UPTOWN VISION

Patient_____ DOB_____ SSN_____

Address_____ City_____ State_____ Zip_____

Home phone_____ Mobile phone_____

Email_____ Work Phone_____

Employer_____ Occupation_____

Emergency Contact/Phone #_____ Relationship_____

Who can we thank for this referral? Name_____ Relationship_____

How did you hear about us? (Please circle) Google Facebook Yelp Insurance Search

HIPAA ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, the "Patient" or "Patient's Legal Representative", have been presented with the Notice of Privacy Policy of Uptown Vision, and have been offered a copy of such policy to keep for my records. *(Upon request, a personal copy of the policy may either be emailed or dispensed in person)*

- **ACKNOWLEDGEMENT:** X_____(Please initial) I *ACKNOWLEDGE* that I have been presented with a copy of the Policy
- **REFUSAL:** _____ I *REFUSE* to acknowledge receipt of the Policy. I understand that even though I may refuse to sign this acknowledgement, Provider may still provide treatment to me.

ACCEPTANCE OF INSURANCE & FINANCIAL RESPONSIBILITIES

X _____(Please initial) As a service, Uptown Vision verifies and files insurance claims on the behalf of their patients. However, I understand what may be quoted as my portion of financial responsibility (co-payment and/or co-insurance) is only an estimate provided by my insurance carrier. I agree to be responsible for what insurance does not cover for the services rendered. I realize that insurance benefits must be presented and verified at the time of service date. We cannot refund you for insurance benefits that were not verified at the time of service date.

Uptown Vision strives to guarantee their patients' complete satisfaction. Our doctors and staff promise to provide the best customer service possible, and to attempt to resolve any conflicts or concerns that may arise. However, I understand that all professional fees collected are ultimately non-refundable.

CANCELLATION POLICY

X _____(Please initial) We require at least 24 hours advanced notice for any changes or cancellations of your appointment. This allows us the time we initially reserved especially for you in our schedule to be filled by another patient who may have been waiting for this appointment time. **We will charge a $50.00 fee for patients who do not show up for their scheduled appointments and for patients who fail to give us sufficient notice that they have a conflict.**

We reserve time in our schedule for you in advance in order to accommodate your busy schedule. We ask that you give us the same consideration when needing to change or cancel your appointment. **Patients with a history of failing appointments or repeated late cancellations may be dismissed from the practice.**

FOR CONTACT LENS PATIENTS

X _____(Please initial) Your contact lens prescription will not be finalized until the doctor has checked your trial lenses to determine that they fit properly. In most cases, at least one follow-up visit is required in order to finalize your prescription, usually one week after your trials are dispensed. YOUR EXAM FEES INCLUDES THESE VISITS WITHIN 30 DAYS. **It is your responsibility to keep your follow-up appointment. It is a must you wear your trial contacts when you come in for your visit.** If your follow-up is more than 30 days after your initial visit the following fees will apply:

>30 days – 6 months: $50
More than 6 months: The cost of a new examination.

X _____

Signature of patient (parent/guardian of minor) Date

EYE HISTORY

Reason for visit: ☐ Glasses ☐ Contact Lens ☐ Eye infection or injury ☐ Medical ☐ Other: _____

Last Eye Exam: _____ Age of glasses:_____ Have you ever worn contact lenses? ☐ Yes ☐ No

Current type of glasses: ☐ Single ☐ Progressive ☐ Lined Bifocal/Trifocal Hours on computer/ digital devices: _____daily

Current Contact Brand & Rx: (R) brand _____ Rx_____

(L) brand _____ Rx_____

Currently experiencing eye symptoms (please check all that apply):

☐ Blurred Distance
☐ Blurred Near
☐ Double Vision
☐ Loss of Side Vision
☐ Other:_____

☐ Flashes of light
☐ Headaches
☐ Itching
☐ Redness

☐ Burning
☐ Dryness
☐ Floaters
☐ Light Sensitivity
☐ Other:_____

☐ Discharge/Matting
☐ Excess Tearing/Watering
☐ Foreign Body Sensation
☐ Eye Pain or Soreness

PATIENT and FAMILY MEDICAL HISTORY

Please check the box ☐ for your **self** (the patient) and the circle ○ for a **family** history.

S F
☐ ○ Glaucoma
☐ ○ Macular Degeneration
☐ ○ Retinal Detachment
☐ ○ Color Blindness
☐ ○ Strabismus
☐ ○ Amblyopia (lazy eye)
☐ ○ Diabetic Retinopathy
☐ ○ Cataract
☐ Previous Eye Injuries
☐ Lasik
☐ Eye Surgery

Constitutional
☐ ○ Developmental Disorder
☐ ○ Cancer:_____
☐ ○ Fatigue Syndrome

Ear, Nose, Throat
☐ Allergies
☐ Sinusitis
☐ Dry Mouth
☐ Hearing Loss
☐ Laryngitis
☐ Ear ache

S F Neurological
☐ ○ Epilepsy/ Seizures
☐ ○ Cerebral Palsy
☐ ○ Stroke
☐ Migraines

Psychiatric
☐ ○ Depression
☐ ○ Bipolar
☐ ○ Anxiety
☐ ○ Attention Deficit

Cardiovascular
☐ ○ High Blood Pressure
☐ ○ Stroke
☐ ○ Heart Disease
☐ ○ Vascular Disease
☐ ○ Congestive Heart Failure

Respiratory
☐ Smoker/former smoker
☐ Bronchitis
☐ ○ COPD
☐ ○ Emphysema
☐ ○ Asthma
☐ Sleep Apnea

S F Gastrointestinal
☐ ○ Celiac Disease
☐ Ulcer
☐ Colitis
☐ Acid Reflux

Genitourinary
☐ ○ Kidneys disease
☐ ○ STD-Herpetic/Chlamydia
☐ Pregnant/ Planning
☐ Nursing

Muscles/Bones/Joints
☐ ○ Arthritis
☐ ○ Ankylosing-Spondylitis
☐ ○ Fibromyalgia
☐ ○ Muscular Dystrophy
☐ ○ Osteoarthritis
☐ ○ Gout

Integumentary
☐ ○ Herpes Simplex/Cold Sores
☐ ○ Herpes Zoster/ Shingles
☐ Rosacea
☐ Psoriasis
☐ Eczema

S F Endocrine
☐ ○ Diabetes type I
☐ ○ Diabetes type II
☐ ○ Hormonal Dysfunction
☐ ○ Thyroid Dysfunction

Hematologic
☐ ○ Anemia
☐ ○ High Cholesterol

Immunologic
☐ HIV/AIDS
☐ Environmental Allergies
☐ ○ Lupus
☐ ○ Rheumatoid Arthritis
☐ ○ Sjogren Syndrome
☐ Drug Allergies:

_____

☐ **NONE OF THE ABOVE APPLIES**

For previous patients:
☐ **SAME AS LAST YEAR / NO CHANGES**

Smoke: ☐ No ☐ Yes, amount daily_____ Alcohol Consumption: ☐ None ☐ Rarely ☐ Occasionally ☐ Daily:_____

If you would like to explain more to any of the above or have a condition not listed:

_____

Current medication:_____

Previous Surgeries:_____

X_____

Signature of patient (parent/guardian of minor) Date

DILATION/OPTOMAP & VISUAL FIELD SCREENING INFORMED CONSENT

We are committed to maintaining the highest level of care for the early detection and prevention of eye disease. Our doctors strongly advise an annual retinal health examination for every patient.

There are two ways your retina can be examined. We would like you to choose one of the following options for your exam:

OPTION #1:

Optomap offers **a non-invasive and painless alternative to traditional dilation** by capturing a digital scan of the retina in less than a second, with no side effects. A healthy retina is critical to vision and needs to be examined for problems such as macular degeneration, glaucoma, cataracts, holes/detachments and complications from high blood pressure, diabetes, and HIV, etc.

The scans become permanent records that will assist the doctor to monitor and compare any changes annually helping maintain good eye health. **It is the doctor's preferred method of evaluating the internal health of your eye.**

The fee for the Optomap is $50.00. Your vision insurance <u>will not</u> cover this procedure.

_____Yes, I consent to having the Optomap (in lieu of a standard dilated exam) today.

_____No, I do not consent to having the Optomap (in lieu of a standard dilated exam) today.

Dilation involves instilling eye drops to enlarge the pupils and to obtain a better view of the back of the eyes. Dilation causes **blurriness of near vision for 4-6 hours and increased sensitivity to light.**

OPTION #2:

Dilation Only. Included with your exam and covered by your vision insurance.

_____Yes, I consent to having my eyes dilated.

_____No, I do not consent to having my eyes dilated.

VISUAL FIELD SCREENING

The visual field screening, tests the integrity of the optic nerve pathway. It is a non-invasive computerized test which helps detect early signs of glaucoma, optic nerve disorders, retinal diseases and even certain brain tumors.

The fee for the visual field test is $ 20.00. Most insurance does not cover this procedure.

_____Yes, I consent to having my visual field tested today.

_____No, I do not consent to having my visual field tested today.

UPTOWN VISION

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 an appointment for you, testing or examining your eyes, prescribing glasses, contact lenses, or eye medications and faxing them to be filled, showing 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 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 matters, 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 usually will ask you for special written permission.

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 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 services, 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 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 subpoena 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 services
- 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 helping you with your eye care.)

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a postcard, leave you a reminder message on your answering machine or with someone who answers your phone if you are not available, and/or contact you via email.

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. Sometimes we may initiate the authorization process if the use or disclosure is our idea. Sometimes you may initiate the process if it's your idea for us to send your information to someone else. Typically in this situation you will give us a properly completed authorization form, or you may 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 not 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 end of the 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 restriction, send a written request to the office contact person at the address, fax, or email shown at the end of this notice
- 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 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 end of the Notice.
- 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. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or 60 days if the information is stored off-site). 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 available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax, or email shown at the end of the 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 end of the notice.
- 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). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations, disclosures with your authorization, incidental 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 shown at the beginning of the Notice.
- Get additional paper copies of the 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 end 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 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 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 would like 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.

- Contact Person: Practice Administrator
- Telephone: 214-953-3937
- Address: 3710 Rawlins St, Suite 100 Dallas, TX 75219