CENTER FOR
ADVANCED EYE CARE

NEW PATIENT HISTORY FORM

Date	Account number		
First name	Last name	Date of birth	
Address	City	State	ZIP
Sex	Marital status	Race	Ethnicity
Email address	Home phone	Cell phone	

EMERGENCY CONTACT

Name	Phone	Relationship

PRIMARY CARE PHYSICIAN

Name	Phone

REFERRED BY

Name	Phone

PHARMACY

Name	Phone		
Address	City	State	ZIP

Date of last eye exam

Do you wear ◯ Glasses ◯ Contacts

Reason for today's visit (symptoms)

List any significant eye conditions and surgeries with dates
(cataracts, macular degeneration, diabetic retinopathy, glaucoma, injuries to the eye, lasers, injections, lazy eye, crossed eyes, etc)

MEDICAL HISTORY - Have you ever had any problems in the following areas?

Diabetes	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Anemia	◯ Yes ◯ No
Degenerative arthritis	◯ Yes ◯ No	Hiatal Hernia	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No
Rheumatoid arthritis	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No	Sickle cell disease	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Skin Disease	◯ Yes ◯ No	Thyroid problems	◯ Yes ◯ No
Migraines	◯ Yes ◯ No	Kidney Disease	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No
Convulsions/seizures	◯ Yes ◯ No	Pregnant	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Stroke/paralysis	◯ Yes ◯ No	Congestive Heart Failure	◯ Yes ◯ No	Sarcoidosis	◯ Yes ◯ No
Parkinson's Disease	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Immune Problems	◯ Yes ◯ No
Multiple Sclerosis	◯ Yes ◯ No	Heart Attack	◯ Yes ◯ No	High cholesterol	◯ Yes ◯ No
Schizophrenia	◯ Yes ◯ No	Irregular/fast heartbeat	◯ Yes ◯ No	Cancer	◯ Yes ◯ No
Lupus	◯ Yes ◯ No	High blood pressure	◯ Yes ◯ No	Please specify:	

List any surgeries with dates

Patient name	Date of birth

Do you smoke or use tobacco? ☐ Never smoked/used tobacco ☐ Former smoker ☐ Unknown ☐ Current daily smoker ☐ Current heavy smoker ☐ Current casual smoker

Have you fallen in the last year? ◯ Yes ◯ No
If yes, how many falls in the last year? ________ Did the fall result in an injury? ◯ Yes ◯ No

REVIEW OF SYSTEMS - Do you presently have any problems in the following area? (Please select Yes or No)

CONSTITUTIONAL SYMPTOMS		CARDIOVASCULAR	
Fatigue	◯ Yes ◯ No	Chest pressure/discomfort	◯ Yes ◯ No
Fever	◯ Yes ◯ No	Irregular Hearbeat/palpitations	◯ Yes ◯ No
Night Sweats	◯ Yes ◯ No	Other	
Other		**GENITOURINARY (GENITALS/KIDNEY/BLADDER)**	
HEAD, EARS, NOSE, AND THROAT		Dysuria (painful urination)	◯ Yes ◯ No
Hearing Loss	◯ Yes ◯ No	Hematuria (blood in urine)	◯ Yes ◯ No
Other		Other	
RESPIRATORY (LUNGS/BREATHING)		**NEUROLOGICAL**	
Cough	◯ Yes ◯ No	Dizziness	◯ Yes ◯ No
Wheezing	◯ Yes ◯ No	Headaches	◯ Yes ◯ No
Other		Other	
GASTROINTESTINAL (STOMACH/INTESTINES)		**METABOLIC/ENDROCRINE**	
Constipation	◯ Yes ◯ No	Cold Intolerance	◯ Yes ◯ No
Diarrhea	◯ Yes ◯ No	Heat Intolerance	◯ Yes ◯ No
Vomiting	◯ Yes ◯ No	Polydipsia (excessive thirst)	◯ Yes ◯ No
Other		Polyphagia (excessive hunger)	◯ Yes ◯ No
MUSCULOSKELETAL		Polyuria (frequent urination)	◯ Yes ◯ No
Arthralgia (joint pain)	◯ Yes ◯ No	Other	
Gait disturbance	◯ Yes ◯ No	**PSYCHIATRIC**	
Joint swelling	◯ Yes ◯ No	Emotional Changes	◯ Yes ◯ No
Muscle weakness	◯ Yes ◯ No	Other	
Other		**ALLERGIC/IMMUNOLOGIC**	
HEMATOLOGIC/LYMPHATIC		Environmental allergies	◯ Yes ◯ No
Bleeding	◯ Yes ◯ No	Food allergies	◯ Yes ◯ No
Bruising	◯ Yes ◯ No	Other	
Other			
INTEGUMENTARY (SKIN)			
Rash	◯ Yes ◯ No		
Other			

COMMENTS:

Patient name	Date of birth

FAMILY AND SOCIAL HISTORY:

Eye Diseases	Relationship to patient	Medical Diseases	Relationship to patient	Medical Diseases	Relationship to patient
☐ Amblyopia (lazy eye)		☐ Arthritis		☐ Respiratory disease	
☐ Blindness		☐ Asthma		☐ Stroke	
☐ Cataracts		☐ Cancer		☐ Thyroid disease	
☐ Corneal Disease		☐ Circulatory disorders		☐ Tuberculosis	
☐ Glaucoma		☐ Diabetes		☐ Other	
☐ Macular Degeneration		☐ Heart attack			
☐ Retinal detachment		☐ Heart disease			
☐ Retinal disorders		☐ High blood pressure			
☐ Strabismus		☐ Kidney disease			

MEDICATIONS AND ALLERGIES:

List all eye medications you take (prescription and over the counter). Attach a list if necessary.

Name of Eye Medication	Dosage	Start Date

List all other (non-eye) medications you take (prescription and over the counter).
Attach a list if necessary.

Name of Medication	Dosage	Start Date

List all known allergies.
☐ Check here if you have no known allergies

Allergen	Reaction	Severity

Patient name	Date of birth

INSURANCE INFORMATION

VISION INSURANCE:	
Identification Number:	
Group Number:	
Subscriber Name:	
Relationship to Subscriber:	☐ Self ☐ Spouse ☐ Parent
Subscriber's Employer:	
Subscriber's Date of Birth:	
Social Security Number:	

Medical Primary Carrier:	
Identification Number:	
Group Number:	
Subscriber Name:	
Relationship to Subscriber:	☐ Self ☐ Spouse ☐ Parent
Subscriber's Employer:	
Subscriber's Date of Birth:	
Social Security Number:	

Medical Secondary Carrier:	
Identification Number:	
Group Number:	
Subscriber Name:	
Relationship to Subscriber:	☐ Self ☐ Spouse ☐ Parent
Subscriber's Employer:	
Subscriber's Date of Birth:	
Social Security Number:	

Individual Responsible for Payment

Name:	
Address:	
Phone Number:	
Relationship to Patient:	
Date of Birth:	

PLEASE NOTE:

If you are scheduled for a routine vision exam and the physician determines that there is a medical diagnosis, Center for Advanced Eye Care **CANNOT** bill this visit to your vision insurance plan. This visit will be billed to your medical insurance. We will bill your vision insurance for a refraction service should one be performed.

PATIENT 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.*

Center for Advanced Eye Care respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. We use and disclose your PHI for many different reasons. For some of these uses and disclosures, we need your specific authorization. Below, we describe the different categories of uses and disclosures.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Whenever we make an important change in our policies, we will promptly change this notice and post a new notice in public areas of our offices.

This notice is also on our website at www.centerforeyes.com.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations.

FOR TREATMENT:

Information obtained by a technician, physician or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.

- We may also provide information to others providing you care, except where the PHI is related to HIV/AIDS, genetic testing, or services from federally funded drug or alcohol abuse treatment facilities, or where otherwise prohibited pursuant to State or Federal law. This will help them stay informed about your care.

FOR PAYMENT:

- We request payment from your vision/medical health insurance plan. These plans need information from us about your medical care. Information provided to health plans may include your diagnosis, diagnostic tests performed or recommended care.
- We also may provide portions of your PHI to our billing staff and any management services organization we use to handle our billing to get paid for the health care services we provided to you.

FOR HEALTH CARE OPERATIONS:

- We use your medical records to assess and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We also may provide portions of your PHI to any management services organization we use to handle our operations.
- We may also provide your PHI to our accountants, attorneys, consultants, and others to make sure we're complying with the laws that affect us or for services they provide to our organizations.
- We may contact you to remind you about your appointments.

- We may use and disclose your information to conduct or arrange services, including:
    1. Medical quality review by your health plan
    2. Accounting, legal, risk management and insurance services
    3. Audit functions, including fraud and abuse detection and compliance programs
- All Other Uses and Disclosures Require Your Prior Written Authorization. Other than as stated herein, we will not disclose your PHI without your written authorization. You can later revoke your authorization in writing except to the extent that we have acted in reliance upon the authorization.
- Incidental Uses and Disclosures. Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure. However, such incidental uses or disclosure are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your PHI than is necessary to accomplish the permitted use or disclosure. For example, disclosures about a patient within the office that might be overheard by persons not involved in your care would be permitted.

YOUR HEALTH INFORMATION RIGHTS

The health care billing records we create and store are the property of Center For Advanced Eye Care. The protected health information in it, however, generally belongs to you. Under certain circumstances we have the right to deny you access. You have a right to:

- Receive, read and ask questions about this Notice;
- Restrict certain uses and disclosures. With the exception of the right to limit disclosures to insurers if you, as the patient, paid for the services, we are not required to grant the request. In this case, your medical records will be released directly to you;
- Request and receive from us a paper copy of the most current Privacy Policy Notice for Protected Health Information;
- Request that you be allowed to see and get a copy of your protected health information. This request must be in writing. We have a form available for this type of request. If you request a copy of your information, we reserve the right to charge reasonable fees for the costs of copying, mailing or other costs incurred by us in complying with your request, in accordance with applicable law.
- Have us review a denial of access to your health information.
- Ask us to change your health information. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payers. You may receive this information, as well as a copy of your health information, without a charge every 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us request in writing.
- You have the right to receive notification of a “breach” of your unsecured PHI.

For help with these rights during normal business hours, please contact:
Privacy Officer at (302) 485-0699

OUR RESPONSIBILITIES:

- Keep your health information private;
- Give you this notice;
- Notify you of a breach of unsecured protected health information;
- Follow the terms of this Notice.

We have a right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting one of our locations.

TO ASK QUESTIONS OR TO FILE A COMPLAINT:

If you have questions, want more information, or want to report a problem about the handling of your Protected Health Information, you may contact: Privacy Officer at (302) 485-0699

If you believe your privacy rights have been violated, you may discuss your concerns with the physician or the Privacy Officer. You may also deliver a written complaint to any Center For Advanced Eye Care location. You may also file a complaint with the U.S. Department of Health and Human Services via email at OCRComplaint@hhs.gov or through the mail at 200 Independence Ave., S.W.; Room 509F; HHH Bldg., Washington, DC 20201. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information

NOTIFICATION OF FAMILY AND OTHERS

- Unless you object, we may release health information about you to a friend or family member who is involved with your medical care. We may also give you information to someone who helps pay for your care. In addition, we may disclose health information about you to assist in disaster relief. If you object, we will not use or disclose it.

WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION AS FOLLOWS:

- Another physician within Center for Advanced Eye Care may review records for the purpose of random review as part of quality improvement.
- To Funeral Directors/Coroners
- To Organ Procurement Organizations
- To the FDA
- To comply with Workers' Compensation Laws; if you made a workers' compensation claim
- For Public Health& Safety purposes as allowed or required by law
- To report suspected abuse or neglect
- For Law Enforcement Purposes & to Correctional Institutions
- For work-related conditions that could affect employee health
- To the Military Authorities of U.S. & Foreign Military Personnel as required by law
- In the Course of Judicial Administration Proceedings at your request or as directed by a subpoena or court order.
- For Specialized Government Function
- Uses & disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

EFFECTIVE DATE OF THIS NOTICE: APRIL 30, 2021

CENTER FOR
ADVANCED EYE CARE

HIPAA PATIENT NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS & RESPONSIBILITIES ACKNOWLEDGEMENT

We keep a record of the health care services we provide to you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Privacy Officer at Center for Advanced Eye Care at (302) 485-0699.

Our ***Patient Notice of Privacy Practices*** describes in more detail how your health information may be used and disclosed, and how you can access your information.

Our ***Patient Rights & Responsibilities*** provides guidelines for your care in our facility and contact information for concerns.

By my signature below I acknowledge receipt of the Patient Notice of Privacy Practices and Patient Rights & Responsibilities.

PRINTED PATIENT NAME OR LEGALLY AUTHORIZED INDIVIDUAL	RELATIONSHIP TO PATIENT

SIGNATURE OF PATIENT OR LEGALLY AUTHORIZED INDIVIDUAL	DATE

PATIENT DATE OF BIRTH

This form will be retained in your medical record.

CENTER FOR
ADVANCED EYE CARE

CONSENT FOR DISCLOSURE

I understand that my healthcare information at Center for Advanced Eye Care is protected, and I have received a copy of their Patient Notice of Privacy Practices.

For Center for Advanced Eye Care to leave detailed messages on my voicemail or answering machine, I need to give permission to Center for Advanced Eye Care to do so.

CONSENT FOR LEAVING MESSAGES

I consent to information regarding my or my child's (under the age of 18) test results or detailed appointment reminders/instructions be left on my voicemail or answering machine. I understand that "sensitive" information as noted below will be excluded.

Patient Initials	

CONSENT FOR SHARED INFORMATION WITH FAMILY AND FRIENDS

I wish family members or friends to have access to my health care information. Name(s) listed below are family members to whom I grant access to my healthcare information through limited verbal disclosures.

Patient Initials	

NAME	RELATIONSHIP

I understand that some information is considered "sensitive". I understand that I must check the specific boxes in order for my provider, or his/her designee, to release any "sensitive" information.

- ☐ Mental Health/Psychiatric Disorders (including depression)
- ☐ Chemical Dependency (drug and/or alcohol abuse/treatment)
- ☐ Pregnancy Information
- ☐ Sexually Transmitted Diseases
- ☐ HIV/AIDS Virus

Patient Name (Print)	Date of Birth
Patient/Parent Signature	Date

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information up-to-date.

CENTER FOR
ADVANCED EYE CARE

FINANCIAL POLICY

Thank you for choosing Center for Advanced Eye Care for your eye care needs. We are committed to providing you with the best treatment available. The following is a statement of our Financial Policy.

All new patients must complete our patient registration forms before seeing the physician.

- *ALL CO-PAYS ARE DUE AT DATE OF SERVICE*
- *UNLESS WE ARE BILLING YOUR INSURANCE, PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE*
- *FOR YOUR CONVENIENCE WE ACCEPT CASH, CHECK, ALL MAJOR CREDIT CARDS AND CARE CREDIT*
- *RETURNED CHECKS ARE SUBJECT TO A FEE*

REGARDING INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will bill your insurance plan for you if you provide us with the correct information. ***Please be aware that some of the services offered may be a non-covered service or not considered medically necessary under your insurance plan.*** You, as the patient, are ultimately responsible for payment for all services provided by Center for Advanced Eye Care. While payment is your responsibility, we will assist you in negotiating a settlement with your insurance company for any disputed claim.

PATIENTS WITH BOTH MEDICAL AND VISION COVERAGE: Your vision insurance is intended to provide you with a routine eye exam. If you are being evaluated for medical reasons (corneal disorders, diabetes, cataracts, glaucoma suspect, double vision, etc.), you are being provided with medical care. Typically, your vision company does not provide coverage for medical care. Therefore, we will file a claim with your medical insurance for visits related to medical complaints and problems. Your doctor will be able to answer any questions about your treatment.

MEDICALLY NECESSARY CARE: We will only provide you with a service if we consider it medically necessary. We routinely perform diagnostic tests, which some insurance carriers will not cover. Therefore, if your insurance company arbitrarily determines that a service, we have rendered to you is not a covered benefit, you will be responsible for the bill.

Printed Name	Date of Birth
Patient Initials	Date

ASSIGNMENT OF BENEFITS

I request the payment of authorized Medicare or other insurance company benefits to be made on behalf of me or my dependent(s) to Center for Advanced Eye Care for any services rendered. Regulations about Medicare assignment of benefits apply. Center for Advanced Eye Care accepts Medicare Part B assignment.

I authorize Center for Advanced Eye Care to release medical or other information about me or my dependent(s) insurance carriers for related Medicare or other insurance company claims. I permit a copy of this authorization to be used in place of the original and request medical insurance benefits from the party who accepts the assignment. I understand that it is mandatory to notify the health care provider of any other party responsible for paying for me or my dependent(s) treatment. I agree to pay all fees for such treatment. I agree that I will not withhold or delay payments if Medicare or other insurance companies deny payment on any of my or my dependent(s) charges.

Signature	Date