CENTER FOR SIGHT

First Name:________________________ Middle:____________ Last Name:____________________

☐ Male ☐ Female Birthdate:__________________ Social Security:__________________________

Home Phone:__________________ Work Phone:______________ Cell Phone:__________________

Home Address:_____________________________ City/State/Zip:__________________________

Email Address:_____________________________ Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐White ☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐Native Hawaiian/Pacific Islander

Emergency contact:_________________________ Relationship:_______________ Phone:___________

Primary Care Doctor:____________________________________ Phone:______________________

If Patient is a minor, Parent/Guardian's Name:___________________________ Birthdate:____________

Relationship to Patient:____________ Phone Number: _______________ Drivers' License: _____________

Social Security: _________________ Address:_________________ City/State/Zip:________________

FINANCIAL ACKNOWLEDGEMENTS

Please initial acknowledgement of the following:

_______ I understand all co-payments and deductibles are due at time of service.
_______ I have read/received a copy of Center for Sight's Notice of Privacy Disclosures.
_______ I understand there is a $25 fee for missed appointments or appointments canceled without notice.
_______ I understand my insurance may not cover all tests/services recommended by Center for Sight. If I choose to have these tests/services, I may be responsible to pay for these tests/services.

The insurance information I have given is accurate. I understand that it is my responsibility to notify Center for Sight if any change in insurance coverage takes place. I realize that by withholding the correct insurance information, including the required authorizations or referrals, I am financially responsible for payment should my claims be denied.

Patient/Guardian Signature:_______________________________________ Date:________________

CLAIMS AUTHORIZATION

I request that payment of authorized Health Insurance benefits (including Medicare) be made on my behalf to Center for Sight for services provided to me. I authorize the release of my medical information to the Centers for Medicare and MediCaid services and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If a claim form is submitted, my signature authorizes release of the information to the Insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and patient is responsible only for the deductible, coinsurance, and non-covered services. The coinsurance and deductible are based upon the charge determination carrier. I also understand that Medicare will not cover the refraction (measurement for glasses) portion of the examination. Therefore, I accept responsibility for payment.

Signature:____ Date:__________________

Patient Name:____Date:________________

Date of Birth:____________________________Primary Care Doctor:___________________________

Patient Phone Number:____

Please complete the following sections:

Do you wear glasses: ❑ No ❑ Yes If Yes since what year?_________Used for Distance / Near
Do you wear Contact Lenses: ❑ No ❑ Yes

Patient's Eye History (past surgeries or eye conditions): ❑ None

____

____

Patient's Eye Medication: ❑ None

____

____

Patient's Medical History, including ALL operations: ❑ None

____

____

Blood Relative Family History:

1. High Blood Pressure: ❑ No ❑ Yes If Yes, what relation?______________________
2. Glaucoma: ❑ No ❑ Yes If Yes, what relation?______________________
3. Diabetes: ❑ No ❑ Yes If Yes, what relation?______________________
4. Macular Degeneration: ❑ No ❑ Yes If Yes, what relation?______________________
5. Retinal Detachment: ❑ No ❑ Yes If Yes, what relation?______________________
6. Color Blindness: ❑ No ❑ Yes If Yes, what relation?______________________
7. Other Eye Condition ❑ no ❑ Yes If Yes, what relation?______________________

Please circle all that apply to the PATIENT:

1. Smoking Status: Former Current Never
2. Tobacco Use: Former Current Never

Allergies to Medications and reactions: ❑ No Know Medication Allergies:

____

____

____

Medications, including over the counter medications and vitamin/herbal supplements:

____

____

Blood Sugar (If known)_____________Date Last Taken:____________
Hemoglobin A1C__________________Date Last Taken:____________

(OVER)

Patient Name:____Date:________________

Please **CHECK YES OR NO;** If YES, circle all that apply to you:

❑ No	❑ Yes	**Constitutional (general health)**: ie: fever, fatigue, night sweats, weight gain/loss, insomnia, weakness. Other:________________
❑ No	❑ Yes	**Ear/Nose/Throat:** aches/ringing of ears, hearing loss, nasal congestion, nose bleeds, sinus problems, sore throat, vertigo. Other:________________
❑ No	❑ Yes	**Respiratory (lungs):** asthma, blood in sputum, cough, shortness of breath, TB exposure, wheezing. Other:________________
❑ No	❑ Yes	**Cardiovascular (heart):** calf pain with exercise, chest pain or pressure, hypertension (high blood pressure), irregular/rapid heart rate, leg swelling, palpitations, shortness of breath with exertion. Other:________________
❑ No	❑ Yes	**Gastrointestinal (stomach):** increased/decreased appetite, food intolerance, heart burn, jaundice, or trouble swallowing. Other:________________
❑ No	❑ Yes	**Genitourinary (urinary tract):** blood in urine, painful urination, urinary urgency, discharge Other:________________
❑ No	❑ Yes	**Integumentary (skin):** abnormal change in lesion, change in fingernails or hair, acne, skin rash or skin cancer, sores, warts, hives. Other:________________
❑ No	❑ Yes	**Endocrine (glands):** diabetes, hypo/hyper thyroid, increased thirst, bulging of eyes, heat/cold intolerance, mass in front of neck. Other:________________
❑ No	❑ Yes	**Neurological (nerves):** balance/memory problems, dizziness, fainting, vertigo, headaches, weakness, seizures, numbness of extremities, tremors, tingling. Other________________
❑ No	❑ Yes	**Psychological:** depression/anxiety, frequent nightmares, hallucinations, low mood, nervousness. Other________________
❑ No	❑ Yes	**Musculoskeletal (muscles/bones):** joint/back or muscle pain, stiffness/weakness, night cramps, easily broken. Other________________
❑ No	❑ Yes	**Hematological/Lymphatic (blood):** anemia, bleeding, blood transfusion, bruising, tender or enlarged lymph nodes. Other:________________
❑ No	❑ Yes	**Immunological (immune system):** seasonal allergies, hay fever, lupus, arthritis or rheumatoid arthritis. Other:________________

Patient/Guardian Signature:____

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 READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse protected health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of PHI by alterative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of October 1, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information, in person or in writing.

Center for Sight

I ____________________ (Parent/Legal Guardian) of ______________(Child's Name) consent to have ___________________ (Name) _______________ (Relationship) accompany and discuss any type of medical care for my child.

This consent is effective from: ______________________ to ______________________

Parent/Legal Guardian Name: ____

Signature: _____________________________ Date: _____________________________