# PLEASE COMPLETE ALL PAPERWORK IN BLACK OR BLUE INK

## PATIENT INFORMATION

NAME:_____DOB_____AGE_____
*First* *MI* *Last*

_____ BIRTH SEX: M F
*Address* *City* *St* *Zip*

HOME # _____ CELL # _____ WORK #_____

**NOTE: Appointment reminders are sent via text and email. If you do not want reminders for either / both, you may "opt out" of receiving these messages after your initial text/email. If possible, we would appreciate having at least 2 phone numbers on file in case of emergency.**

EMAIL_____ MARITAL STATUS:_____

EMPLOYER:_____OCCUPATION_____

HOW DID YOU HEAR ABOUT US?_____

WHO IS YOUR OPTOMETRIST?_____ YEAR OF LAST EYE EXAM (estimate)?_____

MEDICAL INSURANCE NAME_____VISION INSURANCE NAME_____

PHARMACY NAME AND LOCATION_____

## DEMOGRAPHIC

**Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino **Language:** ☐ English ☐ Spanish ☐ Other

**Race:** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown ☐ Other

## PATIENT RELEASE FORM

The doctors / staff of Clear Advantage Vision Correction Center may release my medical information or answer questions about my care, either verbally or in writing, to the following: **(To grant us permission, please initial each appropriate answer and complete the blank)**

_____ **Family member(s)** – Name(s)_____
*(initials)*

_____ **Optometrist** or Name of Practice _____
*(initials)*

Address_____

Phone_____ **If the service was offered at no additional charge, would you be interested in seeing your optometrist for your follow up care after LASIK?* ☐ Yes ☐ No ☐ Not sure

_____ **Other** _____
*(initials)*

****** Due to HIPAA regulations, without your consent, we can't discuss anything about you with anyone, including confirming appointment times.***

**ABOUT YOUR EVALUATION:** Your appointment is to determine your candidacy for refractive procedures. Although the comprehensive evaluation will determine your prescription as well as your overall ocular health, this evaluation cannot be billed through your insurance company. Because the exam involves measurements specifically for refractive surgery, we will not be able to provide you with a prescription for glasses or contact lenses.

FOR OFFICE USE ONLY KT HV KS AB CML AMB _____

Treatment: ADVANCED OD/OS/OU MIXED OD/OS/OU MONO OD/OS PRK OD/OS/OU BLADELESS OD/OS/OU EVO VISIAN ICL OD/OS/OU EVO VISIAN TORIC ICL OD/OS/OU STUDY

SX Scheduled? Y N NAC _____ Eye(s) OD OS OU 15 20 1 _____

Call in RX / Given RX Follow up with regular OD? ___Yes ___No OD NAME_____

Is this a NEW patient? ___Yes ___No OD office_____

## MEDICAL HISTORY

What type of glasses do you wear? ☐ Distance ONLY ☐ Reading ONLY ☐ Bi-Focals ☐ Tri-Focal / Progressive ☐ None

Do you wear contact lenses? Yes* ☐ No** ☐

*** If YES:** What type? ☐ Soft ☐ Soft Toric or Astigmatism Correcting ☐ Hard / Gas Permeable

Number of years you have worn contact lenses? Years: _____

Were they mono-vision (one eye near, one eye far) or multi-focal lenses? Yes ☐ No ☐

In preparation for your exam today, what is the date or length of time you took out your contact lenses? Date:_____

*(**Note**: if you are having a <u>full</u> exam, you should be out of contact lenses prior to your evaluation: Soft=5 days / Toric=2 wks / Hard=8wks)*

****If NO:** Have you ever tried contact lenses? Yes ☐ No ☐

When you tried the lenses, how long did you wear them? _____years / months / days

What type were the lenses? ☐ Soft ☐ Soft Toric ☐ Hard / Gas Permeable

Have you ever had any prior eye surgery? If yes, please describe:

_____ ☐ None

Have you ever had an eye trauma (i.e. scratched cornea, something lodged in eye, etc.)? If yes, please describe:

_____ ☐ None

Have you ever been diagnosed with an eye condition / disease? (i.e. glaucoma, strabismus, keratoconus, lazy eye as a child, etc.)?
If yes, please describe:

_____ ☐ None

Any family history of eye problems (i.e. cataracts, macular degeneration, retinal detachment, etc.)? If yes, please describe and note your relationship to the individual (i.e. cataracts-grandmother, glaucoma-father, etc.)

_____ ☐ None

_____

Do you have any of the following? (Please check all that apply)

| | | |
|---|---|---|
| ☐ Diabetes (Type I) | ☐ Rheumatic disorders | ☐ Sleep using a CPAP mask |
| ☐ Diabetes (Type II) | ☐ Stomach ulcers | ☐ Auto-immune deficiencies (Lupus, HIV, colitis, etc.) |
| ☐ Pacemaker | ☐ Keloid scarring | ☐ Pregnant or actively trying to become pregnant** |
| ☐ Bleeding Disorders | ☐ Herpes Simplex / Zoster (i.e. Cold Sores or Shingles) | ☐ Breastfeeding** *(Please contact us prior to your appt if you are pregnant or breastfeeding)* |

☐ Other:_____ ☐ None

Do you smoke? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No
If yes, how many drinks per week?_____

Your height _____
Your weight_____

## MEDICATIONS

Are you taking any of the following (please indicate with a √ ):

☐ Prescription migraine medication (i.e. Imitrex or Accutane). If yes, date last taken:_____

☐ Blood thinners (i.e. Coumadin, Plavix, Warfarin) ☐ None

Please list any medications and the condition you are treating:

_____ ☐ None

_____

Any allergies to medications (i.e. latex, iodine, valium, antibiotics, steroids, etc.) If yes, please list:

_____ ☐ None

_____

# HIPAA CONSENT FORM

Our Notice of Privacy Practices provides information about our use of a patient's protected health information. The Notice contains a Patient Rights section describing your rights under the law. Patients have the right to access, inspect and copy protected health care information used to make decisions about them.

The Practice will only include information used to make decisions about the patient. This includes medical records, but does not include psychotherapy notes. Under some circumstances, such as increased risk of harm or injury, the Practice may withhold the requested information. The Privacy Officer of this Practice will evaluate this Request and notify the patient of our decision within fifteen (15) days of this Request. If the Request is approved, the Practice will provide the information within thirty (30) days or within sixty (60) days if such an extension is necessary. Reasonable costs will be charged for the Request. Costs will be submitted to the patient upon approval of the Request. The Practice may provide a summary of the requested information if you are agreeable. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA), including subsequent modifications to the HIPPA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Omnibus Final Rule.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full-length Notice is available in our office.

**Date of last revision: September 23, 2013** **Effective Date: Immediately**

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 understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information? Here are a few examples:

- For medical treatment
- To obtain payment for services
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and ensure all our patients receive quality care
- For research
- To avert a serious threat to health or safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain request arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our Office Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy your records
- The right to amend
- The right to an accounting of disclosures
- The right to an electronic copy of electronic medical records
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications
- The right to get a notice of a breach
- The right to restrict the disclosure to a health plan for those services for which you have paid out of pocket

**I acknowledge that I have been given access to, and/or received a copy of the Providers Notice of Privacy Practices with the effective date of September 23, 2013.**

**The information contained in this document is accurate to the best of my knowledge. Signing this also serves as your authorization for your patient release form on page 2.**

**Today's Date:_____/_____/_____** **Patient Date of Birth:_____/_____/_____**

_____ _____

**Printed name of person completing this form** **Signature / Patient Signature**