Precision Eye Group
Medical/Eye History

Name _____ Birth Date _____

Medical Dr. _____ Pharmacy _____

Do YOU have any of the following (if so, please circle and explain)?
Genitourinary problems (bladder/Kidney) _____
Ear/Nose/Throat problems _____
Gastrointestinal problems _____
Musculoskeletal disorders _____
Heart Disease _____
Blood Disorders (anemia) _____
Allergies _____
Breathing problems (asthma/COPD) _____
Neurological disorders (MS/migraines) _____
Skin diseases (rosacea/eczema) _____
Psychiatric disorders (anxiety/depression) _____
Endocrine disorders (diabetes/thyroid) _____
Other _____

What, if any, medications are you allergic to?_____
Do you drive? _____YES _____NO Do you use tobacco? _____YES_____NO
Do you use recreational drugs?_____YES_____NO Do you use alcohol? _____YES_____NO
Have you ever had surgery? (if so, explain) _____
Have you ever been hospitalized? (if so, explain)_____
Have you ever had eye surgery? (if so, explain) _____
Are you pregnant?_____YES_____NO

Does anyone in your family (parents, maternal/paternal grandparents, aunts, uncles, siblings) have any of the following? (if so, please circle and list who)

Diabetes _____
High Blood Pressure _____
Heart Disease _____
Stroke _____
Lung Disease _____
Thyroid Disease_____
Cancer (what type?) _____

Does anyone in your family (parents, maternal/paternal grandparents, aunts, uncles, siblings) have any of the following? (if so, please circle and list who)

Cataracts _____
Glaucoma _____
Macular Degeneration _____
Lazy Eye _____
Dry Eye _____
Diabetic Retinopathy _____
Blepharitis _____

Please list all medications, including over-the-counter products, vitamins and nutritional supplements

_____

_____

_____

PRECISION EYE GROUP

PATIENT NAME _____ BIRTHDATE _____Title:
LAST FIRST M.I.

Mr. ☐
Mrs. ☐
Ms. ☐
Miss. ☐
Dr. ☐
Rev. ☐

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ EMAIL ADDRESS_____

PREFERRED CONTACT: HOME ☐ CELL ☐ WORK ☐ EMAIL ☐ SEX: MALE ☐ FEMALE ☐

PLACE OF EMPLOYMENT _____ OCCUPATION _____

STATUS: FULL TIME ☐ PART TIME ☐ UNEMPLOYED ☐ DISABLED ☐ STUDENT ☐ RETIRED ☐

MARITAL STATUS: SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐

ETHNICITY: HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐

Race:
Native American ☐
Alaska Native ☐
Asian ☐
African American ☐
Pacific Islander ☐
White ☐

PREFERERRED LANGUAGE_____

SOCIAL SECURITY NUMBER_____

HOW DID YOU HEAR ABOUT US_____

PERSON RESPONSIBLE FOR PAYMENT IF DIFFERENT FROM ABOVE

NAME _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ CITY _____ STATE_____

PHONE _____ SOCIAL SECURITY NUMBER _____ DOB _____

INSURANCE INFORMATION

INSURANCE NAME _____ INSURED'S NAME_____

INSURED'S EMPLOYER _____ INSURED'S BIRTHDATE _____

SOCIAL SECURITY NUMBER _____ MEDICARE NUMBER _____

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR INSURANCE AND/OR MEDICARE PAYMENT IS CORRECT. I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PAYMENT OF MY INSURANCE AND/OR MEDICARE BENEFITS, AND I AUTHORIZE PAYMENT OF THESE BENEFITS DIRECTLY TO PRECISION EYE CARE ON MY BEHALF FOR ANY SERVICES AND MATERIALS FURNISHED. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND IT'S AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE TO RELATED SERVICES. IF I HAVE OTHER HEALTH INSURANCE COVERAGE (AS INDICATED ON ITEM 9 OF THE HCFA-1500 CLAIM FORM OR ELECTRONICALLY SUBMITTED CLAIM), MY SIGNATURE AUTHORIZES RELEASE OF THE ABOVE MEDICAL INFORMATION TO THE INSURER OR AGENCY SHOWN, AND AUTHORIZES MY DOCTOR TO ACT AS MY AGENT, AS ABOVE. FURTHER, IT IS THE PATIENT'S UNDERSTANDING THAT HE/SHE IS RESPONSIBLE FOR ALL FEES OF PRECISION EYE GROUP NOT COVERED BY MEDICAL INSURANCE AND IN THE EVENT THAT A STATEMENT FOR FEES IS NOT PAID WITHIN THIRTY (30) DAYS OF THE DATE DUE, THE PATIENT SHALL BE FURTHER OBLIGATED TO PAY INTEREST ON ANY OUTSTANDING BALANCE AT THE RATE OF 18% PER ANNUM. REVISED MAY 2018.

SIGNATURE _____ **DATE** _____

PARENT/GUARDIAN ☐ POA ☐ CAREGIVER ☐ PATIENT NOT MENTALLY/PHYSICALLY CAPABLE OF SIGNING ☐

PRECISION EYEGROUP

About Your Vision Care Plan & Your Medical Insurance

There are two types of health insurance that will help pay for your eye health services and products. You may have both types and Precision Eye Group accepts most vision care plans and insurance plans in both categories: (1) vision plans and (2) medical insurance (such as Blue Cross/Blue Shield, Medicare and others).

- Vision Plans cover ONLY routine vision wellness exams and may include eyeglasses, sunglasses and contact lenses. Vision plans do NOT provide MEDICAL EYE HEALTH CARE NEEDS.
- Medical Insurance MUST be submitted for any medical eye healthcare diagnoses and treatment care and follow-up.
- If you have both vision care benefits and medical insurance plans, it may be necessary for us to submit and bill some services to one plan provider and some services to the other plan provider. We will follow a procedure called "Coordination of Benefits" to do this properly and to maximize your best advantage and least cost to you.
- Where some fees for services and products are not paid by your vision plan or medical insurance providers, you will be responsible for them, including deductibles, co-payments and non-provider services as specified by the insurance contract.

Please provide both your vision plan provider and medical insurance card(s) and identification, for your benefit, to our team member so we can make a copy. We will need your medical insurance or Medicare card on file in case we should need it in the future for submitting a claim on your behalf with your insurance.

☐ I have read and accept this office procedure.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Printed Name

Precision Eye Group
Notice of Privacy Practices
Effective date of notice: February 2018

3319 Lake Ariel Highway
Honesdale, PA 18431
570 – 253-6551

1409 Route 739
Dingmans Ferry, PA 18328
570-686-1102

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

General rule
We respect our legal obligation to keep health information, that identifies you, private. The law obligates us to give you notice of our privacy practices.
Generally, we can only use your health information in our office or disclose it outside of our office, without your written permission, for purposes of treatment, payment or healthcare operations. In most other situations, we will not use or disclose your health information unless you sign a written authorization form. In some limited situations, the law allows or requires us to disclose your health information without written authorizations.

Uses of Disclosures of Health Information
Examples of how we use information for **treatment** purposes:

- When we set up an appointment for you.
- When our technician or doctor tests your eyes.
- When the doctor prescribes glasses or contact lenses.
- When the doctor prescribes medication.
- When our staff helps you select and order glasses or contact lenses.
- When we show you low vision aids.
- When a doctor or vision therapist administers vision therapy.
- When office staff bills an account, receives phone calls and conducts business in and around front desk area.
- When we work with an ophthalmologist providing care to you.

We may disclose your health information outside of our office for **treatment** purposes, for example:

- If we refer you to another doctor or clinic for eye care or low vision aids or services.
- If we send a prescription for glasses or contacts to another professional to be filled.
- When we provide a prescription for medication to a pharmacist.
- When we phone to let you know that our glasses or contact lenses are ready to be picked up.
- When we work with an ophthalmologist providing care to you.

Sometimes we may ask for copies of your health information from another professional that you may have seen before.

We may use your health information within our office or disclose your health information outside of our office for **payment** purposes. Some examples are:

- When our staff asks you about health or vision care plans that you may belong to, or about other sources of payment for our services.
- When we prepare bills to send to you or your health or vision care plan.
- When we process payment by credit card and when we try to collect unpaid amounts due.
- When bills or claims for payment are mailed, faxed, or sent by computer to you or your health or vision plan.
- When we occasionally have to ask a collection agency or attorney to help us with unpaid amounts due.

We use and disclose our health information for healthcare operations in a number of ways. Health care operations mean those administrative and managerial functions that we have to do in order to run our office. We may use or disclose your health information, for example, for financial or billing audits, for internal quality assurance, for personnel decisions, to enable our doctors to participate in managed care plans, for the defense of legal matters, to develop business plans, and for outside storage of our records.

Appointment Reminders
We may call to remind you of scheduled appointments. We may also call to notify you of other treatments or services available at our office that might help you. We may call you to reschedule missed appointments.

Uses & Disclosures without an Authorization

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 happen at our office at all. Such uses or disclosures are:

- A state or federal law that mandates certain health information is reported for a specific purpose.
- Public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the 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, audits by Medicare or Medicaid, or any other insurance Precision Eye Group may participate in, or investigation of possible violations of healthcare 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 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 Services
- Disclosures relating to workers' compensation programs.
- A disclosure to business associates who perform healthcare operations for us and who agree to keep your health information private.

Other Disclosures

We will not make any other uses or disclosures of your health information unless you sign a written **authorization form.** You do not have to sign such a form. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it.

Your Rights Regarding Your Health Information

The law gives you many rights regarding your health information.

- You can ask us to restrict our uses and disclosures for purpose of treatment (except emergency treatment) payment or healthcare 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 Precision Eye Group, at the address shown at the beginning of this notice.
- You can 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 email 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 Precision Eye Group at the address shown at the beginning of this notice. If no special request is made, then it is to our understanding that the patient agrees to have their care and patient health information administered with current layout within our office.
- You can ask 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. Primarily, however, you will be able to review or have a copy of your health information within 30 days of asking us. 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 required. By law, we can have one 320-day extension of the time for us to give you access or photocopies if we sent you a written notice of the extension. If you want to a review or get photocopies of your health information, send a written request to Precision Eye Group at the address shown at the beginning of this notice.
- You can 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 persons 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 ament your health information, send a

written request, including your reasons for the amendment, to Precision Eye Group at the address shown at the beginning of this notice.

- You can get a list of the disclosures that we have made of your health information within the past six years (or for a shorter period if you want), except disclosures for purposes of treatment, payment or health care operations, disclosures made in accordance with an authorization signed by our, 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 Precision Eye Group at the address 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 in compliance with and 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 Practice, we will post the new notice in our office and have copies available in our office for you.

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 Precision Eye Group at the address 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 Precision Eye Group at the address or phone number shown at the beginning of this notice.

Privacy Officer is Dr. Matthew P. Corso, OD
Contact Officer is Patricia Spaulding

PRECISION EYEGROUP

Precision Eye Group

Medical Information Release Form
(HIPAA Release Form)

Patient Name_____ Date of Birth_____

Release of Information

☐ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

- ☐ Spouse/Significant Other_____
- ☐ Child (s) _____
- ☐ Parent/Guardian(s)_____
- ☐ Other _____

☐ Information is not to be released to anyone.

Patient Signature _____ Date_____

Parent/Guardian Signature (if patient is under age 18) _____

PRECISION EYEGROUP

Precision Eye Group

Patient Name _____ *Patient Phone* _____

Patient Address _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office. The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices***. You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our ***Notice of Privacy Practices***, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from Precision Eye Group.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Printed Name

If signed by legal representative, relationship to patient _____

□ Patient refused to acknowledge the Notice of Privacy Practices of Precision Eye Group.

Witness: _____