Patient Information

Eye Associates Group, LLC - Low Vision Centers of Indiana

Patient's Name (First, MI, Last) _____ Date _____
Social Security #_____ Race: _____
Home Phone _____ Cell Phone _____
Address _____ City _____ State _____ Zip _____
Date of Birth _____ Age _____ Marital Status (circle one) S M W D
Patient's Employer _____ Work Phone_____
Employer Address _____ City_____ State_____ Zip _____
School Name, if student _____ City _____
If Married: Spouse's Name _____Spouse's Employer _____
If Minor: Father's Name _____ Father's Employer _____ City _____
Father's Social Security # _____ Father's Date of Birth _____
Mother's Name _____ Mother's Employer_____ City _____
Mother's Social Security # _____ Mother's Date of Birth _____
Emergency Contact Name: (closest relative or friend) _____
Relationship to Patient_____ Phone #_____
Have you ever been examined by our doctors? Yes / No Which Doctor? _____
How did you hear about our office/who referred you? _____
Are you a resident of a Skilled Nursing Facility? (circle one) Yes No
If Yes, Name & Address of Facility_____

Email: Please enter your email here if you would like us to be able to contact you by email with information on vision and eye health or to reach you if we are unable to contact you by telephone. We do not share your email with any outside entities.
Print Email Address _____
What is the best way to contact you (Circle One): Home Phone Cell Phone Work Phone Email

INSURANCE (Please complete all information even if a copy of your insurance card(s) was provided)

Primary *Medical* Insurance_____ Insured ID#_____
Insured's Name _____ Insured's Date of Birth _____
Relationship to Patient_____ Employer_____

Secondary *Medical* Insurance _____ Insured ID#_____
Insured's Name _____ Insured's Date of Birth _____
Relationship to Patient_____ Employer_____

Primary *Vision* Insurance_____ Secondary *Vision* Insurance_____
Insured's Name_____ Insured's Name_____
Insured's Date of Birth_____ Insured's Date of Birth_____

Please turn over and complete the other side of this form.

Account Responsibility, Signature on File, Assignment of Benefits & Financial Agreement

I request that payment of authorized insurance benefits, including Medicare, be made on my behalf to Eye Associates Group, LLC for services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the release of medical information necessary to pay the claim. My signature authorizes releasing the information to the insurer or agency shown. I further authorize releasing information to all insurances companies including Medigap policies. Eye Associates Group, LLC/Low Vision Centers may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation 1) which is or may be liable or under contract to for reimbursement for services rendered, and 2) any health care provider for continued patient care. I understand that I am responsible for any and all charges that are not paid for by my insurance company. This authorization remains in effect until withdrawn by me.

Signature_____ Date _____

HIPAA Privacy Notification and Authorizations

To comply with the HIPAA Federal Privacy Regulations, we must receive your written approval to discuss your case with anyone else including your spouse, children, family members, caregivers, friends, etc. By authorizing this, we will be able to, without requiring your presence, discuss your case, answer questions, leave detailed messages, and contact, in the event of an emergency, the person(s) listed below. If you would like us to answer questions or discuss your case with anyone other than yourself, you must include them below. This authorization is optional and can be withdrawn by you at any time.

Name_____ Relationship_____
Phone _____

Name _____ Relationship_____
Phone_____

By signing below, I acknowledge that I have received HIPAA notification and authorize the Eye Associates Group, LLC/Low Vision Centers to share information with any persons listed above.

Signature _____ Date _____

Medical History Questionnaire - Eye Associates Group, LLC

Name _____ **Date** _____

Please list current problems with eye health and vision.

Please circle those that apply to your eyes:

Burning	Light Sensitivity	Tearing or watering	Blurred or Reduced Vision
Itching	Pain	Discharge	Foreign Body Sensation
Irritation	Headaches	Floaters or Flashes	Double Vision

List problems with your eyewear.

Family Doctor _____ **Last Eye Doctor** _____

Other eye specialists currently treating you: _____

Review of Systems:

Height: _____ Weight:_____

Please circle those items that apply to you:

Current Constitutional: Fever Weight Loss Headache Pains Dizziness Inflammation Fatigue Joint Pain Shortness of Breath

Ears, Nose & Throat: Hearing Loss Sore Throat Cough Dry Mouth Earache Sinus Infections Pain in Jaw or Temple Pain on Chewing

Cardiovascular: Heart Attack Bypass Angina High Blood Pressure High Cholesterol Congestive Heart Failure Arrhythmia Pacemaker Coronary Artery Disease Valve Disease

Respiratory: Emphysema Asthma COPD Lung Cancer Tuberculosis Bronchitis Pneumonia

Gastrointestinal: Stomach Cancer Ulcers GERD Reflux Colon Cancer Crohn's Disease

Genitourinary: Kidney Disease Dialysis Bladder Infections Prostate Problems or Cancer Ovarian Cancer Pregnancy

Musculoskeletal: Arthritis Rheumatoid Arthritis Spinal Disorders Osteoporosis

Integumentary: Breast Cancer Skin Cancer Melanoma Psoriasis Skin Infections

Neurological: Stroke Mini Stroke Brain Injury Seizures Migraines Tremors MS Parkinsonism Alzheimer's Brain Tumor Aneurysm

Psychiatric /Emotional: ADHD Bipolar Depression Schizophrenia Anxiety Dementia Insomnia

Endocrine: Diabetes Growth Problems Thyroid Pituitary Tumor

Blood /Lympathatic: Bleeding Disorder Anemia Leukemia Lymphoma

Allergies/Immune: Seasonal Allergy Medication Allergies Food Allergies Lupus

Please List Any Other Serious Illnesses, Not Listed Above:

List Medications You Are Allergic to:

Circle Those That Apply to You:

Tobacco None Per Day 1/ Pack or less More than 1 Pack/day

Alcohol None Social Moderate Heavy

Ocular History:

Circle Those That Apply to You Personally:

- Glaucoma
- Cataract
- Macular Degeneration
- Other Eye Disease
- Retinal Disease
- Blindness
- Crossed Eyes
- Lazy Eyes
- Histoplamosis
- Diabetes
- Cancer
- Heart Disease
- High Blood Pressure

Family History:

Circle Those That Apply to Your Family. (Blood Relationships Only)

Please Indicate the Relationship to You (i.e. Mother, Father, Sister, etc)

- Glaucoma _____
- Cataract _____
- Macular Degeneration _____
- Other Eye Disease _____
- Retinal Disease _____
- Blindness _____
- Crossed Eyes _____
- Lazy Eyes _____
- Diabetes _____
- Cancer _____
- Heart Disease _____
- High Blood Pressure _____

Eye Medications:

List any eye medications (drops, ointments and/or vitamins). Please include tears and other over-the-counter drops.

[ ] No Eye Medications

Systemic Medications:

Please list all other general medications and vitamins you are taking. Indicate the reason for the medication when possible. You may attach a list of your medications if you have one.

[ ] No Systemic Medications

Medication	**Condition Medication is Treating**	**Dosage**

Use this space to discuss any other problems or additional medications.

Eye Surgeries:

Please list any eye surgeries, lasers or eye injection treatments you may have had.

[ ] No Eye Surgeries

Date	Which Eye	Type of Surgery	Surgeon

General Surgeries:

Please list all other general surgeries you have had.

[ ] No General Surgeries

Date	Type of Surgery	Surgeon

Use this space to discuss any problems or complications from any Ocular Surgeries you have had.

Eye Associates Group, LLC
Low Vision Centers of Indiana

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY. Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice).

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care 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 must carry out 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 matters; business planning; and outside storage of our records.

OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. 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 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 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;
- 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 foreign 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" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA;
- [specify other uses and disclosures affected by state law].

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for health care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION

The following are some specific uses and disclosures we may not make of your health information **without** your authorization:

Marketing activities. We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent to such payment.

Sale of health information. We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.

Psychotherapy notes. Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

- Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization.

- You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.

- We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.

- We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right:

- **To request restrictions on the health information we may use and disclose for treatment, payment and health care operations.** We are not required to agree to these requests. To request restrictions, please send a written request to us at the address below.

- **To receive confidential communications of health information about you in any manner other than described in our authorization request form**. You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.

- **To inspect or copy your health information.** You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.

- **To amend health information.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it

is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:

- o was not created by us, unless the person that created the information is no longer available to make the amendment,
- o is not part of the health information kept by or for us,
- o is not part of the information you would be permitted to inspect or copy, or
- o is accurate and complete.

- **To receive an accounting of disclosures of your health information.** You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).

- **To designate another party to receive your health information.** If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

Contact Person:

Our contact person for all questions, requests or for further information related to the privacy of your health information is:

Deb Runyon	Hartford City	765-348-2020	Albany	765-789-4404
	Fort Wayne	260-432-0575	Lafayette	765-490-5164
	Indianapolis	317-844-0919		

Complaints:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to 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 E mail shown above. If you prefer, you can discuss your complaint in person or by phone.

Changes to This Notice:

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

Notice Revised and Effective: September 11, 2013