VISION 2020 P.L.L.C
OPTOMETRY

Patient Name: ______________________________ Sex M/F: ________

SSN:____________________ DOB: ______________ Race: ______________

Marital Status: ______________ Email: ______________________________

Home Phone: ______________ Work: ______________ Cell: ______________

Address: ____

City: ______________________________ State: ________ Zip: ______________

Spouse's Name/If child, Parent's Name: ______________________________

Patient's Employer or School: __________________ Occupation/Grade: ______________

Name of Person Responsible for Account: ______________ Employed By: ______________

Date of Last Eye Exam: __________ Doctor/Facility: ______________________

Primary Care Medical Doctor/Facility: ______________________________

Year of Last Physical Exam: ________ Phone Number of Primary Care: ______________

Please Indicate any of the following ocular problems you have had:

___Cataracts

___Glaucoma

___Lazy Eye

___Macular Degeneration

___Retinal Detachments

___Other

Any Eye Surgeries?

(if so, please include the dates)

Any Injuries to the Eye?

(if so, please include the dates)

If Female: Are you Pregnant: ________ **Have you had any history of seizures:** ________

Please check conditions which you have or are experiencing:

___ Abdominal

___ Liver Failure

___ Acne

___ Dizziness

___ Lupus

___ Allergies

___ Ear Pain

___ Multiple Sclerosis

___ Anemia

___ Easy Bruising/Bleeding

___ Nasal Congestion

___ Anxiety

___ Fever

___ Arthritis

___ Headaches

___ Skin Problems

___ Asthma

___ Hearing Loss

___ Sleep Apnea

___ Autoimmune Disease

___ Heart Palpitations

___ Sore Throat

___ Blood Clots

___ Heart Problem

___ Stroke

___ Thyroid Over-active

___ Carotid Artery Stenosis

___ High Blood Pressure

___ Thyroid Under Active

___ Chest Pain

___ High Cholesterol

___ Vomiting

___ Cold/Heat Intolerance

___ Joint Pain

___ Weight Loss

___ Confusion

___ Wheezing ___ Depression ___ Kidney Failure ___ Joint Swelling	___ Diabetes (*If so, whast type):* ______________________________ ___Cancer *(If so, what type):* ______________________________	___Hepatitis *(If so, what type):* ______________________________ Other:

Please indicate when you last had any of the following preventative test or services:
(If selected, please put the date or year it was completed)

___ Blood Sugar ___________

___ Blood Pressure ___________

___ Cholesterol ___________

___ Carotid Artery ___________

Please list any surgeries you have had, as well as where and when you've had them:

Surgery	Hospital/Facility	Date

Please select the information which applies best to you *(If indicated, please fill out the rest)*:

Tobacco:

Habits: _____ Never _____ Past _____ Current
If you selected never, move to the next substance:
Year started _____ if stopped, year stopped _____
Type: _____ Smoke _____Chew
Occurrences: _____ Packs/Day _____ Cans/Week

Alcohol:

Habits: _____ Never _____ Past _____ Current
If you selected never, move to the next substance:
Occurrences: _____ Drinks/Day or _____ Drinks/Week or _____ Drinks/Month

Caffeine:

Habits: _____ Never _____ Past _____ Current
If you selected never, move to the next substance:
Type: _____ Coffee _____ Tea _____Soda
Occurrences: _____ Cans/Day or _____ Cups/Day

Please select if you are on any of the following medications:

___Topamax:

Dose: ________

___Elmiron:

Dose: ________

___Flomax:

Dose: ________

___Prednisone:

Dose: ________

___Flonase:

Dose: ________

___Tamoxifem:

Dose: ________

___Hydroxychloroquine (Plaquenil) or Chloroquine:
If taken, fill out the HCQ Questionnaire on last page

Dose: ________

Please list all other medications you're on:

(include vitamins & over the counter medicine)
If more room is needed, bring/attach a copy of the medications.
If none, state "none"; if bringing a list, state "list"

Please select or list any major illness that you know of in your family members:
(Family members include Mother, Father, Brother, Sister, Grandparents, or Children)

_____ Cancer
_____ Cataracts
_____ Diabetes
_____ Glaucoma
_____ Heart Disease
_____ High Blood Pressure
_____ Kidney Disease
_____ Lazy Eye
_____ Liver Disease
_____ Macular Degeneration
_____ Retinal Detachments
_____ Thyroid Disease

Other: ____

Are you allergic to Latex? __________

List any other allergies or intolerances to drugs or other substances you might have:

Patient Signature (or Parent/Guardian): ________________________________ Date:______________

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;

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 AUTHORIZATIONFOR 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.

Contact Person:

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

____ ____

Name Address

Complaints:

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.

Changes to This Notice:

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: 6/23/2020

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Vision 2020, PLLC , Notice of Privacy Practices.

Date_____________ Patient name ____________________________

Signature (or Parent/Guardian) _________________________________

Financial Responsibility / Wavier Form

Positive verification of your coverage cannot always be made at the time of service. You will receive services with the understanding that in the event your coverage is not effective, you will be billed and held financially responsible for these services rendered.

____

Patient's Name Insurance Carrier

____

Subscriber's Name Employer/Group

____

Permanent Address Group Policy Number

____

City, State, Zip < Of Insurance > Telephone Number

I have read above and understand my possible financial responsibility of services rendered and herby sign my signature as an acknowledgment of this understanding.

____

Patient's Signature (or Parent/Guardian) Date

Contact Lens Prescription

I acknowledge that my eye care provider will be providing me my contact lens prescription at the end of my contact lens eye exam.

____

Patient's Signature (or Parent/Guardian) Date

HCQ Questionnaire

Only complete if you are taking Hydroxychloroquine or Chloroquine

Age: _____ **Weight** (important for medication dosage)**:** _________ **Date of Birth:** _______________

Race: ____American Indian or Alaska Native ____Native Hawaiian or Other Pacific Islander ____Asian

____Black or African American ____Caucasian

Primary Care Physician: _________________________ **Last seen:** ______

Referring /Specialty Dr. __________________________ **Last seen:** ______

Are you currently under the care of an ophthalmologist or optometrist?

____Yes ____No If yes, please include name and date last seen _______________________

Have you ever had ocular baseline testing done?

____Yes ____No ____Unsure

Which medication are you taking that you are being monitored for ocular toxicity?

____Chloroquine ____Hydroxychloroquine ____Other: __________________

Dosage: _______________________ **Duration:** ________________________

Why are you taking this medication?

____Lupus ____Rheumatoid Arthritis ____Other: _________________

Are you currently being treated or monitored for kidney disease?

____Yes ____No

Any recent major weight loss?

____Yes ____No

Are you also using the medication Tamoxifen (commonly used to prevent breast cancer)?

____Yes ____No

Any changes in your vision or color vision?

____Yes ____No If yes, please explain: __________________________________

Any changes seen with your at home Amsler grid testing?

____Yes ____No ____Unsure If yes, please attach Amsler with explanation ______________________