FAMILY VISION CLINIC, P.C. Date _____

PATIENT INFORMATION

Thank you for choosing our practice for your eye care needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.
(Please Print)

Name_____ Birth Date _____ Gender: ❑ Male ❑ Female

Are You: ❑ Married - Spouse's Name _____ ❑ Single ❑ Widowed ❑ Divorced ❑ Separated

Address _____ City_____ State_____ Zip_____

Do you prefer to receive calls at (check all that apply): ❑ Home ❑ Work ❑ Cell ❑ Email

Do you give us permission to leave messages at above phone numbers: ❑ Yes ❑ No

Home phone # _____Work phone # _____ Cell phone # _____

Email: _____ ❑ Decline to provide

Preferred Language: ❑ English ❑ Spanish ❑ Other _____

Race: ❑ White ❑ Asian ❑ Black or African American ❑ Hispanic/Latino ❑ American Indian ❑ Native Hawaii or other Pacific Islander ❑ Unknown ❑ Other Race _____

Employer _____ Occupation _____

Employer Address _____ City _____ State _____ Zip _____

If you are a student, name of school/college _____ City _____ State _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone # _____

Family Physician: _____ Preferred Pharmacy _____

RESPONSIBLE PARTY

Name of person responsible for this account (if other than self):_____

Birth date _____ Relationship to patient _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work phone # _____

INSURANCE INFORMATION

The insurance that we will bill as courtesies to you are: Blue Cross/Blue Shield, VSP, UMR, Medicaid, Medicare and its affiliates. If you currently have coverage with one of the above insurance, please provide insurance cards to receptionist or continue below. Please be aware that your eyecare insurance carrier may pay less than the actual bill for services and materials and that you are ultimately responsible for the balance on the account.

Primary Vision Insurance: _____ Policy # _____ Group # _____

Policy Holder: _____ Relationship to Patient _____ Birth date _____

Last four numbers of Social Security # _____ Name of employer _____

DO YOU HAVE ADDITIONAL INSURANCE? ❑ No ❑ Yes IF YES, PLEASE COMPLETE THE FOLLOWING

Secondary Vision Insurance: _____ Policy # _____ Group # _____

Policy Holder: _____ Relationship to Patient _____ Birth date _____

Last four numbers of Social Security # _____ Name of employer _____

Patient Name: _____ DOB: _____ Today's Date: _____

Medical/Social History: The Federal Government has mandated that we collect certain information from you concerning your health history. Some of this information includes medication, allergies, health history, blood pressure etc. They ask that we also include information concerning your social history. Please help us comply with federal mandates by providing the information requested below:

Height: _____ Weight: _____

Alcohol Use: ☐ No ☐ Yes Amount _____ Tobacco Use: ☐ No ☐ Yes Type _____

If you smoke, please choose the option that best describes your use:

☐ Current some day smoker ☐ Current every day smoker ☐ Former Smoker ☐ Never smoked ☐ Unknown

---

Review of Systems: Put an "X" in box. S = Self F= Family

S	F	**Constitution**
☐	☐	Developmental Disability
☐	☐	Cancer: Type _____
☐	☐	Fatigue Syndrome
☐	☐	Other _____

S	F	**Ear, Nose, Throat**
☐	☐	Hearing Loss
☐	☐	Sinusitis
☐	☐	Dry Mouth
☐	☐	Laryngitis
☐	☐	Other _____

S	F	**Neurology**
☐	☐	Multiple Sclerosis
☐	☐	Epilepsy
☐	☐	Cerebral Palsy
☐	☐	Tumor
☐	☐	Stroke/CVA
☐	☐	Headache/Migraine
☐	☐	Other _____

S	F	**Psych**
☐	☐	Depression
☐	☐	Attention Deficit
☐	☐	Anxiety Disorder
☐	☐	Bipolar Disorder
☐	☐	Other _____

S	F	**Cardiovascular**
☐	☐	Hypertension
☐	☐	Stroke/CVA
☐	☐	Heart Disease
☐	☐	Vascular Disease
☐	☐	Congestive Heart Failure
☐	☐	Other _____

S	F	**Respiratory**
☐	☐	Asthma
☐	☐	Bronchitis
☐	☐	Emphysema
☐	☐	COPD
☐	☐	Sleep Apnea
☐	☐	Other _____

S	F	**Gastrointestinal**
☐	☐	Crohn's
☐	☐	Ulcer
☐	☐	Acid Reflux
☐	☐	Celiac Disease
☐	☐	Other _____

S	F	**Genito-Urinary**
☐	☐	Kidney Disease
☐	☐	Prostate Disease/Cancer
☐	☐	STD-herpetic/Chlamydia
☐		Pregnant
☐		Nursing
☐	☐	Other _____

S	F	**Muscle/Skeleton**
☐	☐	Osteoarthritis
☐	☐	Arthritis
☐	☐	Fibromyalgia
☐	☐	Muscular Dystrophy
☐	☐	Osteoporosis
☐	☐	Gout
☐	☐	Other _____

S	F	**Skin**
☐	☐	Rosacea
☐	☐	Psoriasis
☐	☐	Herpes Simplex/Cold Sore
☐	☐	Herpes Zoster/Shingles
☐	☐	Other _____

S	F	**Endocrine**
☐	☐	Type 2 Diabetes
☐	☐	Type 1 Diabetes
☐	☐	Thyroid Dysfunction
☐	☐	Hormonal Dysfunction
☐	☐	Other _____

S	F	**Hematologic/Lymphatic**
☐	☐	Anemia
☐	☐	Large volume blood loss
☐	☐	High Cholesterol
☐	☐	Other _____

S	F	**Allergy/Immune**
☐		Drug Allergies

Name(s): _____

_____

☐	☐	Environmental Allergies
☐	☐	Rheumatoid Arthritis
☐	☐	Lupus
☐	☐	Sjogren's syndrome
☐	☐	Other _____

Current Medications: _____

_____

Drug Allergies not listed above: _____

Have you ever had any of the following conditions involving your eyes?

☐ Eye surgery Type: _____ ☐ Eye injury Describe: _____

☐ Eye infection or disease: _____ ☐ Flashes/Floater ☐ Pain/Redness ☐ Double Vision

Do you wear ☐ Glasses ☐ Contact Lenses Are you interested in wearing contact lenses ☐ Yes ☐ NO

When do you wear your glasses? ☐ Full time ☐ Reading /near work ☐ Work safety ☐ Distance Only ☐ Computer ☐ Other

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature _____ Date _____

Signature of Patient or Responsible Party

Family Vision Clinic, P.C.

Richard P. Canestrini, OD
Todd E. Sholey, OD
Helen D. Kim, OD

544 Broadway
Rock Springs, WY 82901
Phone: (307) 382-3937
Fax: (307) 382-2918

Office Contact: Bernadette Legerski
FamilyVisionClinicPC @gmail.com

NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be to call a prescription into a pharmacist.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internalquality assessment review.

We may also create and distribute de-identified information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

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 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 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;
- 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 relating to worker's compensation programs;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 15, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office.

Please contact us for more information:

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1 -877-696-6775

FAMILY VISION CLINIC, P.C.

Patient Name: _____ Date of Birth: _____ Today's Date: _____

FINANCIAL POLICY

Thank you for choosing Family Vision Clinic, PC for your eye care needs. Please understand that payment for provided services and materials is due at the time they are rendered. We accept Cash, Checks, and Credit Cards (Discover, Visa or MasterCard)

IF YOU HAVE INSURANCE

When we are a Participating Provider, all applicable Co-Payments, deductible, materials, lens fittings and refractions charges which are not covered by your Insurance Company, are due at the time they are provided. **Refraction** tests are $34.00-$45.00 and are necessary to determine if you eye prescription has changed, or if glasses will be necessary to correct your vision. **Medicare** and many supplemental insurances DO NOT cover this test. All non-covered services will be the responsibility of the patient and are due at the time of service.

When we are NOT a Participating Provider, the patient is fully responsible for all charges. Your insurance policy is a contract between the insurance company and yourself. Please note that some, perhaps all of the services provided may be non-covered under the Medicare program.

Statement Charges and Collection Fees

All returned checks, regardless of reason, will be assessed a $30.00 fee and any additional collection expenses incurred to recover the original amount due for the services and/or materials supplied.

By signing below, I agree to pay all amounts owed within 30 days of when such amounts are incurred. I understand that it is my responsibility to provide my correct/updated insurance information. Regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. I agree that statement charges will accrue on all past-due amounts at the rate of $3.00 per month until paid in full. In the event any amount(s) is/are referred to a third party debt collection agency, I agree that I will be responsible for any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual from whom I have legal responsibility whether such amount(s) are incurred today or after today.

Signature _____ Date_____
Signature of Patient or Responsible Party

.....

HIPAA Disclosure

We are required to notify you of our privacy practices and have you sign that you have reviewed this information. Family Vision Clinic, PC maintains a record of each patient visit, describing your history, symptoms, exam findings, diagnosis, and suggested treatment. Medical records are needed to provide you with proper care, coordinate with other physicians involved with your care, and for communication with your insurance company. We do not share your personal medical information with any unauthorized entity without your permission. More details of our Notice of Privacy Practices may be found in our written publication.

I have been given a copy of Family Vision Clinic, PC's Notice of Privacy Practices, which describes how my health information is used and shared. I understand that Family Vision Clinic, PC has the right to change this notice at any time.

My Signature below acknowledges that I have read and understand the Notice of Privacy Practices.

Signature _____ Date_____
Signature of Patient or Responsible Party

I would like to share my medical information with the following person(s):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____