

BAYHEAD EYE CENTRE

Welcome To Our Office

Date: _____

Patient's Legal Name: _____ Nickname: _____ Mr. ___ Mrs. ___ Miss ___ Ms. ___

Spouse or Parent Name: _____ Mother's Maiden Name _____ Marital Status: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone (Home): _____ (Cell): _____ (Work): _____

E-mail Address: _____ Occupation: _____

Ethnicity: Asian _____ African American _____ Caucasian _____ Hispanic _____ Other _____

Birth Date: _____ Birth State: _____ Age: _____ Sex: M / F Preferred Language: _____

Family Physician Name: _____ Phone Number: _____

Do You Currently Wear Glasses? Y / N Contact Lenses? Y / N

Date of Last Eye Exam: _____ Dr.'s Name: _____

In Case Of Emergency Please Contact: Name: _____ Phone: _____

If this is your first visit, how did you hear of us? (Please Circle One)

Family Friends Doctor Advertising/Yellow Pages Passing by Insurance Other: _____

If referred, whom may we thank for the referral? _____

Vision Insurance: _____ *D.O.B. of Primary:* _____

Medical Insurance: _____ *S.S. # of Primary:* _____

PLEASE PRESENT YOUR INSURANCE CARD FOR US TO COPY FOR YOUR FILE.
PLEASE READ AND SIGN THE FOLLOWING:

Filing insurance claims is a service provided as a courtesy to our patients and in no way relieves patients of responsibility for payment. Patient is responsible for any balance not paid by the insurance company. Florida law requires insurance companies to pay within 30 days. It is the patients responsibility to resolve any conflict of benefits of payment.

HIPAA Privacy Disclosure: We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information. I authorize you to use or disclose my health information I am also acknowledging that I understand I may receive a paper copy with this authorization at my request.

Print Full Name: _____

Signature: _____ Date: _____

PRELIMINARY HISTORY

EHR Information: The electronic health record, or EHR, is a means of storing important patient information and electronic medical records. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations. EHR, technology represents a vast improvement over paper-based systems, and is changing the way healthcare is administered in medical practices.

GENERAL HEALTH

CURRENT VISION PROBLEMS

SELF		DURATION	FAMILY		CURRENT VISION PROBLEMS		
YES			YES - Relationship to You		YES	DURATION	
Glaucoma.....	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	Distance Blurry.....	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	Near Vision Blurry	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	Problems Seeing At Night	<input type="checkbox"/>	_____
Blindness.....	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	Frequent Headaches	<input type="checkbox"/>	_____
Lazy Eye.....	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	Double Vision	<input type="checkbox"/>	_____
Retinal Disease.....	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	Objects Floating In Vision	<input type="checkbox"/>	_____
Diabetes.....	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	Flashes Of Light.....	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	Eyes Itch/Burn/Water.....	<input type="checkbox"/>	_____
Thyroid.....	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	Red/Dry Eyes	<input type="checkbox"/>	_____
High Cholesterol	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	Eyestrain/Sore Eyes	<input type="checkbox"/>	_____
HIV⊕	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____	Matter Or Discharge.....	<input type="checkbox"/>	_____
Other Conditions	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____			

List Any Eye Surgery Or Injury _____

If Pregnant: Due Date _____

Height: _____ Weight: _____

Smoking Status: Current / Former / None / Number of years: _____

Allergies: _____

List All Current Medications:

Names:	Dose:	Times per day:	Medical Condition:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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;
- [specify other uses and disclosures affected by state law].

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 health 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 AUTHORIZATION FOR 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.** We are not required to agree to these requests. To request restrictions, please send a written request to us.
- **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. 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. 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. 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.

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 email 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.