REVIEW OF SYMPTOM

PATIENT NAME: ____ **DATE:** ________________

Pleas mark **YES or NO** for any of the following medical conditions that you have and/or are taking medication to control.

	YES	NO		YES	NO	
HIGH/LOW BLOOD PRESSURE	[]	[]	BREATHING PROBLEMS	[]	[]	ASTHMA, COPD, EMPHYSEMA
CHOLESTEROL	[]	[]	HEART DISEASE	[]	[]	
THYROID/GOITER	[]	[]	DIABETIC Type ______	[]	[]	YEARS: ____________
GOUT/GERD/ACID REFLUX	[]	[]	ARTHIRTIS; WHERE______________________________			

PSYCHIATRIC (PLEASE CIRCLE) DEPRESSION, ANXIETY, BIPLOAR, Other:

____

AUTO IMMUNE CONDITION: MS, RA, LUPUS, SJORGREN'S, HIV POSITIVE, AIDS, Other:

____

Please list any additional health conditions not listed above, that you are currently being treated for:

____

____

CURRENT LIST OF MEDICATION:

____

____

____

ALLERGIES TO MEDICATION, PLEASE LIST NAME AND REACTION:

____

SURGICAL HISTORY EYES. PLEASE CHECK ALL THE APPLY

[] CATARACT SURGERY [] MUSCLE SURGERY [] LASIK/PRK/RK (CIRCLE PROCEDURE)

[] RETINAL SURGERY [] GLAUCOMA LASER / OTHER: ______________________________

SURGICAL HISTORY ON BODY: ____

____

SOCIAL HISTORY:

1. Are you or have you ever been a smoker? YES NO **Past smoker? When** did you quit __________.
   If yes, how many packs per day _________ for how many years _______________.
2. Alcohol use: YES NO How often _______________. Beer / Wine / Alcohol
3. Recreational drug use: YES NO If yes, what ________________________________.

Family History:

[] CATARACT WHO__________________. [] GLAUCOMA WHO____________________.

[] MACULAR DEGENERATION WHO __________________. [] DIABETES WHO ____________________.

REVIEWED (Initial and Date): ____

____

SWITCH EYE CENTER DEMOGRAPHIC FORM

NAME: ______________________________ AGE: __________
LAST FIRST MIDDLE INITIAL

ADDRESS: ______________________________

CITY: ______________ STATE: __________ ZIP: ________

HOME PHONE: ______________ CELL PHONE: ______________

DATE OF BIRTH: __________ SOCIAL SECURITY: ______________

RACE: __________ PREFERRED LANGUAGE: __________ SEX: MALE FEMALE

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDIWED

EMAIL ADDRESS: ______________________________

EMPLOYER: ______________________________
Company Name Address City State Zip Phone

EMERGENCY CONTACT PERSON: ______________________________
Name/Relationship Phone

*PRIMARY CARE PHYSICIAN: ______________________________
Name Phone

*PHARMACY: ______________________________
Name City Street Phone

INSURANCE INFORMATION:
(WE ONLY BILL MEDICALLY, WE DO NOT BILL ANY VISION INSURANCE. BOTH DOCTOR'S ARE SPECIALIST)

PRIMARY INSURANCE: __________ SUBSCRIBER: __________ DOB: __________

SECONDARY INSURANCE: __________ SUBSCRIBER: __________ DOB: __________

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NEEDED TO PROCESS ALL CLAIMS, AND I AUTHORIZE THE RELEASE OF PAYMENT FOR MEDICAL BENEFITS TO MY PHYSICIAN.

Patient or Legal Guardian Signature: ______________________________ Date: __________

Reviewed by patient. Initials/Date __________ __________ __________ __________

OFFICE FINANCIAL POLICY

1. There will be a charge for all services performed by the doctor in the office and/or the hospital. By allowing the doctor to care for you, you agree to pay for the services rendered. If you have an insurance with which we do not participate, you are expected to pay for your care at the time of your visit. **WE ACCEPT CASH, CHECK, VISA, MASTER CARD, AMERICAN EXPRESS, AND CARE CREDIT.** There will be an NFS fee on all returned checks, and cash payments will be required for all future transactions. Any procedures, which are performed, will be billed to your insurance company. If there are any co-payments or deductibles, your portion, will be billed to your insurance company. If the procedure is not covered by your insurance, you will be responsible for the entire fee. If you do not make full payment within 30 days of your billing statement, an additional $5.00 fee will be applied to your current balance, for every statement mailed.

2. **SURGERY:** If there are any co-payments or deductibles for surgeries to be performed, we may require payment prior to the date of surgery.

3. **MASTER MEDICAL POLICY:** All Master Medical patients are required to pay services in full on the service date. As a courtesy, we will file your Master Medical Claim, and the insurance company will reimburse you directly.

4. If payment is received by the office, for services that have been paid in full, a credit balance will be applied to your account or refund may be issued.

5. We reserve the right to charge a $10.00 fee for all disability and financial forms or patient records, etc., that are requested by the patient.

6. **REFERRALS:** Some insurance companies require written referral authorizations from your primary care physician **(i.e., AETNA/HAP/BLUE CARE NETWORK/HMO).** It is YOUR responsibility to make sure the proper referral has been received or brought with you on the day of your appointment. If you do not have your referral the day of your appointment, you may be asked to reschedule your appointment.

Patient Signature: ______________________________ Date: ______________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy pf the "Notice of Privacy Practices" for Switch Eye Center

Patient Name (Print): ______________________________

Patient Signature: ______________________________ Date: ____________

Signature of Patient Representative: ______________________________

(Required if the patient is a minor or an adult who is unable to sign this form for themselves.)

*LEGAL GUARDIAN

I approve the sharing of my medical billing information with the following:

Name: ______________________________ Relationship: ____________

Name: ______________________________ Relationship: ____________

Name: ______________________________ Relationship: ____________

DOCUMENTATION OF AN ATTEMPT TO OBTAIN

An attempt was made to obtain an "Acknowledgment of Receipt of the Notice of Privacy Practices"

On ____________________. The Acknowledgement was not obtained because

__________ THE PATIENT WAS UNDERGOING EMERGENCY TREATMENT/SURGERY.

__________ THE PATIENT DECLINED TO SIGN THE ACKNOWLEDGEMENT FORM.

__________ OTHER. ______________________________

(Required if the patient is a minor or an adult who is unable to sign this form for themselves.)

*LEGAL GUARDIAN

Notice of Privacy Practices

Effective January 1, 2013

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions please contact our office. We are required by law to: Maintain the privacy of your protected health information, give you this notice of our duties and privacy practices regarding health information about you, and follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION:

Described as follows are the ways we may use and disclose health information that identifies you (Health Information, or PHI). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to us and stating that you wish to revoke permission you previously gave us.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment. We may use and disclose Health Information so that we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment. However, if you pay for your services yourself (e.g. out-of-pocket and without any third party contribution or billing), we will not disclose Health Information to a health plan if you instruct us to not do so.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the care you receive is of the highest quality. Subject to the exception above if you pay for your care yourself, we also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operations.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you. We will not, however, send you communications about health-related or non health-related products or services that are subsidized by a third party without your authorization.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through an approval process. Even without approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising and Marketing. Health Information may be used for fundraising communications, but you have the right to opt-out of receiving such communications. Except for the exceptions detailed above, uses and disclosures of Health Information for marketing purposes, as well as disclosures that constitute a sale of Health Information, require your authorization if we receive any financial remuneration from a third party in exchange for making the communication, and we must advise you that we are receiving remuneration.

Other Uses. Other uses and disclosures of Health Information not contained in this Notice may be made only with your authorization.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or

problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

YOUR RIGHTS: You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to our office.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our office.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our office.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our office. ***We are not required to agree to all such requests.*** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing, to our office. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.____________________.com. To obtain a paper copy of this notice please request it in writing.

Right to Electronic Records. You have the right to receive a copy of your electronic health records in electronic form.

Right to Breach Notification. You have the right to be notified if there is a Breach of privacy such that your Health Information is disclosed or used improperly or in an unsecured way.

CHANGES TO THIS NOTICE: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

What is a refraction?

A refraction is a vision test that determines your best corrected visual acuity with eyeglasses. This is a measurement that a doctor or technician takes with an instrument called a phoropter that holds corrective lenses in front of your eyes. While you look at the eye chart, through the phoropter. The lenses are adjusted until the clearest vision is achieved. You may hear the doctor or technician say something like, "which lens is better, lens one or two", for example.

The test is usually performed on your first visit with us, your annual visit and anytime your vision drops significantly. The refraction is a vital test to help with the care of your eyes. It allows for assessment of your current eye health and detection of eye diseases. With it, we may provide you with a prescription for updated glasses or it may be required by Medicare and/or other insurance plans to determine if you qualify for a particular eye procedure such as cataract or laser eye surgery.

Will your insurance pay for a refraction?

Even though this is a vital test to care for the care of your eyes, the refraction is a non-covered service through Medicare and most medical insurance plans. Unfortunately, they do not differentiate between "medical refractions" and refractions performed solely for the purpose of providing glasses. We are required to charge for this service regardless of whether insurance pays.

There is a fee of $30.00 for this test that you will be asked to pay. **If and only when you decide to take the prescription for glasses.**

This is a routine charge at all MEDICAL and SURGICAL OPHTHALMOLOGY offices. We do not charge the patient for this test UNLESS they ask to have the eye glasses prescription that was determined by this test.

I UNDERSTAND THE DIFFERENCE BETWEEN ROUTINE (VISION EXAM) AND MEDICAL EYE EXAMINATION (DRS SWITCH AND RASANSKY ONLY DO MEDICAL EYE EXAMS).

Patient Signature: ______________________________ **Date:** ____________