NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Probability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually used or identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and healthcare operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations includes the business aspects of running our practice such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction, if we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effected as of June 10, 2002, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a format, written complain with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice of the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information by asking to speak to our Privacy Officer or for written inquires, note "Attention Privacy Officer"

For more information about HIPPA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

MERCY EYE CARE

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM.

I, ______________________________, have received a copy of **Mercy Eye Care** Notice of
Patient Name
Privacy Practices.

____
Signature of Patient

____
Date

© Gates, Moore & Company

New Patient Information

PERSONAL INFORMATION (Please Print)

Name ______________________________ Date ______________

Date of Birth ____________ Age _____ M / F _____ Soc Security # ______________

Address ____
Street City State Zip

Phone: Home (____) ______________ Work (____) ______________

Complete if under 18 years or a student

Name of Father ______________ Name of Mother ______________

Address ____
Street City State Zip

Phone: Home (____) ______________

Referred by : ☐ Friend/Relative ______________ Doctor ______________
Name Name

☐ Yellow Pages ☐ Television ☐ Newspaper ☐ Other ______________

INSURANCE INFORMATION

☐ Medicare # ______________ ☐ Medical # ______________

☐ Workers Compensation (job injury) to whom is bill to be sent? ______________

☐ Other Medical Insurance ______________

Group # ______________ ID# ______________

Name/Address 2nd Insurance ______________

Are you personally responsible for the payment of your fees? ☐ Yes ☐ No If not, who is?

Name ______________ Relationship ______________ DOB ______________

Who to notify in emergency (nearest relative or friend)?

Name ______________ Relationship ______________

Address ____
Street City State Zip

Home Phone (____) ______________ Work Phone (____) ______________

1FINANCIAL ASSIGNMENT AND AGREEMENT:

2. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.**

3. In Order To Control Your Cost of Billings, We Request That Your Charges For Office Visits Be Paid At The Conclusion Of Each Visit Unless You Are Covered By Insurance.

4. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize Mercy EyeCare Inc. to release all information necessary to secure the payment.

Signed (Patient or parent if minor) Date

MERCY EYE CARE

Medical History Questionnaire

PATIENT'S NAME ______________________ SEX ______ AGE ______

Thank you for choosing our office for your eyecare. To better serve you, please answer the following questions:

1. Do you wear glasses? ☐ Yes ☐ No   2. Do you wear contact lenses? ☐ Yes ☐ No

2. Are you currently experiencing any eye symptoms? Please circle all that apply:

Eye Pain	Blurred Vision	Eyelid Crusting	Flashes of Light	Halos
Discharge	Light Sensitivity	Double Vision	Decreased Vision	Floaters

3. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc)?
   Yes ☐ No ☐ If YES, please explain: ______________________
4. Have you ever had any eye injury/disease (e.g., glaucoma, cataract, wandering or"lazy"eye, retinal detachment)?
   Yes ☐ No ☐ If YES, please explain: ______________________
5. Have you ever had any surgery?
   Yes ☐ No ☐ If YES, please provide date and reason ______________________
6. Have you ever been hospitalized?
   Yes ☐ No ☐ If YES, please provide date and reason ______________________
7. Do you take any medications?
   Yes ☐ No ☐ If YES, please list: ______________________
   Do you take any eye medications: ______________________
   Yes ☐ No ☐ If YES, please list: ______________________
8. Do you have any drug or food allergies?
   Yes ☐ No ☐ If YES, please list: ______________________

Review of Systems

Do you currently have any of the follow problems?

	Yes	No	If YES, please explain:
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat)	☐	☐	
Heart problems (e.g. chest pain, irregular heart beat)	☐	☐	
Respiratory problems (e.g., shortness of breath, wheezing, coughing)	☐	☐	
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting)	☐	☐	
Urinal problems (e.g. pain or discomfort, blood in urine)	☐	☐	
Skin problems (e.g. rashes, excessive dryness)	☐	☐	
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)	☐	☐	
Neurologic problems (e.g., numbness, weakness, headaches, paralysis)	☐	☐	
Psychiatric problems (e.g., depression, anxiety)	☐	☐	

Family and Social History

Do any medical or eye diseases run in your family (e.g., diabetes, high blood Pressure, cancer, glaucoma, macular degeneration)?

Yes ☐ No ☐ If YES, please explain: ______________________

Do you smoke? If Yes, how much? ☐   Drink alcohol? If Yes, how much ☐

Signature ______________________ Date ______