Eye Designs VISION

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. SS#____/____/_____ Today's date ____/____/_____

Last Name_____ First_____ MI_____ Gender____ DOB____/____/_____

Address_____ Home Ph. (____)_____ Cell Ph. (___)_____

City_____ State____ Zip_____ E-mail_____

Occupation _____ Employer_____

Date of last eye exam _____ Were you dilated?_____ Referred by_____

Emergency contact name (s)_____ Phone number(s)_____

Personal Eye Information

Reason(s) for visit: ☐ Eye Exam ☐ First time contact lens fitting ☐ Update for current contact lenses ☐ Medical problem

Do you have any of the following? (circle all that apply or ____ check here if none apply)

Blurred Vision Glaucoma Cataracts Dry Eyes Macular Degeneration Retinal Detachment Flashes/Floaters

Do you have any other eye conditions or problems? yes/no Describe_____

Have you had any eye injuries or surgeries? yes/no Describe _____

Do you wear glasses? yes/no Contact Lenses? yes/no What type?_____

Do you use a computer? yes/no How many hours per day? _____ Additional Information_____

General Medical Information

Name of family doctor_____ Phone # (____)_____ Pregnant? yes/no

Do you have problems with any of these systems? (Please choose yes or no)

Cardiovascular (Heart) Yes / No	Urinary / Genital Yes / No	Endocrine (glands) Yes / No
High Blood Pressure Yes / No	Muscles / Bones Yes / No	Blood / Lymph Yes / No
Ears / Nose / Throat Yes / No	Integumentary (Skin) Yes / No	Allergic / Immunologic Yes / No
Respiratory (Lungs) Yes / No	Nervous System Yes / No	Headaches Yes / No
Gastrointestinal Yes / No	Psychiatric Yes / No	Eyes Yes / No

Please explain_____

Diabetes Yes / No Type _____Date of diagnosis _____

Allergies to medication? Yes / No Which? _____ Reactions?_____

Other health problems_____

Currents medication(s) (□ check if none) _____

Family History

High Blood Pressure Yes / No Relation _____ Macular Degeneration Yes / No Relation _____

Diabetes Yes / No Relation _____ Retinal Detachment Yes / No Relation _____

Glaucoma Yes / No Relation _____ Cataracts Yes / No Relation _____

Cancer Yes/No Relation_____ Other Yes/ No Relation_____

Dilation Information

It is our goal to provide a complete and thorough comprehensive eye examination. To effectively accomplish our goal, we feel it is important to dilate the pupils of your eyes. This will require placing drops in your eyes. As with many medications, there are some side effects of the drops used to dilate the pupil. These include sensitivity to light and blurred reading vision. In most cases, the distance vision will not be affected. The side effects usually last several hours but can, in some instances, last up to 24 hours. While we believe that dilation is an important part of the eye examination process, we understand that you may wish to defer or decline this procedure. Please indicate your preference below:

□ I wish to be dilated today.
□ I do not wish to be dilated at this time but will return for this procedure at a later date (there is no additional charge when you return for routine dilation within 90 days from your examination date).
□ I do not wish to be dilated and agree to hold Valerie Potter, O.D./ Victoria Melcher, O.D., harmless as a result of my actions.

HIPPA Compliance Acknowledgement of Receipt

I acknowledge that I received a copy of Valerie Potter, O.D./ Victoria Melcher. O.D., Notice of Privacy Practices.
Allow access to all patient records and information to: (none or full name/relationship):_____

Patient, Parent or Guardian Signature:__ _____ Date: _____/_____/_____

Financial Information

Payment for services is required at the time of service. To our patients with Medical and/or Vision benefits: We will be happy to file your insurance claim forms or take assignment on your medical/vision benefits. Plan(s) of which you state you are a member, we will do all we can to help you receive maximum benefits. However, in the event that the plan sponsor determines that you are not eligible for coverage at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you hereby agree to be financially responsible for any and all charges incurred by you and not paid by the plan sponsor.

Patient, Parent or Guardian Signature: _____Date: _____/_____/_____

If you are using insurance, please complete the following section:

Name of insurance _____

Primary insured's name _____ Relationship to patient _____

Policy # _____ Group # _____ Primary's DOB _____/_____/_____

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please read it carefully. The privacy of your health information is important to us.

Our Legal Duty: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We will use and communicate your health information only for the purpose of providing your treatment, obtaining payments and conducting health care operations.

USES AND DISCLOSURES OF HEALTHCARE INFORMATION:

To Provide Treatment: We will use and disclose your health information within our office to provide you with the best health care possible. This may include business office staff, assistants, opticians, physician assistants, nurses, and physicians. In addition, we may share our health information with referring physicians, laboratories, pharmacies, and other health care personnel providing you treatment, including contact lens and frame companies.

To Obtain Payment: We may use and disclose your health information to obtain payment for services, materials, and treatment you received in our office. We may do this with insurance forms filed for you by mail or send electronically.

Healthcare Operations: Your health information may be used during performance evaluation of our staff, training programs for students, interns, associates, and business and/or clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing or credentialing activities.

Appointment Reminders: Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time to contact us for an appointment. Additionally, we may contact you for follow up on your care and inform you of treatment options or services that may interest you or a family member. These may include postcards, folding cards, letters, telephone, voice mail, or email.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we believe a patient is a victim of abuse, neglect or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Public Health and National Security: We may disclose to Federal Officials or military authorities your health information required for lawful intelligence, counterintelligence, and other national security activities.

Law Enforcement: As permitted or required by State or Federal Law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends, and Caregivers: We may disclose your health information to a family member, friends, care giver, or other person who you tell us will be helping you with your home hygiene, treatment, medications, or payment. In case of an emergency, where you are unable to tell us what you want we will use our very professional judgment when sharing your health information. We will also use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, materials, or other similar forms of health information.

To Coroners, Funeral Directors, and Medical Examiners: We may be required by law to provide information about your health to coroners, funeral directors, and medical examiners for the purpose of determining a cause of death and preparing for a funeral.

Required by Law: We may use or disclose your health information when required to do so by law.

Your Authorization: Other than stated above or where Federal, State or Local Law requires us, we will not disclose your health information without your written authorization. You may revoke your authorization in writing at any time. Your revocation will not effect any use of disclosures permitted by your authorization while it was in effect.

PATIENT RIGHTS:

Access: You have the right to look or get copies of your health information, with limited exceptions (you must make a request in writing to obtain access to your health information). If you request copies, we will charge you a fee for each page, and per hour for staff time to locate, duplicate and assemble your copy, and postage if you request the copies to be mailed to you.

Documentation of Health Information: You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health care operations and certain other activities. Our documentation procedures will enable us to provide information form April 14, 2002 and forward. Please let us know in writing the time period for which you are interested. Your request must be limited to no more than six years at a time. We may charge you a reasonable fee for your request.

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative location. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location. We will make every effort to honor your reasonable request for confidential communications.

Amendments: You have the right to ask us to amend your health information. In order to standardize our process, please submit your request in writing and describe the reason for the change. Your request may be denied under certain circumstances.

Request a Paper Copy of this Notice: You have the right to obtain a copy of this Notice of Privacy Practices from our office at any time.

Complaints: If you think that we have not properly respected the Privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office of Civil Rights. We support your right to the privacy of your health information. If you want more information please contact our office.