

HIPPA PRIVACY NOTICE

- **If you 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 request (or sixty 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 time for us to give you access for photocopies if we send you written notice of the extension.

- **If you ask 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 the date of request. We will send you the corrected information and persons who we know received the incorrect information, and any 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 give you written notice of the extension.

- **Get a list of the disclosures that we have made of your health information within the last 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 be required to pay for them in advance. We will make every effort to respond to your request within 60 days. By law, we can have one 30-day extension of time to consider a request for amendment if we give you written notice of the extension.

- **Get additional paper copies of this Notice of Privacy Practices upon request**

It does not matter whether you received the notice electronically or in paper form.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we chose to change it. We reserve the right to change the 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 at 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 make a complaint 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 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 the office/contact person of your choice.

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT:

I, (patient name) _____

Have read and agree to the Privacy Practices.

Patient Signature: _____ Date: _____

Welcome to our office. The following information will assist your doctor with the examination.
(If you need help completing this form, ask at the desk.)

Last Name _____ First Name _____ MI _____ Date _____
Address _____ City _____ State _____ Zip _____
Telephone (W) _____ (H) _____
SSN _____ Date of Birth _____
Occupation _____ Insurance Type _____
Employer _____ Insured's Name _____ DOB _____
Emergency Contact/Telephone Number _____
Date of last eye exam _____ Dilated? _____ Today's Date _____

MEDICAL INFORMATION

What is your general health? _____

Do you have problems with any of these symptoms? (Please circle all that apply)

Gastrointestinal	Yes / No	Nervous	Yes / No	Eyes	Yes / No
Ears/Nose/Throat	Yes / No	Genitourinary	Yes / No	Mental	Yes / No
Cardiovascular	Yes / No	Musculoskeletal	Yes / No	Endocrine (glands)	Yes / No
Respiratory	Yes / No	Integumentary (skin)	Yes / No	Blood/lymph	Yes / No
				Allergic/immunologic	Yes / No

Please explain _____

Please answer all that apply:

Diabetes Yes / No Type _____ Date of diagnosis _____

Allergies Yes / No Allergic to what? _____ What happens? _____

Medication allergy Yes / No What happens? _____ Headaches Yes / No

Other health problems _____

Current medication(s) _____

Have you had any operations? Yes / No Kind? _____ When? _____

Do you use cigarettes/tobacco? _____ Alcohol? _____ Other substance(s)? _____

Name of family doctor _____ Date of last visit _____

Date of last tetanus shot _____

FAMILY HISTORY

High blood pressure Yes / No Relation _____ Macular degeneration Yes / No Relation _____

Diabetes Yes / No Relation _____ Retinal detachment Yes / No Relation _____

Glaucoma Yes / No Relation _____ Cataracts Yes / No Relation _____

Other eye condition(s) Yes / No What kind? _____ Relation _____

PERSONAL INFORMATION

Have you had an eye operation? Yes / No Type _____ Date _____

Have you had an eye injury? Yes / No Kind _____ Date _____

Do you have glaucoma? Yes / No Cataracts? Yes / No Dry Eyes? Yes / No Blurred Vision? Yes / No

Other eye problems? Yes / No What kind? _____

Do you wear glasses? Yes / No Contact Lenses? Yes / No Type _____

Additional Information _____

Whom may we thank for referring you? _____

Doctor's Initials _____