Eyecare For You

Welcome to Eyecare For You

13433 SH 249 (Tomball Parkway)
Suite #9
Houston, TX 77086-3170
281 272-2555 Fax: 281 272-2556
www.eyecareforyouonline.com

PATIENT INFORMATION

Last Name:	First Name:	MI:

Address:	Home Phone:
City, State, Zip:	Work Phone:

DOB:	Age:	SS #:	Sex: ☐ M ☐ F	Cell Phone:

Occupation:	Employer	☐ Full Time ☐ Part Time

Referred By:

Reason For Visit:	Date Of Last Eye Exam:

INSURANCE INFORMATION

Primary Insurance Holder/Parent Name

Vision Insurance:	Medical Insurance:

SS #	DOB:	Relation to Patient

HEALTH HISTORY (Please check all conditions that apply to you)

☐ Glaucoma	☐ Retinal hole or tear	☐ Previous Eye Infection	☐ Diabetes	☐ Thyroid Condition
☐ Cataracts	☐ Retinal Detachment	☐ Previous Eye Injury	☐ High Blood Pressure	☐ Pregnant or Nursing
☐ Macular Degeneration	☐ Lazy Eye	☐ Previous Eye Surgery	☐ Heart Condition	☐ Other

FAMILY HISTORY (Check if a relative has any of the following)

☐ Glaucoma	☐ Blindness
☐ Cataracts	☐ Diabetes
☐ Macular Degeneration	☐ Other

MEDICATIONS (List all medications you are currently taking)

Do you currently wear contacts? ☐ Yes ☐ No

ALLERGIES:

PRIMARY CARE PHYSICIAN:

Phone Number:	Fax Number:

DILATION & VISUAL FIELD TESTING

Dilation of the eyes allows the doctor to more thoroughly examine the inside of the eyes for problems such as glaucoma, cataracts, diabetes, high blood pressure, macular degeneration, and retinal holes, tears, or detachments. Side effects of dilation include sensitivity to light and slightly blurred vision (mostly near vision) lasting a few hours.

The Visual Field Analyzer is a computerized instrument that provides a more detailed examination of both your central and peripheral vision. Visual field screening assists in the early detection of glaucoma, retinal problems, and some neurological diseases such as brain tumors and optic nerve conditions. It may also diagnose causes of headaches.

We are committed to early detection and prevention of eye diseases. We strongly recommend these procedures to all of our patients as part of their yearly comprehensive eye exam. There is an additional fee of $38.00 for DILATION and $35.00 for the VISUAL FIELD TEST. Please check the appropriate boxes below:

☑ Yes, I want to have my eyes dilated. ☐ Yes, I want the visual field test performed.
☐ No, I do not want to have my eyes dilated. ☐ No, I do not want the visual field test performed.

Professional service fees are NON-REFUNDABLE and payment is due at the time of your visit.

Signature: ______________________________ Date: ______________
(patient or guardian)

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Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatments needed to restore your eye health and vision; therefore, if you have any questions or concerns about our payments policies, please do not hesitate to ask our office manager.

Please note:

- We are not responsible for any items left over 30 days.
- We will gladly adjust your glasses at no charge; however we are not responsible for any breakage.
- Glasses and contacts are custom made items, there is no refund.
- Deposits are required before all custom orders.
- Orders cannot be cancelled once they have been placed.
- We are not responsible for custom orders using patient's own outside frames.

Again, thank you for choosing us as your eye care provider. We appreciate your trust in us and the opportunity to serve you.

I acknowledge that I have read and understand the policy documented above.

Signature: ______________________________ Date: ________________

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Medical History

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Patient: ______________________ DOB: ______________ Date: ______________

Drug Allergies: ______________________________ Are you pregnant and/or nursing? ☐ Y ☐ N

Medications: ______________________________

List all major illnesses, injuries, surgeries, and/or hospitalizations: ______________________________

Do you have/had any eye disease/conditions (amblyopia, CAT, GLC, retinal disease, eye infections/injuries)?: ______________________________

____

REVIEW OF SYSTEMS

EYE

Distance Vision Blurry	☐ Y ☐ N	Floaters in Vision	☐ Y ☐ N	Itching	☐ Y ☐ N
Near Vision Blurry	☐ Y ☐ N	Distorted Vision	☐ Y ☐ N	Redness	☐ Y ☐ N
Intermed Distance Blurry	☐ Y ☐ N	Glare/Light Sensitivity	☐ Y ☐ N	Eye Pain/Soreness	☐ Y ☐ N
Double Vision	☐ Y ☐ N	Loss of Side Vision	☐ Y ☐ N	Eye Discharge	☐ Y ☐ N
Headaches	☐ Y ☐ N	Crossed Eyes	☐ Y ☐ N		
Flashes in Vision	☐ Y ☐ N	Dry Eyes	☐ Y ☐ N		

Constitutional (Fever, Weight Loss/Gain)	☐ Y ☐ N	Respiratory (Asthma, Emphysema)	☐ Y ☐ N
Skin	☐ Y ☐ N	Vascular (DM, Heart, HTN)	☐ Y ☐ N
Neurological (MS, Headaches, Seizures)	☐ Y ☐ N	Gastrointestional (Diarrhea, Constipation)	☐ Y ☐ N
Endocrine (Thyroid, Other Glands)	☐ Y ☐ N	Genitourinary (Kidney, Bladder)	☐ Y ☐ N
Psychiatric (Anxiety, Depression)	☐ Y ☐ N	Bones/Joints/Muscles (Arthritis)	☐ Y ☐ N
Ear/Nose/Throat/Mouth	☐ Y ☐ N	Blood/Lymph (Anemia, Cholesterol)	☐ Y ☐ N
		Allergic/Immunological	☐ Y ☐ N

SOCIAL HISTORY

Do you smoke? ☐ Y ☐ N
How much/ How long? ______________

Do you drink alcohol? ☐ Y ☐ N
How much/ How long? ______________

FAMILY HISTORY

Glaucoma	☐ Y ☐ N	Other Eye Disease	☐ Y ☐ N	Heart	☐ Y ☐ N
Macular Degeneration	☐ Y ☐ N	Cancer	☐ Y ☐ N	Other Systemic Disease	☐ Y ☐ N
Lazy Eye/ Eye Turn	☐ Y ☐ N	Diabetes	☐ Y ☐ N		
Blindness	☐ Y ☐ N	High Blood Pressure	☐ Y ☐ N		

Please explain all "yes" answers above:

____

____

____

Reviewed with patient: ______________________________ Date: ______________
Doctor's Signature

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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. PLEAES REVIEW IT CAREFULLY

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment, or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining you 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 visions 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 have to do 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

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. 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 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

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- 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" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS

We may call or write to remind you of schedule appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- asks us to restrict our uses and disclosures for purposed of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax, or e-mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using e-mail to your personal e-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax, or e-mail shown at the beginning of this Notice.
- Asks to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the other information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax, or e-mail shown at the beginning of this Notice.
- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to person who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax, or e-mail shown at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment, or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax, or e-mail shown at the beginning of this Notice.

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- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electrionically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax, or e-mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our website.

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 for Civil Rights. We will not retaliate against your 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 at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy Eyecare For You's Notice of Privacy Practices.

Patient Name ______________________________

Signature ______________________________ Date ______________________________

I give permission to share my medical information with:

______ Spouse/Other ______________________________

______ Voicemail

______ E-mail ______________________________