LaserVue EYE CENTER

# *MEDICAL HISTORY*

Date: _____ / _____ / _____

Name: _____ DOB: _____ / _____ / _____ Age: _____ Sex: *M*☐*F*☐

Address: _____ City: _____ State: ____ Zip: _____

Phone: ( _____ ) _____ Email: _____

Eye Doctor:_____ Phone: _____ Last Eye Exam: _____

Medical Doctor: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Preferred Pharmacy: _____ Phone: _____

Whom may we thank for this referral? _____

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

**Medication Allergies?** ☐ None ☐ PCN ☐ Sulfa ☐ Codeine ☐ Iodine ☐ Latex
Other: _____

**List all medications you're taking with dosage & frequency** (including over-the-counter):

_____

_____

_____

**List all previous surgeries / procedures** (including year): _____

_____

_____

**Ocular History: (Mark all that apply)**

❑ Overall Healthy ❑ Amblyopia (Lazy Eye) ❑ Injury / Abrasion ❑ Glaucoma

❑ Cataract ❑ Corneal Disease: Keratoconus ❑ Crossed Eyes ❑ Retinal Disease / Detachment

❑ Dry Eye(s) ❑ Macular Degeneration ❑ Optic Neuritis **Other:** _____

**Ocular Surgeries: (Mark all that apply)**

❑ No prior ocular surgery ❑ LASIK / PRK / RK ❑ Cataract Surgery

❑ Corneal Transplant ❑ Glaucoma Surgery ❑ Strabismus / Muscle Surgery

❑ Eyelid Surgery ❑ Retina Surgery **Other:** _____

| Social History | | | |
|---|---|---|---|
| | **YES** | **NO** | **How much / How many years?** |
| Do you smoke? | ☐ | ☐ | |
| Do you consume alcohol? | ☐ | ☐ | |
| Other Substances: | ☐ | ☐ | |

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Do **YOU** have any problems in the following areas? If YES, please provide additional information.

| | | YES | NO | Details |
|---|---|---|---|---|
| **GENERAL** | fever, weight loss or gain, tiredness, etc. | ☐ | ☐ | |
| **EARS, NOSE, THROAT** | hearing loss, sinus problems, cough, etc. | ☐ | ☐ | |
| **HEART / CIRCULATION** | chest pain, irregular heartbeat, high blood pressure, extremity swelling, etc. | ☐ | ☐ | |
| **RESPIRATORY** | asthma, bronchitis, emphysema, etc. | ☐ | ☐ | |
| **GASTROINTESTINAL** | nausea, vomiting, diarrhea, constipation, etc. | ☐ | ☐ | |
| **GENITAL / URINARY** | frequent urination, kidney stones, etc. | ☐ | ☐ | |
| **FEMALES** | are you pregnant? nursing? | ☐ | ☐ | |
| **MUSCULOSKELETAL** | muscle / joint pain, arthritis, etc. | ☐ | ☐ | |
| **SKIN** | rashes, skin ulcers, etc. | ☐ | ☐ | |
| **NEUROLOGICAL** | stroke, headache, seizures, paralysis, etc. | ☐ | ☐ | |
| **PSYCHIATRIC** | anxiety, depression, insomnia, etc. | ☐ | ☐ | |
| **ENDOCRINE** | diabetes, thyroid, other glands, etc. | ☐ | ☐ | |
| **BLOOD** | anemia, bleeding problems, bruising, etc. | ☐ | ☐ | |
| **ALLERGIC** | environmental allergies, hay fever, etc. | ☐ | ☐ | |
| **IMMUNOLOGIC / STD** | lupus, rheumatoid arthritis, HIV / AIDS, herpes, hepatitis, syphilis, etc. | ☐ | ☐ | |

## Family History

**Have any blood relatives had the following** (mark all that apply)**?** ☐ **YES** ☐ **NO** ☐ **UNKNOWN**

☐ Glaucoma ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Cancer ☐ Thyroid Disease ☐ Arthritis

## Vision Questionnaire

| **Do you have difficulty, even with glasses, with these activities?** | **YES** | **NO** | **Details** |
|---|---|---|---|
| Reading small print or watching television | ☐ | ☐ | |
| Reading traffic signs while driving | ☐ | ☐ | |
| Seeing glare, halos, or poor dim light / night time vision | ☐ | ☐ | |
| Poor color vision | ☐ | ☐ | |
| Double vision | ☐ | ☐ | |

Do you have difficulty driving during the day due to your vision? ❑ None ❑ A little ❑ Moderate ❑ Severe

Do you have difficulty driving at night because of your vision? ❑ None ❑ A little ❑ Moderate ❑ Severe

***Cataract surgery can almost always be safely postponed until you feel you need better vision. If stronger glasses won't improve your vision any more, and if the only way to help you see better is cataract surgery, do you feel your vision problem is bad enough to consider cataract surgery now?***

☐ **Yes** ☐ **No**

Patient Signature: _____ Date: _____ / _____ / _____

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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 & CareCredit / Alphaeon 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 been 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: _____ / _____ / _____

# 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:_____/_____/_____