Patient Registration And Health Form

Date_____

Patient Name_____
Age/ Date of Birth _____
Sex ____Male ____Female
Parent or Guardian's Name_____
Marital Status_____

Mailing Address_____
Apartment number/unit_____
City_____ Zip Code_____
Home Phone_____ Work Phone_____
Cell Phone_____E-mail:_____

Occupation/ Employer_____
Vision Insurance Plan_____
Social Security Number_____

Referred by_____
What is the reason for seeking care at this time?_____
_____
Do you wear glasses or contacts or both?_____

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1. Date of last eye exam/ Previous Doctor's Name_____
2. Do you have any history of eye injury, eye surgery, or eye disease? If so please list these with date of diagnosis:_____
   _____
3. Do you have any of the following conditions: eyestrain, double vision, turned eye, flashes/floaters/spots, poor color vision, severe headaches, dry/itchy/ red eyes? If so, please list which ones:_____
4. Date of last dilated exam:_____
5. Do you have any medical diseases/conditions? If so please list these with date of diagnosis:_____
   _____
   _____
6. Are you taking any medications? If so, please list these:_____
   _____
   _____
7. List any allergies (to medication, food, other allergens):_____
   _____
8. List any Family Eye History of glaucoma, blindness, or hereditary eye diseases:_____
   _____
9. List any Family Medical History of diabetes, high blood pressure, or heart disease_____
   _____

10. Are you pregnant? _____Yes _____No

Dilation

Dilation of the eyes utilizes the use of dilation drops to temporarily increase the size of your pupils in order to perform a more thorough medical analysis of your eyes. Dilation assists us in the early detection of many disorders including glaucoma, retinal detachments, macular degeneration, and brain tumors; and, is considered part of a comprehensive eye exam.

It will usually take 3-5 hours for the effects of the drops to wear off. In the meantime, your ability to focus up close may become more difficult and you will be more sensitive to light. Wearing sunglasses outdoors will increase comfort.

We strongly recommend that all our patients undergo routine dilation. It is especially important for patients who have:

1. diabetes
2. high blood pressure
3. circulatory problems
4. headaches
5. floaters
6. flashes of light
7. high myopia (i.e., high nearsightedness)
8. are 35 years of age or older
9. a family history of glaucoma or blindness
10. never had a dilated eye exam

There is an additional charge of $30.00 for this procedure. However, this is covered under most insurance plans.

Please check the appropriate line below and sign at the bottom.

( ) I **DO** want this procedure.
( ) I **DO NOT** want this procedure.

_____
Patient's Signature

_____
Date

VISION DESIGNS OPTOMETRIC CENTER
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 OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Overview

The law requires us to keep your protected health information ("PHI") private in accordance with this Notice of Privacy Practices ("Notice"), as long as this Notice remains in effect. We are also required to provide you with a paper copy of this Notice, which contains our privacy practices, our legal duties, and your rights concerning your PHI. From time to time, we may revise our privacy practices and the terms of our Notice at any time, as permitted or required by applicable law. Such revisions to our privacy practices and our Notice may be retroactive. Our Notice will be updated and made available to our patients prior to any significant revisions of our privacy practices and policies.

Our Privacy Practices

Use and Disclosure. We may use or disclose your PHI for treatment, payment, or health care operations. For your convenience, we have provided the following examples of such potential uses or disclosures:

> *Treatment.* Your PHI may be used by or disclosed to any physicians or other health care providers involved with the medical services provided to you.
>
> *Payment.* Your PHI may be used or disclosed in order to collect payment for the medical services provided to you.
>
> *Health Care Operations.* Your PHI may be used or disclosed as part of our internal health care operations. Such health care operations may include, among other things, quality of care audits of our staff and affiliates, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Authorizations. We will not use or disclose your medical information for any reason except those described in this Notice, unless you provide us with a written authorization to do so. We may request such an authorization to use or disclose your PHI for any purpose, but you are not required to give us such authorization as a condition of your treatment. Any written authorization from you may be revoked by you in writing at any time, but such revocation will not affect any prior authorized uses or disclosures.

Patient Access. We will provide you with access to your PHI, as described below in the Individual Rights section of this Notice. With your permission, or in some emergencies, we may disclose your PHI to your family members, friends, or other people to aid in your treatment or the collection of payment. A disclosure of your PHI may also be made if we determine it is reasonably necessary or in your best interests for such purposes as allowing a person acting on your behalf to receive filled prescriptions, medical supplies, X rays, etc.

Locating Responsible Parties. Your PHI may be disclosed in order to locate, identify or notify a family member, your personal representative, or other person responsible for your care. If we determine in our reasonable professional judgment that you are capable of doing so, you will be given the opportunity to consent to or to prohibit or restrict the extent or recipients of such disclosure. If we determine that you are unable to provide such consent, we will limit the PHI disclosed to the minimum necessary.

Disasters. We may use or disclose your PHI to any public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Required by Law. We may use or disclose your medical information when we are required to do so by law. For example, your PHI may be released when required by privacy laws, workers' compensation or similar laws, public health laws, court or administrative orders, subpoenas, certain discovery requests, or other laws, regulations or legal processes. Under certain circumstances, we may make limited disclosures of PHI directly to law

enforcement officials or correctional institutions regarding an inmate, lawful detainee, suspect, fugitive, material witness, missing person, or a victim or suspected victim of abuse, neglect, domestic violence or other crimes. We may disclose your PHI to the extent reasonably necessary to avert a serious threat to your health or safety or the health or safety of others. We may disclose your PHI when necessary to assist law enforcement officials to capture a third party who has admitted to a crime against you or who has escaped from lawful custody.

Deceased Persons. After your death, we may disclose your PHI to a coroner, medical examiner, funeral director, or organ procurement organization in limited circumstances.

Research. Your PHI may also be used or disclosed for research purposes only in those limited circumstances not requiring your written authorization, such as those which have been approved by an institutional review board that has established procedures for ensuring the privacy of your PHI.

Military and National Security. We may disclose to military authorities the medical information of Armed Forces personnel under certain circumstances. When required by law, we may disclose your PHI for intelligence, counterintelligence, and other national security activities.

Your Individual Rights

Access and Copies. In most cases, you have the right to review or to purchase copies of your PHI by requesting access or copies in writing to our Privacy Officer. Please contact our Privacy Officer regarding our copying fees.

Disclosure Accounting. You have the right to receive an accounting of the instances, if any, in which your PHI was disclosed for purposes other than those described in the following sections above: Use and Disclosures, Facility Directories, Patient Access, and Locating Responsible Parties. For each 12-month period, you have the right to receive one free copy of an accounting certain details surrounding such disclosures that occurred after April 13, 2003. If you request a disclosure accounting more than once in a 12-month period, we will charge you a reasonable, cost-based fee for each additional request. Please contact our Privacy Officer regarding these fees.

Additional Restrictions. You have the right to request that we place additional restrictions on our use or disclosure of your PHI, but we are not required to honor such a request. We will be bound by such restrictions only if we agree to do so in writing signed by our Privacy Officer.

Alternate Communications. You have the right to request that we communicate with you about your PHI by alternative means or in alternative locations. We will accommodate any reasonable request if it specifies in writing the alternative means or location, and provides a satisfactory explanation of how future payments will be handled.

Amendments to PHI. You have the right to request that we amend your PHI. Any such request must be in writing and contain a detailed explanation for the requested amendment. Under certain circumstances, we may deny your request but will provide you a written explanation of the denial. You have the right to send us a statement of disagreement to which we may prepare a rebuttal, a copy of which will be provided to you at no cost. Please contact our Privacy Officer with any further questions about amending your medical record.

Complaints

If you believe we have violated your privacy rights, you may complain to us or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with us by notifying our Privacy Officer.
We support your right to protect the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Us

Privacy Officer:
Elizabeth Mukai
35 Linden Ave. Suite #102, Long Beach, CA 90802
Phone: (562) 435-2020/ Fax: (562) 435-2026

VISION DESIGNS OPTOMETRIC CENTER, INC.

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally received a copy of the VISION DESIGNS OPTOMETRIC CENTER's Notice of Privacy Policies on the date indicated below.

Signature: _____ Date: _____

Patient: _____

Information about Agent (attach appropriate documentation):

Agent: _____

Title: _____

VISION DESIGNS OPTOMETRIC CENTER, INC.

ACKNOWLEDGEMENT OF THE

90-DAY CONTACT LENS POLICY

This notice describes the ninety-day contact lens policy. Filling the contact lens prescription constitutes an agreement to remake the contact lens prescription at the doctor's direction for a period of 90 days without charge to the patient. We understand that some contact lens fittings may take several visits or more. The Patient acknowledges that this office will provide contact lens fitting(s) up until 90 days from the initial eye exam. After 90-days, the Patient will be charged $20 per visit for any additional contact lens fitting(s) up to 6 months. After 6 months, the Patient will be required to pay for another eye exam, including the contact lens fitting.

The Patient acknowledges that he or she will adhere to the ninety-day contact lens policy.

Signature: _____ Date: _____

Patient: _____