901 OPTICAL
PATIENT INFORMATION

Mr. / Mrs. / Ms. / Dr. **Patient Name** _____

Male / Female **Preferred name** _____ **DOB** _____/_____/_____

Cell Phone (_____)_____-_____ **Address** Street_____

Home Phone (_____)_____-_____ City_____State_____Zip_____

Email _____

Occupation ☐Student ☐Retired _____
How many **hours per day are you on a screen** (computer/tablet/phone)?_____
How many screens do you use at a time? _____
Do you participate in any **sports**?_____
Do you have any **hobbies**?_____

Do you currently wear:

Yes	*No*	
☐	☐	Glasses
☐	☐	Contact lenses

Have YOU have been diagnosed with:

Yes	*No*	
☐	☐	Cataract
☐	☐	Glaucoma
☐	☐	Macular degeneration
☐	☐	Dry eye
☐	☐	Retinal detachment or holes

Other: _____

Are there any of the following in your FAMILY?

	Parent	*Sibling*	*Child*	*Other*
Diabetes	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Macular degeneration	☐	☐	☐	☐
Cataract	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐

Other_____

Have YOU have been diagnosed with: (CIRCLE CONDITION)

Yes	*No*	
☐	☐	Constitution (developmental disabilities, cancer, fatigue)
☐	☐	Ear/nose/throat (hearing loss, sinusitis, dry mouth)
☐	☐	Neurological (MS, epilepsy, stroke, migraine, autism)
☐	☐	Psychological (depression, ADHD, anxiety, bipolar)
☐	☐	Cardiovascular (high blood pressure, heart disease, congestive heart failure, vascular disease)
☐	☐	Respiratory (asthma, emphysema, sleep apnea)
☐	☐	Gastrointestinal (Crohn's, colitis)
☐	☐	Genitourinary (kidney disease, prostate)
☐	☐	Musculoskeletal (fibromyalgia, muscular dystrophy, ankylosing spondylitis, arthritis)
☐	☐	Integumentary (rosacea, psoriasis, cold sores, shingles)
☐	☐	Endocrine (diabetes, thyroid, hormonal dysfunction)
☐	☐	Hematologic/lymphatic (anemia, high cholesterol)
☐	☐	Allergy/immune (rheumatoid arthritis, Sjorgren's, lupus)

Other: _____

Please list any medications or supplements you are taking:

_____
_____
_____
_____
_____

Are you allergic to any medications: ☐ No known allergies

_____
_____

FOR OFFICE USE ONLY
Acct #

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Digital Retinal Imaging

Digital retinal imaging allows us to accurately detect and identify problems and abnormalities in the eyes, which could affect your eyesight and/or general health. Earlier detection and diagnosis is often the key to a better outcome.

The OCT 500 digital retinal imaging takes high-definition digital photographs of the retina (the light-sensitive nerve layer covering the back wall of the eye which is continuous with the optic nerve), as well as obtains images similar to a CT scan of the inner layers of the retina. These images show us many fine details and small abnormalities ***not visible with standard examination procedures.***

It is strongly recommended that ALL patients have this procedure performed routinely. It is especially important for people who are new patients to our office and/or have:

- Headaches
- Diabetes
- High cholesterol
- Glaucoma
- Macular degeneration
- Family history or glaucoma, macular degeneration, and/or blindness
- Family history of diabetes and/or high blood pressure
- 40 years of age or older

Please check below, sign, and date, indicating your choice.

__ Yes, I want to receive this baseline service/procedure. ***I understand and agree to the fee of $39.***
Insurance does not pay for routine screening (baseline) imaging.

__ No, I do not wish to have this service/procedure done at this time.

Patient's Signature _____ Date _____

Print Name _____

901 OPTICAL
Insurance Policies and Billing Procedures and Privacy Practice Acknowledgement

Patient name (printed): _____

Vision Care Plan (ie. Eyemed, VSP, Davis Vision, Spectera, etc.)

I understand that vision insurance covers only routine/preventative eye examinations for purposes of vision correction and/or eye health screening and may be subject to a copay. It may provide discounts for glasses or contact lenses. It does not cover the diagnosis or management of medical eye conditions.

Medical Health Insurance Plan (BCBS, Cigna, Medicare, UHC, etc.)

I understand that examinations for concerns such as diabetes, cataracts, glaucoma, macular degeneration, eye pain, infections, redness, “spots in vision”, sudden loss of vision, eye discomfort (dry eye, itching, burning, tearing), flashes and/or floaters, blurry vision not due to the need for glasses/contacts, among other problem focused complaints are not addressed during a routine/preventative examination and any visit for those complaints will be considered a medical visit and will be billed through my medical insurance provider. Medical insurance does not cover refractions for glasses prescriptions, and I will be responsible for this service if performed.

I understand that the billing of insurance is determined by the reason for my visit as well as ultimate diagnosis. I understand that, outside of urgent eye issues, I can request that my vision plan be used if eligible and may then return at a later date and time to address specific medical eye concerns.

I understand that it is my responsibility to know the details of my individual insurance plan deductibles and copay/coinsurance amounts. I understand that although a procedure may be covered by my insurance I may have amounts out-of-pocket for copays and coinsurance or if I have not yet met my deductible that will be payable by me to 901 Optical.

I understand I am ultimately responsible for charges if unpaid or denied by insurance as my insurance is a contract between myself and my insurance company, and payment for materials and services rendered is due regardless of insurance determination of coverage.

I understand that it is my responsibility to supply the Practice with current insurance information and/or any referral authorization forms that may be necessary for my insurance. I authorize 901 Optical to use this authorization in place of my physical signature on submissions to my insurance carrier. I authorize assignment of payments directly to 901 Optical when applicable.

I understand that there are no refunds on services or custom made eyewear. Returned unopened, unmarked contact lenses are subject to a restocking fee.

In the event that an outstanding balance is transferred to collections, after 120 days past due, a collections fee equal to 25% of the unpaid balance will be added to the amount due.

Acknowledgement of Receipt of Privacy Practices

By my signature below, I hereby acknowledge that I have received a copy of the Practice’s Notice of Privacy Practices. **I authorize the Practice to communicate with me by phone and to disclose my general health information on my answering machine/voicemail, and to my spouse, children, and additional family and friends:**

_____.

Signed: _____ Date: _____/_____/_____

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 Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) requires us to maintain the privacy of protected health information (“PHI”), provide notice of our legal duties and privacy practices with respect to protected health information, abide by the terms of our Notice of Privacy Practices currently in effect, and notify affected individuals following a breach of unsecured PHI.

Information Collected About You

In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as your name, address, phone number, email address, medical history, insurance information, and information concerning your doctor, nurse or other medical providers. In addition, we will gather certain medical information about you to create a medical record of the care provided to you. This information may be stored in a paper chart and/or electronically. This medical record is the property of our practice, but the information in the medical record belongs to you. Some information may also be provided to us by other individuals or organizations that are part of your “circle of care”, such as your primary care provider, other docs, your health plan, or your selected family members and close friends.

How We May Use And Disclose Information About You

The law permits us to use and disclose personal and identifiable health information about you for the following purposes:

We may use your PHI in order to provide your medical care. For example, we may use a history of diabetes to assess the health of your eyes for related damage. We may disclose information to others who are involved in providing your care, such as your primary care doctor, endocrinologist, another eye specialist, or pharmacist.

We may use and disclose your PHI to bill for our services and to collect payment from your insurance company. If you have paid for services “out of pocket” and in full, we will accommodate your request not to disclose PHI related solely to those services to a health plan. We may disclose your PHI as necessary to comply with workman’s compensation laws.

We may disclose your PHI to notify persons responsible for your care about your general condition. We may also disclose your PHI to someone who is involved with your care or helps pay for your care. Generally, we will obtain your oral agreement before using or disclosing health information in this way. However, under certain circumstances, such as in an emergency situation, we may make these uses and disclosures without your agreement. If you are unable or unavailable to agree or object, we will use our best judgment in communicating with your family and others.

We may use and disclose your PHI for general operation of our business, such as an audit or consultant.

As required by law, we will use and disclose your PHI, but we will limit our disclosure to relevant requirements of the law. We may disclose your PHI in the course of administrative or judicial proceedings in response to a subpoena, discovery request, or other lawful process. We may require your PHI as required by law to assist law enforcement to identify or locate a suspect, fugitive, material witness, or missing person, or for the purposes of complying with a court order, warrant, or grand jury subpoena.

We may disclose your PHI to a public health authority authorized to collect or receive PHI for the purpose of preventing or controlling disease, injury, or disability. We may also use and disclose your PHI in order to notify persons who may have been exposed to a disease or who are at risk of contracting or spreading a disease. We may disclose your PHI when necessary to prevent a serious threat to the health and safety of you or others.

As required by law, we may disclose PHI to a public health authority or other government authority authorized by law to receive reports of child, elder, or dependent abuse, neglect, or domestic violence.

We may disclose PHI to a person subject to the jurisdiction of the Food and Drug Administration for the following activities: the report adverse events, product defects, or problems, or biological product deviations, to track products, to enable product recalls, repairs, or replacements, or to conduct post-marketing surveillance.

We may disclose your PHI to your employer if we provide health services at the request of your employer and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work related injury. If you are a member of the Armed Forces, we may disclose your PHI for activities deemed necessary by military command authorities.

In the event this medical practice is sold or merged with another organization, your medical record will become property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

We may create or distribute de-identified health information by removing all reference to individually identifiable information.

We do not need your authorization to send you reminders or information about appointments, treatment, or medication that you are currently prescribed. We may use and disclose medical information to contact you as a reminder that you have an appointment, that you should schedule an appointment, or that you have orders ready for pick up. If you do not answer, we may leave this information in a telephone message or a message with the person answering the phone.

We will not sell your health information.

We are required to obtain written authorization from you for any uses and disclosures of PHI other than those described about. If you provide us with such permission, you may revoke that permission, in writing, at any time.

With limited exceptions, you have the right to inspect and copy medical, billing, and other records used to make decisions about you. We will send a copy to any other person you designate in writing. We may charge a reasonable fee for the cost of copying and mailing. If you believe the information in your record is incorrect or incomplete, you have the right to ask us to correct the existing information or add missing information. You must state the reason for making such a request. Under certain circumstances, we may deny your request, such as when we do not have the information, the information was not created by us, or the information is accurate and complete.

In case of a breach of unsecured PHI, you have the right to be notified, as provided by law.

We reserve the right to make changes to this notice at any time. We reserve the right to make the revised notice effective for all PHI we maintain and any we may receive in the future. In the event there is a material change to this notice, the revised notice will be posted in our practice and on oru website. In addition, you may request a copy of the revised notice at any time.

If you feel that your privacy protections have been violated, you have the right to file a formal, written complaint with the Secretary of the Department of Health and Human Services, Office of Civil Rights:
Office for Civil Rights:
U.S. Department of Health & Human Services
61 Forsyth Street, SW - Suite 3B70
Atlanta, GA 30323
(404) 562-7886
OCRMail@hhs.gov

If you have any questions or concerns, contact office@901optical.com or call (901) 737-1333.