HEALTH INFORMATION

PATIENT NAME: ____ **DATE:** ___________________

MAIN COMPLAINT/REASON FOR YOUR VISIT TODAY: (Check one or more)

Routine exam / No problems / Distance blur / Near blur / Eye irritation / Headaches / New glasses / New contacts

Other (Describe) ____

EXPLAIN SYMPTOMS RELATED TO REASON FOR VISIT: ____

____

When was your last formal eyg"gzco A""" Less than ☐ 1 yr ☐ 2yrs ☐ 3yrs ☐ 4yrs ☐ Longer ☐ Never

How many hours a day do you spend viewing a computer monitor? ☐ 0 hrs ☐ 1-3 hrs ☐ 4-6 hrs ☐ 7 or more hrs

While doing computer work, how far is your monitor from your eyes? ______________________ inches

Do you now wear contacts regularlyA""" Yes ☐ No If yes, are they: ☐ Hard /RGP or ☐ Soft.

""If you wear contacts, please list your contact lens prescription below:

""Right Eyg"Dase Curve ______ Power__________________________ Diameter ___________ Type _____________________
""Left E{g"""Dase Curve ______ Power _________________________ Diameter ___________ Type _____________________

OCULAR HISTORY

SELF HISTORY :

Y N Macular degeneration
Y N Cataracts
Y N Glaucoma
Y N Retinal detachment/tear
Y N Retinitis Pigmentosa
Y N Eye surgeries
Y N Lazy eye
Y N Styes or chalazions
Y N Pain on movement of eye
Y N Double vision (two separate images)
Y N Eye infections
Y N Floaters
Y N Flashes of light
Y N Eye injuries
Y N Eye pain
Other ________________________________

FAMILY HISTORY:

Y N Blindness
Y N Glaucoma
Y N Macular degeneration
Y N Cataracts (under age 60)
Y N Retinal detachment /tear/disease
Y N Crossed eyes
Other ____

SOCIAL HISTORY

Current occupation: ______________________________
Hobbies/Interest: _________________________________
Do you use tobacco now? Y N
Often drink more than 2-3 drinks per day Y N
Have you ever had a blood transfusion? Y N

Family physician: ____ Phone:___________________

Other physicians: ____ Phone: ___________________

REVIEW OF SYSTEMS:

CONSTITUTIONAL/GENERAL:
Y N Fever within last month
Y N Chronic fatigue
Y N Significant weight loss

MUSCULOSKELETAL:
Y N Polymyalgia Rheumatica
Y N Lupus
Y N Osteoporosis
Y N Rheumatoid Arthritis
Y N Osteoarthritis

RESPIRATORY:
Y N Asthma / Emphysema
Y N Tuberculosis

ALLERGY/IMMUNOLOGY
Y N Sarcodosis
Y N Allergies / Hayfever

ENDOCRINE:
Y N Diabetes
Y N Thyroid Disease

GENITOURINARY:
Y N Kidney problems
Y N Pregnant NOW

NEUROLOGICAL:
Y N Frequent headaches
Y N Migraines
Y N Seizures, convulsions, epilepsy
Y N Blacked-out or lost consciousness
Y N Stroke or TIA

EARS, NOSE, MOUTH, THROAT:
Y N Sinus problems
Y N Frequent cold sores

CARDIOVASCULAR:
Y N Angina
Y N Rapid or irregular heart beat
Y N High blood pressure
Y N Coronary artery disease
Y N Valve disease
Y N Heart attack

SKIN:
Y N Skin rashes
Y N Acne Rosacea
Y N Psoriasis
Y N Basal cell, Squamous, Melanoma

GASTROINTESTINAL:
Y N Nausea / Vomiting
Y N Heartburn or Hiatal hernia
Y N Ulcers or bleeding

PSYCHIATRIC:
Y N Anxiety
Y N Memory loss
Y N Depression
Y N Mental illness

HEMATOLOGIC/LYMPHATIC:
Y N Enlarged lymph glands/nodes
Y N Bleeding disorder
Y N Anemia
Y N High cholesterol
Y N HIV/AIDS
Y N Leukemia or blood cancer
Y N Sickle Cell Disease

LIST ALL MAJOR ILLNESSES, INJURIES AND SURGERIES

Problem or Procedure	Year	Physician
1.____________________	_____	____________________
2.____________________	_____	____________________
3.____________________	_____	____________________
4.____________________	_____	____________________

CURRENT MEDICATIONS AND SUPPLEMENTS:

1.____________________ 3.____________________ 5. ____________________
2.____________________ 4.____________________ 6. ____________________

ALLERGIES/SENSITIVITY TO ANY MEDICATIONS OR SUBSTANCES:

1.____________________ 3.____________________ 5.____________________
2.____________________ 4.____________________ 6.____________________
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PERSONAL INFORMATION

Patient: ____ Birthdate: _________ Date: _________________
Last First Middle

Address: ____ City/State:_____________________________Zip: __________

Phone: ________________________ Cell Number: _______________________

E-Mail : ____

Marital Status: ☐ Married ☐ Single **Sex**: ☐ M ☐ F

SS # : ________________________________

Occupation: ___________________________________ Employer: ____

RESPONSIBLE PARTY INFORMATION (If different than above)

Name: ____ Date of Birth: _______________

Address: _______________________________________ City/State: ___________________________ Zip: ___________

Relationship to patient: ______________________ Phone Number: __________________ SS # : _____________________

Employer: ____

PLEASE HAVE YOUR MEDICARE AND INSURANCE CARDS READY FOR US TO COPY

Please list your PRIMARY MEDICAL INSURANCE : ____

Please list your SECONDARY MEDICAL INSURANCE: ____

Please check your VISION BENEFIT PLAN:

☐ VSP ☐ EYECARE DIRECT ☐ AVESIS ☐ EYEMED

Cardholder's Name: _____________________________________ Cardholder's SS#: _________________________________

TOTAL EYECARE CENTER FINANCIAL POLICY

Your complete understanding of your financial responsibilities is an essential element of your care and treatment.

MISSED APPOINTMENTS

Our office requires a 24-hour notification if you need to cancel or reschedule an appointment. Failure to contact our office in advance prohibits our doctor from treating other patients who are in need of care, creating a hardship on the practice. Consequently, you may be charged a no-show fee of $50.00. Continued no-show appointments will result in a practice discharge.

COVERED AND NON-COVERD SERVICES

Patients with medical insurance plans or vision covered plans are asked to pay their co-payment, co-insurance, deductibles, or any non-covered services at the time of their visit. Patients are expected to know the benefits provided by their insurance company. Please contact your insurance company to review your benefits and eligibility prior to making an appointment. You will be responsible for all non-covered services provided to you and your family. Services for your care and treatment that are not paid by an insurance plan or vision plan will be billed to you. You are responsible for all charges regardless of insurance coverage. You agree to pay your account with this office in accordance with the standard rates and payment terms of this office. If it is deemed necessary, in the sole discretion of this office, to refer your account to a collection agency as a result of nonpayment, you agree to pay all cost of collection including attorney fees, collection fees, and contingent fees to collection agencies of not less than 35%. Such contingency fee is to be added and collected by the collection agency immediately upon our referral of your account to the collection agency of our choice. I acknowledge full responsibility for all charges incurred in the collection of this account, if your medical plan or vision plan determines later that our services including any additional charges incurred to be not covered or not a benefit.

CHANGE IN MEDICAL OR VISION PLAN

You are expected to notify our office if your medical or vision coverage changes. Our office will periodically ask you to update your records. You will be expected to provide full and complete information to our office in order to bill the correct insurance company.

LIFETIME INSURANCE AUTHORIZATION

To assist in the payment of my claim, I authorize and request that payments under my medical insurance program or vision benefit plan be made directly to the provider to pay for any services furnished to me. I also authorize the provider to release any information that is needed to expedite payment of my claim. I further permit copies of this authorization to be used in place of the original.

PAYMENT METHODS

For your convenience, we accept Visa/Mastercard/Discover/American Express, in addition to cash or check. Any returned check will constitute a $25.00 fee.

RELEASE OF INFORMATION

I understand that HIPAA has implemented procedures that require specific authorization for release of my information. I understand that I can revoke these at any time, by informing our Privacy Officer in writing. I have read and fully understand all of the above statements and agree to be bound by its terms. I also understand that the above terms may be amended from time to time by the practice.

______________________________________ ____________
Signature: Date

____
Print Patient Name

Notice of Privacy Practices

Effective date of notice: **April 10, 2003**

Total Eyecare Center / Larry D. Holle, O.D.
11230 N. Tatum Blvd. Suite 100 Phoenix, AZ. 85028
602-263-0850 (Phone) 602-266-5490 (Fax)
www.holleeyecare.com

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

General Rule

We respect our legal obligation to keep health information, that identifies you, private. The law obligates us to give you notice of our privacy practices.

Generally, we can only use your health information in our office or disclose it outside of our office, without your written permission, for purposes of treatment, payment or healthcare operations. In most other situations, we will not use or disclose your health information unless you sign a written authorization form. In some limited situations, the law allows or requires us to disclose your health information without written authorization.

Uses or Disclosures of Health Information

Examples of how we use information for **treatment** purposes:

- When we set up an appointment for you.
- When our technician or doctor tests your eyes.
- When the doctor prescribes glasses or contact lenses.
- When the doctor prescribes medication.
- When our staff helps you select and order glasses or contact lenses.
- When we show you low vision aids.

We may disclose your health information outside of our office for **treatment** purposes, for example:

- If we refer you to another doctor or clinic for eye care or low vision aids or services.
- If we send a prescription for glasses or contacts to another professional to be filled.
- When we provide a prescription for medication to a pharmacist.
- When we phone to let you know that your glasses or contact lenses are ready to be picked up.

Sometimes we may ask for copies of your health information from another professional that you may have seen before.

We may use your health information within our office or disclose your health information outside of our office for **payment** purposes. Some examples are:

- When our staff asks you about health or vision care plans that you may belong to, or about other sources of payment for our services.
- When we prepare bills to send to you or your health or vision care plan.
- When we process payment by credit card and when we try to collect unpaid amounts due.
- When bills or claims for payment are mailed, faxed, or sent by computer to you or your health or vision plan.
- When we occasionally have to ask a collection agency or attorney to help us with unpaid amounts due.

We use and disclose your health information for **healthcare operations** in a number of ways. Health care operations means those administrative and managerial functions that we have to do in order to run our office. We may use or disclose your health information, for example, for financial or billing audits, for internal quality assurance, for personnel decisions, to enable our doctors to participate in managed care plans, for the defense of legal matters, to develop business plans, and for outside storage of our records.

Appointment Reminders

We may call to remind you of scheduled appointments. We may also call to notify you of other treatments or services available at our office that might help you.

Uses & Disclosures without an Authorization

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 happen at our office at all. Such uses or disclosures are:

- A state or federal law that mandates certain health information be reported for a specific purpose.
- 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, audits by Medicare or Medicaid, or investigation of possible violations of healthcare 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 relating to workers' compensation programs.

- Disclosures to business associates who perform healthcare operations for us and who agree to keep your health information private.

Other Disclosures

We will not make any other uses or disclosures of your health information unless you sign a written **authorization form**. You do not have to sign such a form. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it.

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 healthcare 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 **(Privacy Officer)** at the address, fax or e-mail shown at the beginning of this notice.
- You can ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using e-mail 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 **(Privacy Officer)** at the address, fax or e-mail shown at the beginning of this notice.
- You can ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. Primarily, however, you will be able to review or have a copy of your health information within 30 days of asking us. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally required. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we sent you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to **(Privacy Officer)** at the address, fax or e-mail shown at the beginning of this notice.
- You can 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 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 **(Larry D. Holle, O.D.)** at the address, fax or e-mail shown at the beginning of this notice.
- You can get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want), except disclosures for purposes of treatment, payment or health care operations, disclosures made in accordance with an authorization signed by you, 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 **(Larry D. Holle, O.D.)** at the address, fax or e-mail shown at the beginning of this notice.

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 in compliance with and as allowed by law. If we change this notice, the new privacy practices will apply to your health information that we already have, 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)**.

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 Privacy Officer at the address, fax or e-mail 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 privacy practices, call or visit Privacy Officer at the address or phone number shown at the beginning of this notice.

Acknowledgement of Receipt of Notice of Privacy Practices

Larry D. Holle, O.D.
11230 N. Tatum Blvd. Suite #100 Phoenix, Arizona 85028
602-263-0850
602-266-5490 (Fax) tecdocphx@hotmail.com (E-Mail)

Patient Name: ____

Patient Number: ____________________ Patient Phone Number: ________________________

Patient Address: ____

Signing this document signifies that you have received a copy of our Notice of Privacy Practices.

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the *Notice of Privacy Practices* from (Name of Practice).

____ ____________________
Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

____________________________ ____________________________
Relationship to Patient Print Name

Source of Authority: ____