LaserVue EYE CENTER

PATIENT MEDICAL HISTORY / REVIEW OF SYSTEMS

Name _____ Today's Date _____ / _____ / _____

Birthdate _____ / _____ / _____ Age _____ Sex *M* *F* Social Security # _____ / _____ / _____

Address _____ City _____ State ____ Zip _____

Home Ph.# (_____) _____ Cell (_____) _____ Work (_____) _____

Email address: _____

Eye Doctor _____ Last Eye Exam _____ Dr.'s Phone _____

Medical Doctor _____ Last Medical Exam _____ Dr.'s Phone _____

Emergency Contact _____ Relationship _____ Phone _____

Medical History: Do you have any allergies to medications? ☐ no ☐ yes: _____

Contact Lens Use: none **SCL** _____ yrs **RGP** _____ yrs **Last date of CL Wear:**

List the medications you're taking with dosage & frequency (including over-the-counter and home remedies):

_____

_____

_____

List and date all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Circle any of the following conditions that you have been diagnosed with (current or past): crossed eye, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye infections or injuries.

Family History: Please note any family history (blood relatives; living or deceased) for the following:

CONDITIONS	**NO**	**YES**	**Unsure**	**RELATIONSHIP TO YOU / EXPLAIN**
Eye Injury	❑	❑	❑	_____
LASIK / PRK / RK	❑	❑	❑	_____
Glaucoma	❑	❑	❑	_____
Macular Degeneration	❑	❑	❑	_____
Retinal Detachment / Disease	❑	❑	❑	_____
Arthritis	❑	❑	❑	_____
Diabetes	❑	❑	❑	_____
Cardiovascular / Heart Disease	❑	❑	❑	_____
Kidney / Liver Disease	❑	❑	❑	_____
Thyroid Disease	❑	❑	❑	_____
Other(s): _____	❑	❑	❑	_____

---------- *CONTINUE ON BACK SIDE*----------

Doctor's Signature: _____ Date: / /

Social History *This information is kept strictly confidential. However you may discuss this portion directly with the doctor if you prefer.* ❑ Yes, I would prefer to discuss my social history information directly with my doctor. (check box)

Do you drive? ❑ no ❑ yes If yes, do you have visual difficulty when driving? ❑ no ❑ yes

Do you drink alcohol? ❑ no ❑ yes If yes, type / amount / how long: _____

Do you use recreational drugs? ❑ no ❑ yes If yes, type / amount/ how long: _____

Have you ever been exposed to or infected with: ❑ Gonorrhea ❑ Hepatitis ❑ Herpes ❑ HIV ❑ Syphilis

Hobbies: _____ Vision Interfering with Quality of Life? ❑ no ❑ yes Retired? ❑ no ❑ yes

REVIEW OF SYSTEMS Do **<u>you</u>** currently, or have you ever had any problems in the following areas:

SYSTEM	**NO**	**YES**	**?**
CONSTITUTIONAL			
Fever, Weight Loss / Gain	❑	❑	❑
INTEGUMENTARY (Skin)	❑	❑	❑
NEUROLOGICAL			
Numbness / Weakness	❑	❑	❑
Migraines	❑	❑	❑
Seizures	❑	❑	❑
EYES			
Loss of Vision	❑	❑	❑
Blurred Vision	❑	❑	❑
Distorted Vision / Halo	❑	❑	❑
Loss of Peripheral Vision	❑	❑	❑
Double Vision	❑	❑	❑
Dryness	❑	❑	❑
Itching / Burning	❑	❑	❑
Glare / Light Sensitivity	❑	❑	❑
Eye Pain / Soreness	❑	❑	❑
ENDOCRINE			
Thyroid / Other Glands	❑	❑	❑
IMMUNOLOGIC	❑	❑	❑
PSYCHIATRIC			
Anxiety / Depression	❑	❑	❑

	NO	**YES**	**?**
EAR, NOSE, MOUTH, THROAT			
Allergies / Hay Fever	❑	❑	❑
Sinus Problems	❑	❑	❑
RESPIRATORY			
Asthma	❑	❑	❑
Chronic Bronchitis	❑	❑	❑
Emphysema / COPD	❑	❑	❑
VASCULAR/CARDIOVASCULAR			
Diabetes	❑	❑	❑
Irregular Heartbeat	❑	❑	❑
High Blood Pressure	❑	❑	❑
Vascular Disease	❑	❑	❑
GASTROINTESTINAL			
Heartburn	❑	❑	❑
Chronic Diarrhea / Constipation / Vomiting	❑	❑	❑
GENITOURINARY			
Genitals / Kidney / Bladder (pain/discomfort)	❑	❑	❑
Rheumatoid Arthritis	❑	❑	❑
Muscle / Joint Pain	❑	❑	❑
LYMPHATIC / HEMATOLOGIC	❑	❑	❑
Anemia	❑	❑	❑
Bleeding Problems	❑	❑	❑

If you answered **YES** to any of the above or have a condition not listed, please explain on a separate page & list medications.

LaserVue
EYE CENTER

PATIENT FINANCIAL RESPONSIBILITIES AGREEMENT

We understand that health plan benefits are complex and unique for each subscriber. It is important and your obligation to be informed about your health insurance coverage, your benefits, coverage, deductibles, limitations and responsibilities. You are responsible for understanding your health plan coverage; however, we are here to help if you have any questions.

Payment is due in full at the time of service. We accept cash, most major credit cards & GreenSky/CareCredit patient financing. Please have your current insurance information available at the time of your visit to ensure that your claim can be processed. The patient/responsible party will be responsible for any difference between charges for services and insurance payment. Billing statements for balances due are payable upon receipt in full.

At LaserVue Eye Center you can expect to receive medical services in a caring and professional manner. We request that you keep scheduled appointments and arrive at the appointed time. If you are unable to keep you appointment, kindly give 24 hours notice. The doctors and staff at LaserVue Eye Center appreciate your confidence in allowing us to participate in your eye care.

I have received a copy of and given the opportunity to read my Patient Rights, Patient Responsibilities, and Disclosure of Ownership. _____*(initial).*

Your signature below indicates that you have read, understand, and agree to all of the financial terms and obligations set forth in this agreement.

Patient's Name: _____

Signature of Patient/Responsible Party: _____

Relationship to Patient: _____

Date of Review and Signature: _____

HIPAA NOTICE OF PRIVACY PRACTICES

LASERVUE EYE CENTER, A MEDICAL CORPORATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operation (TPO) and for other purposes that are permitted by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in you care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These include, but are not limited to quality assessment activities, employee review activities, training of medical students, licensing, marketing medical school students that see patients at our office. In addition, we may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues a required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; Organ Donation; Research; Criminal Activity; Military Activity; National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures: Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization at any time, in writing, except that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of or use in a civil, criminal, or administrative action or proceeding, and protected health information that is subject to laws that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends whom may be involved in your care or for notification purpose as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that your may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request and receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published or becomes effective on/or before April 1, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print
Name:_____Signature:_____Date:_____/_____/_____