companies, but may be necessary for your care and if performed, you will be responsible for these charges.

We emphasize that as eye care professionals, our relationship is with you and not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or your insurance coverage, please do not hesitate to ask. We are here to help you. Thank You!

My signature below attests that I have received, read, understand and agree to the Financial Policy above and that I have read, acknowledge and agree to Eye Care West Optometry O.C., Inc.'s Privacy Policy.

Signature: ____ Date: ____________

(Patient or Parent/Guardian if minor)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY. Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice).

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we must carry out in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA;
- [specify other uses and disclosures affected by state law].

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for heath care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION

The following are some specific uses and disclosures we may not make of your health information **without** your authorization:

Marketing activities. We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent to such payment.

Sale of health information. We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.

Psychotherapy notes. Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

- Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization.
- You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.
- We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.
- We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right:

- **To request restrictions on the health information we may use and disclose for treatment, payment and health care operations.** <u>We are not required to agree to these requests</u>. To request restrictions, please send a written request to us at the address below.
- **To receive confidential communications of health information about you in any manner other than described in our authorization request form**. You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.
- **To inspect or copy your health information.** You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.
- **To amend health information.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:
    - was not created by us, unless the person that created the information is no longer available to make the amendment,
    - is not part of the health information kept by or for us,
    - is not part of the information you would be permitted to inspect or copy, or
    - is accurate and complete.
- **To receive an accounting of disclosures of your health information.** You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).
- **To designate another party to receive your health information.** If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

<u>Contact Person:</u>

Our contact person for all questions, requests or for further information related to the privacy of your health information is: Carleton Fong

<u>Complaints:</u>

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown above. If you prefer, you can discuss your complaint in person or by phone.

<u>Changes to This Notice:</u>

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

Notice Revised and Effective: February 1, 2014

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Eye Care West Optometry OC, Inc., Notice of Privacy Practices.

Date _____________ Patient name_______________________________________ Signature ____