Patient Demographic Information

Patient Information

Patient Name: _____ Preferred Name: _____
Last First Middle

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ May we send you text messages? Y N

Email: _____ (To receive appointment reminders, vision and health news and more, please update your email address. Your personal information is kept strictly confidential and never shared.)

Birth Date: _____ Social Security Number: _____

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Language: _____ Race: _____ Ethnic Group: _____

Preferred Pharmacy: _____
City Zip

Patient Employment Information

Occupation: _____ Employer: _____

Address: _____
Street City State Zip

Parent/Guardian/Power of Attorney Information (must be filled out for patients under 18)

Guarantor Name: _____ Relationship to Patient: _____
Last First MI

Guarantor DOB: _____ Guarantor SSN: _____

Address: _____
Street City State Zip

Guarantor Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient Insurance Information

Vision Insurance Name: _____ ID #: _____ Group #: _____

Medical Insurance Name: _____ ID #: _____ Group #: _____

Insurance policy holder: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other Insured SSN: _____

Name of Insured: _____ Insured DOB: _____
Last First MI

Insured Address: _____
Street City State Zip

Insured Phone: _____ Insured Employer: _____

Emergency Contact Information

Emergency Contact Name: _____ Relationship: _____

Phone Number: _____

Release and Assignment

I authorize the release of any information necessary to process my insurance claims and assign and request payment to my physicians. I understand that eligibility and/or benefits cannot be guaranteed, therefore all outstanding balances left after insurance reimbursement are my responsibility including collection and attorney fees.

Signature: _____ Date: _____

All eyeglass and contact lens prescriptions expire one year from exam date unless otherwise specified.

Patient History and Review of Systems

Patient Name: _____ DOB: _____/_____/_____

Height: _____ Weight: _____ Race: _____

What do you currently wear? Circle all that apply Eyeglasses Contact Lenses No correction

Please circle if *you* have a history of any of the following *medical* conditions:

Asthma	Diabetes	Hepatitis	HIV/AIDS	Hyperthyroid	Stroke
COPD	End stage renal disease	High blood pressure	High Cholesterol	Hypothyroid	None

Please list any past surgeries: _____

Please circle if *you* have a history of any of the following *eye* conditions:

Cataracts	Dry eyes	Macular degeneration	Strabismus	Floaters
Diabetic retinopathy	Glaucoma/suspect	Retinal tear/detachment	Vitreous detachment	None

Please list any *eye* surgeries or injuries: _____

Do you take any medications? Yes No **Please list *all* medications and dosages:** _____

_____

_____

Are you allergic to any medication? Yes No **If yes, please list the medication *and* give the reaction:**

_____

Do you smoke? Yes No **If yes, how often do you smoke?** Daily Some days

Do you use recreational drugs? Yes No **Do you use IV drugs?** Yes No

How often do you drink alcohol? None less than 1 drink/day 1-2 drinks/day 3 or more drinks/day

Do you feel safe at home? Yes No

Do you drive your car? Daytime only Drive night and day Do not drive

How often do you exercise? Several times/day once/day a few times/week a few times/month never

What is your caffeine use? Several times/day once/day a few times/week a few times/month never

Family History: Check all that apply *and* list the family member(s):

Diabetes_____	Heart disease_____	Macular Degeneration_____
Hypertension_____	Glaucoma_____	Retinal Detachment_____

Please circle if YOU have any of the following:

Poor vision	Diabetes Type 2	Amaurosis fugax	Upset stomach	Seizure
Vision loss	Diabetes Type 1	Fever	Diarrhea	Stroke
Floaters	High blood pressure	Chills	Constipation	Paralysis
Flashes of light	Asthma/COPD	Weight loss	Burning on urination	Anxiety/Depression
Eye surgery/injury	Wheezing	Stuffy nose	Urinary frequency	Insomnia
Glaucoma	Shortness of breath	Ear ache	Incontinence	Thyroid abnormality
Eye pain	Kidney disease/failure	Cough	Joint pain/stiffness	Bleeding
Tearing	Allergies	Dry mouth	Arthritis	Anemia
Redness	Jaw pain	Rapid heart beat	Rash	Hay fever
Headache	Scalp tenderness	Congestion	Changing moles	Hives

Please circle if YOU have any of the following alerts:

Allergy to latex	Artificial joints	MRSA	Rapid heartbeat with epinephrine
Allergy to adhesive	Blood thinners	Narrow angles	Pregnancy or planning pregnancy
Allergy to lidocaine	Defibrillator	Pacemaker	Pseudoexfoliation Syndrome
Artificial heart valve	Flomax	Premedication (prior to procedures)	Steroid responder

EYECARE PLUS
EYEGLASSES · CONTACTS · EYE EXAMS

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. WE ARE REQUIRED TO PROVIDE THIS NOTICE PURSUANT TO FEDERAL LAW, SPECIFICALLY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA").

This Notice of Privacy Practices (the "Notice") describes the privacy practices of Eyecare Plus ("ECP" "we" or "us") as they relate to maintaining the privacy of your health information ("Protected Health Information" or "PHI"), which is important to us. PHI is information about you, including basic information that may identify you and relates to your past, present, or future health or condition and the dispensing of pharmaceutical products to you. We take the responsibility for maintaining the privacy of your PHI very seriously.

Our Pledge Regarding Your Health Information

We are required by federal and applicable state law, regulations, and other authorities to protect the privacy of your PHI and to provide you with this Notice. Our staff is required to protect the confidentiality of your PHI and will disclose your PHI to a person other than you or your personal representative only when permitted under federal or state law. This protection extends to any PHI that is oral, written, or electronic, such as prescriptions transmitted by facsimile, modem, or other electronic device. This Notice describes how we may use and disclose your PHI. In some circumstances, as described in this Notice, the law permits us to use and disclose your PHI without your express permission. In all other circumstances, we will obtain your written authorization before we use or disclose your PHI.

This Notice also describes your rights and the obligations we have regarding the use and disclosure of your PHI. Under federal and applicable state law, we are required to follow the terms of the Notice currently in effect.

How We May Use and Disclose Your PHI Without Your Permission

Treatment, Payment or Health Care Operations

Below are examples of how Federal law permits use or disclosure of your PHI for these purposes without your permission:

1. **Treatment:** Dispensing medications. PHI obtained by ECP will be used to dispense prescription medications. We will document information related to the medications dispensed and services provided in your record. Patient Contacts. We may contact you to provide treatment-related services, such as refill reminders, treatment alternatives (e.g., available generic products), and other health related benefits and services that may be of interest to you.

2. **Payment:** We may contact your insurer, payor, or other agent and share your PHI with that entity to determine whether it will pay for your prescription and the payment amount. We may also contact you about a payment or balance due for prescriptions dispensed to you at ECP.

3. **Health care operations:** Service. Your PHI may be used to monitor the effectiveness of our services. Transfer. Your PHI may be transferred for purposes of carrying out the services if we buy another group practice or sell the group. Benefits/Research. We may also use your PHI to tell you about opportunities that may be of interest to you.

I HAVE RECEIVED A COPY OF THE "NOTICE OF PRIVACY PRACTICES" FROM EYECARE PLUS, WHICH EXPLAINS HOW MY MEDICAL INFORMATION WILL BE USED AND DISCLOSED. I UNDERSTAND THAT I AM ENTITLED TO RECEIVE A COPY OF THIS DOCUMENT.

SIGNATURE _____ DATE _____

RELEASE OF HEALTH INFORMATION

IF YOU WISH TO HAVE YOUR SPOUSE, FAMILY MEMBER, OR OTHER TO HAVE ACCESS TO YOUR PROTECTED HEALTH INFORMATION, PLEASE PROVIDE USE WITH THE NAME(S) OF THE PERSON(S) OR ENTITY.

1. NAME: _____ RELATIONSHIP: _____
2. NAME: _____ RELATIONSHIP: _____

PLACE AN (X) NEXT TO THE INFORMATION YOU ARE AUTHORIZING TO BE RELEASED TO THE ABOVE NAMED PERSON.

_____ ANY AND ALL INFORMATION
_____ MEDICAL RECORDS
_____ APPOINTMENT DATE AND TIME
_____ LAB TEST RESULTS
_____ FINANCIAL HISTORY

SIGNATURE OF PATIENT _____

BY SIGNING THIS FORM, I AUTHORIZE EYECARE PLUS TO USE AND DISCLOSE THE PROTECTED HEALTH INFORMATION AS DESCRIBED ABOVE. THIS AUTHORIZATION SHALL BE IN FORCE AND EFFECTIVE, UNTIL I REVOKE THIS AUTHORIZATION IN WRITING TO THE COMPLIANCE OFFICER.

EYECARE PLUS
EYEGLASSES CONTACTS EYE EXAMS

There are two types of health insurance plans that may help pay for your eye care services and products; you may have both types. Eyecare Plus accepts most insurance plans in both categories:

(1) Vision plans such as VSP, Eyemed, and Superior (2) Medical insurance plans such as Blue Cross/Blue Shield, Cigna, Aetna, and Medicare.

- Vision plans only cover routine vision wellness exams, along with eyeglasses and/or contact lenses. Vison plans do not cover medical eye care (the diagnosis, management or treatment of eye health problems).
- Medical insurance must be used for medical eye care.
- We may ask you for your medical ID card to bill your medical insurance, in addition to your vision insurance. The care provided by your eye doctor leads to continued quality vision, and can also help identify health conditions that are often best detected through an eye exam.
- If you have both types of insurance plans it may be necessary for us to bill some services to one plan and some services to the other. We will follow a procedure called coordination of benefits to file this properly to minimize your out-of-pocket expenses.
- If one of our Optometrist deems it necessary to run medical testing, they will discuss the procedures and what's being billed to your medical insurance with you.
- If some fees are not paid by your insurance, such as deductibles, co-pays or non-covered services as allowed by the insurance contract, we will bill them to you via mail.

Please provide your insurance cards to our front desk staff member so we can make a copy. We need to have your medical insurance card or Medicare card on file in case we should need it in the future for billing your insurance.

I have read and accept these policies

_____ _____

Patient signature (parent if child) Date