Patient Information

Today's Date: _____

Rev: _____ *Initial:* _____ *Rev:* _____ *Initial:* _____

Patient Last Name: _____ Email: _____

Patient First Name: _____ Employer: _____

Parent/Guardian *(Last, First)*: _____ Occupation: _____

DoB: _____ Age: _____ Last 4 of SSN: _____ Insurance Company: _____

Marital Status: ☐ Single ☐ Married Subscriber Last Name: _____

Home Phone: _____ ☐ *Best contact #* Subscriber First Name: _____

Cell Phone: _____ ☐ *Best contact #* ID #: _____ Subscriber DoB: _____

Address: _____ Subscriber Address: _____

City: _____ ST: _____ Zip Code: _____ City: _____ ST: _____ Zip Code: _____

How did you hear about us?

☐ Insurance ☐ Web ☐ Friend/Family: _____

Medical History

Reason for today's exam: _____ Last Exam: _____

Allergies to medications: ☐ No ☐ Yes: _____

Current medications *(including contraceptives, aspirin, over-the-counter medications, and home or herbal remedies)*:

List any major injuries, surgeries, and/or hospitalizations you have had:

Identify any conditions that you have had:

☐ Cross-eyes ☐ Droopy eyelids ☐ Cataracts ☐ Eye Infections ☐ Eye Surgery:

☐ Lazy-eye ☐ Glaucoma ☐ Retinal Disease ☐ Eye Injury _____

Are you pregnant or nursing? ☐ No ☐ Yes

How long? _____

Hours per day in front of a computer: _____

Do you wear glasses? ☐ No ☐ Yes

How old is your current pair? _____

Do you wear contact lenses? ☐ No ☐ Yes

Type? ☐ Rigid ☐ Soft ☐ Disposable ☐ Ext. Wear

Are they comfortable? ☐ No ☐ Yes

How long? _____

Family History

Note any of the following family history *(including parents, grandparents, siblings, children, living or deceased)*:

Disease	N	Y	?	Relationship	Disease	N	Y	?	Relationship
Blindness	☐	☐	☐		Diabetes: ☐ Type I ☐ Type II	☐	☐	☐	
Cataracts	☐	☐	☐		Heart Disease	☐	☐	☐	
Crossed-Eyes	☐	☐	☐		High Blood Pressure	☐	☐	☐	
Glaucoma	☐	☐	☐		Kidney Disease	☐	☐	☐	
Macular Degeneration	☐	☐	☐		Lung Disease	☐	☐	☐	
Retinal Detachment/Disease	☐	☐	☐		Lupus/Auto-Immune Disease	☐	☐	☐	
Arthritis	☐	☐	☐		Thyroid Disease	☐	☐	☐	
Cancer: _____	☐	☐	☐		Other: _____	☐	☐	☐	

Social History

This information is kept strictly confidential. If you would prefer to speak directly with the doctor, check this box: ☐

Do you drive? ☐ No ☐ Yes Any visual difficulty when driving? ☐ No ☐ Yes *(describe below)*:

Do you use tobacco products? ☐ No ☐ Yes Type/amount/how long: _____

Do you use marijuana products? ☐ No ☐ Yes Type/amount/how long: _____

Do you drink alcohol? ☐ No ☐ Yes Type/amount/how long: _____

Do you use illegal drugs? ☐ No ☐ Yes Type/amount/how long: _____

Have you ever been exposed to/infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Review of Systems

Do you currently/have you ever had any SIGNIFICANT problems in the following areas:

	N	Y	?		N	Y	?
Fever, Weight loss/gain	☐	☐	☐	Cholesterol	☐	☐	☐
Integumentary (Skin)	☐	☐	☐	Diabetes	☐	☐	☐
Headaches	☐	☐	☐	Allergies/hay fever	☐	☐	☐
Migraines	☐	☐	☐	Sinus congestion	☐	☐	☐
Seizures	☐	☐	☐	Runny Nose	☐	☐	☐
Loss of vision	☐	☐	☐	Post-nasal drip	☐	☐	☐
Blurred vision	☐	☐	☐	Chronic cough	☐	☐	☐
Distorted vision/halos	☐	☐	☐	Dry throat/mouth	☐	☐	☐
Loss of side vision	☐	☐	☐	Asthma	☐	☐	☐
Double vision	☐	☐	☐	Chronic bronchitis	☐	☐	☐
Dry eyes	☐	☐	☐	Emphysema	☐	☐	☐
Mucous discharge from eyes	☐	☐	☐	Heart pain	☐	☐	☐
Red eyes	☐	☐	☐	High blood pressure	☐	☐	☐
Sandy/gritty feeling in eyes	☐	☐	☐	Vascular disease	☐	☐	☐
Itchy eyes	☐	☐	☐	Diarrhea	☐	☐	☐
Burning eyes	☐	☐	☐	Constipation	☐	☐	☐
Foreign body sensation in eyes	☐	☐	☐	Genitals/kidney/bladder	☐	☐	☐
Excess tearing/watering of eyes	☐	☐	☐	Rheumatoid arthritis	☐	☐	☐
Glare/light sensitivity	☐	☐	☐	Muscle pain	☐	☐	☐
Eye pain or soreness	☐	☐	☐	Joint pain	☐	☐	☐
Chronic infection of eye/lid	☐	☐	☐	Anemia	☐	☐	☐
Styes or chalizion	☐	☐	☐	Bleeding problems	☐	☐	☐
Flashes/floaters in vision	☐	☐	☐	Allergic/Immunologic	☐	☐	☐
Tired eyes/fatigue	☐	☐	☐	Depression/bi-polar	☐	☐	☐
Thyroid/other glands	☐	☐	☐				

If you answered YES to any of the above, or have a condition not listed, please explain and list any medications:

Doctor Signature: _____ **Date:** _____

Vision Care Center, PLLC, Nery C. Sison, O.D.
14700 NE 8th St., Suite 105, Belllevue, WA 98007
Ph. (425) 746-2122 Fax. (425) 746-1588
office@visioncarecenterpllc.com
Allison Mayer (office Contact Person)

Effective Date of Notice: May 1, 2020

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up appointments for you, testing or examining your eyes; prescribing glasses, contact lenses or eye medications and faxing or electronically sending them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care, vision therapy or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matter; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.
[We will ask for special written permission in the following situations: _____]

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all these situations will apply to us; some may neve 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 federal 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 other private insurances we participate with; or for investigation of possible violation 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;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- 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 foeign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

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

APPOINTMENT REMINDERS AND ORDER RECEIPT NOTIFICATIONS

We may call, text or email you to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call, text or email you to notify you of other treatments or services available at our office that might help you. We may also call, text or email you when your order for glasses or contact lenses have arrived and to set up an appointment for a dispensing time. Unless you tell us otherwise, if a text or email is not successful, we will leave a message on your home voicemail if you are not home and leave a message with someone who answers your phone regarding your annual recall reminder, or appointment reminder or order completion.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form'" is determined by federal law. This authorization form may be initiated either by you, the patient or guardian, or by our office, depending on who initiated the request. You may give us a properly completed authorization form or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice
- ask us to communicate with you in a confidential way, such as by phone you at work rather than at home, by mailing health information to a different address or by using email to your personal email address. We will accommodate these requests if they are reasonable and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or email shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or shorter period if you want). By law, the list will not include: disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or email show at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice. You may also download the PDF copy off our website under the "Insurance and Forms" tab.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already hae as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office and post it on our Website www.visioncarecenterpllc.com .

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or email shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our policy, call or visit the office contact person at the phone number shown at the beginning of this Notice.

Office Policies

Payment

I understand that full payment is due at the time of service unless previous arrangements have been made. I acknowledge that a 1% late fee will be applied on any account over 30 days past due.

Initial: _____

If I am covered by insurance, I am responsible for any balance not paid within 90 days. Any quote of benefits made to me by Vision Care Center, PLLC staff is an interpretation of quotes made by your insurance company and is only a review of benefits, not a guarantee of payment.

Initial: _____

Insurance Release and Authorization

I authorize the release of any medical or other information necessary to process my insurance claims. This signature will be on file for future claims.

Initial: _____

I also authorize payment of medical and vision benefits directly to Vision Care Center, PLLC for the services and materials rendered now and in the future.

Initial: _____

Receipt of HIPAA Privacy Policies

I acknowledge that I have read or received a copy of Vision Care Center PLLC's Notice of Privacy Practices.

Initial: _____ **Date:** _____

Contact Lens Fitting and Evaluation

I understand that the fees associated with the contact lens fitting and follow-up are NOT part of the comprehensive eye examination as defined by the insurance companies. As required by law, the prescription for contacts is a separate prescription from glasses. It will be valid at the discretion of the Doctor up to two years, and is a recurring charge any time new parameters are changed. As the policy holder, it is MY responsibility to determine how the insurance will process these charges. I expect to pay this charge myself at the initial visit if this is not a covered service.

Initial: _____

I have read and understand all the statements signed/initialed above.

Patient/Guardian Name *(print)*: _____ **Signature:** _____