Medical History Questionnaire

Name: ______________________________ Date of Birth: ______________
Address: ______________________________ Home Phone: ______________
City, State, ZIP______________________________ Cell Phone: ______________
Guardian (if applicable):______________________________ Occupation: ______________
Email Address: ______________________________ Employer: ______________
Social Security Number: ______________________________ Marital Status: ______________
Name of General Physician: ______________________________ Date of Last Visit: ______________
Location of Last Eye Exam:______________________________ Date of Last Eye Exam: ______________

Ocular System

What is the main purpose of your exam today? ______________________________
Have you ever had any surgery, trauma, or infection to your eyes? Explain: ______________________________
____

Do you currently wear glasses? ☐yes ☐no If yes, how old is your current pair: ______________
Do you wear contact lenses? ☐yes ☐no If yes, how old are your current lenses? ______________

Have you or your family had any of the following? (Check all that apply & the relationship)

Glaucoma: ☐______________ Macular Degeneration: ☐______________ Cataracts: ☐______________
Retinal Detachment: ☐______________ Crossed/Lazy Eye: ☐ ______________ Eye Infections: ☐______________
Explain:______________________________
_
____

Medical History

List any major surgeries and/or hospitalizations you have had: ______________________________
____
List any medications you are currently taking: ______________________________
____
____
Do you have any allergies to medications? ☐yes ☐no If yes, please explain ______________
____

Family Medical History (Check all that apply & list the relationship)

Blindness: ☐______________ Arthritis: ☐______________ Cancer: ☐______________
Diabetes: ☐______________ Heart Disease: ☐______________ High Blood Pressure: ☐______________
Kidney Disease: ☐______________ Lupus: ☐______________ Thyroid Disease: ☐______________
Other: ______________________________

Social History

Do you currently smoke? ☐yes ☐no Type: ______________ How Long? ______________
Do you drink alcohol? ☐yes ☐no Type: ______________ How Often? ______________

Please complete information on back.

Medical History Questionnaire

Do you use illegal drugs? ☐yes ☐no Type: ____________________ How Often? ________________________

Review of Systems (check all that apply)

General:
- Fever ☐
- Weight Loss ☐
- Weight Gain ☐
- Fatigue ☐

Ear, Nose, Throat:
- Allergies ☐
- Sinus ☐
- Dry Mouth ☐
- Cough ☐

Cardiovascular:
- High Blood Pressure ☐
- Heart Surgery ☐
- Heart Disease ☐
- Heart Pain ☐

Respiratory:
- Asthma ☐
- Bronchitis ☐
- Emphysema ☐
- COPD ☐

Kidney and Bladder:
- Kidney Stones ☐
- Frequent Urination ☐

Muscles, Bones, Joints:
- Arthritis ☐
- Joint Pain ☐
- Muscle Pain ☐
- Head or Neck Injury ☐

Skin:
- Growths ☐
- Rashes ☐
- Acne ☐

Neurological:
- Headaches ☐
- Migraines ☐
- Seizures ☐

Psychiatric:
- Depression ☐
- Anxiety ☐
- Insomnia ☐

Endocrine:
- Thyroid ☐
- Diabetes ☐
- Other Glands ☐

Blood/Lymph:
- Anemia ☐
- Cholesterol ☐
- Bleeding Problems ☐

Gastrointestinal:
- Diarrhea ☐
- Constipation ☐
- Ulcer ☐
- Reflux ☐

If you do not have any of the conditions listed above, please check this box ☐

If you answered YES to any of the above or have a condition not listed, please explain:

____

Please complete information on back.

Vision thru Design

138 East Reynolds Road • Suite 101 • Lexington, KY • 40517
T: 859.273.2020 • F: 859.272.8089

Pupilary Dilation

One of the best ways to examine the interior of your eyes is through pupil dilation. We recommend dilation for all of our patients. This will enable to the doctor to see leaking blood vessels, tumors, holes, detachments and other problems that may occur in the peripheral retina. Without dilation retinal problems may go undetected. Dilation is especially important for patients who: have a history of head or eye injuries, over the age of 40, have diabetes, heart disease or hypertension, or have a suspicion of cataracts or glaucoma.

Dilation is painless. The procedure involves placing a drop of anesthetic and a drop of dilation medication into each eye. The side effects of dilation may include: increased glare, sensitivity to bright lights and reduced near vision. These effects may last from 3 to 5 hours. Distance vision is usually not affected. We recommend wearing sunglasses to reduce the sensitivity to bright lights. If you do not have sunglasses, we will provide you with a pair.

Should you prefer not to have your pupils dilated; a retinal photo can be taken instead. If you choose to have a photo there will be a charge of $25.00 for the service.

The importance of Pupilary Dilation has been explained and I understand the importance of dilation to my eye care.

_______ I give Dr. Costa my permission for pupil dilation

_______ I would like to have a retinal photo for $25.00 in lieu of the pupil dilation.

_______ I do not give Dr. Costa my permission for pupil dilation

_______ I would like to discuss my options with Dr. Angela Costa

Patient/Guardian Signature ____ Date____________

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Vision and Medical Insurance Acknowledgement
I understand that I will give all medically necessary information, during my exam, and if there is a medical diagnosis, then Dr. Costa may choose to bill my medical insurance as contracted.

- Accepted Vision Insurance: VSP, Eyemed, VCP, Davis, Blue View Vision, Superior, Metlife, and most Medicaids
- Accepted Medical Insurance: Anthem BCBS, United Healthcare, Bluegrass Family Health, Humana, Medicare and most Medicaids

PATIENT FINANCIAL RESPONSIBILITY
I acknowledge that I am legally responsible for all charges in connection with the medical care, treatments, and any products provided by representatives of Vision thru Design. I understand my insurance carrier may not approve or reimburse for all services in full due to many reasons including: lack of coverage, benefit exclusions, coverage limits, deductible requirements or medical necessity. I understand I am financially responsible for fees not paid in full, co-payments, and policy deductibles. I understand that I will be responsible for any costs incurred attempting to collect an unpaid debt.

Receipt of Notice of Privacy Practices and Consent
The Notice of Privacy Practices contains important information regarding how your medical information may be disclosed and used.

I have read or been offered the Notice of Privacy Practices for Vision thru Design and understand its contents. I consent to the use and disclosure of my health information for the purposes of treatment, payment and regular healthcare operations. I acknowledge that I have received The Notice of Privacy Practices for The Optometric Eye Site.

I have read and understand the office policies of Vision thru Design. I agree to accept responsibility as described on this page and in the Office Policies Notice.

Printed Name: ______________________________

Signature: ___________________________ Date: ____________

Vision thru Design
138 East Reynolds Road • Suite 101 • Lexington, KY • 40517
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NOTICE OF OFFICE POLICIES

- Any and all insurance coverage **MUST** be presented before their time of service.

- There are many different insurance policies, even within the same insurance company. Plans may differ, even within your company. It is the patient's responsibility to know the terms and guidelines of their individual policy. This office is in no way responsible for any decision made by an insurance carrier or any amount paid for services. Any and all questions concerning your insurance coverage should be directed to your insurance company.

- The patient is responsible for any unpaid amount (partial or in full) that is not covered by their insurance company/Medicare/Medicaid/HMO/3rd party.

- This office does accept Medicare. However, Medicare does not cover the Refraction portion of an eye exam. Therefore, each Medicare patient is responsible for payment on refraction and the normal deductibles and co-pays. If Medicare does not cover a vision procedure your co-insurance may not cover it either.

- There will be a $25.00 fee for any returned checks. There is a fee of $15.00 for any forms/reports filled out for a third party. Elementary school, Third party billing and vocational rehabilitation forms are exempt from this fee.

- Our desire is to provide the best patient care possible, in a reasonable time. Any patient who misses an appointment (without prior notice to this office) will be allowed to reschedule ONE time after the missed appointment. If the second appointment is missed, it will be at the discretion of this office whether or not to schedule the patient again.

- It is very important that patients receive the best care afforded by this office. Therefore, some tests may be necessary. The patient may refuse any service at any time. The office may also refuse to provide any service at any time to the patient.

Vision thru Design - HIPAA Notice of Privacy Practices

Effective Date: *September 22, 2013*

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.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Notify you of any breaches involving your Protected Health Information
- Give you this notice of our legal duties and privacy practices regarding health information about you

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

Except for the purposes described below, we will use and disclose Protected Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer. We will only use and disclose your Protected Health Information without your authorization when necessary for:

- ***Treatment***. We may use and disclose Protected Health Information for your treatment and to provide you with treatment-related health care services.
- ***Payment***. We may use and disclose Protected Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received.
- ***Health Care Operations***. We may use and disclose Protected Health Information for health care operations purposes. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.
- ***As Required by Law***. We will disclose Protected Health Information when required to do so by international, federal, state or local law.
- ***To Avert a Serious Threat to Health or Safety***. We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- ***Business Associates***. We may disclose Protected Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. We will only disclose your Protected Health Information to Business Associates who have agreed in writing to maintain the privacy of Protected Health Information as required by law.

- ***Public Health Risks***. We may disclose Protected Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- ***Health Oversight Activities***. We may disclose Protected Health Information to a health oversight agency for activities authorized by law.

- ***Data Breach Notification Purposes.*** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

- ***Lawsuits and Disputes***. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

- ***Law Enforcement***. We may release Protected Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT

Individuals Involved in Your Care or Payment for Your Care. We may disclose your Protected Health Information to a member of your family, a relative, a close friend or any other person you identify, that directly relates to that person's involvement in your health care, if the information is relevant to their involvement and you have agreed or had an opportunity to object.

WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND ISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Protected Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you must make your request, in writing, to Sunil

Chaudhari. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.crystalpm.com.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Protected Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Sunil Chaudhari. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

NOTICE OF PRIVACY PRACTICES

Vision thru Design
138 E. Reynolds Road
Suite 101
Lexington, KY 40511
(859) 273-2020

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW 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 you 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 discloser you health information for payment purposes are: asking you 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 offices. 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 you health information outside of our office for these reasons, we 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. 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 purposes, 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 the 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 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 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 or post card, and/or leave you a reminder message on your answering machine or with someone who answers your phone if you are not home.

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 can 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 to use or disclosure. If you do 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 address listed above.

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 a restriction, send a written request to the office at the address on the top 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 any extra costs. If you want to ask for confidential communications, send a written request to the office address listed at the top of this 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 sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny you 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 at the address listed on the top of this 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 asked us. We will send the corrected information to persons who we know got the wrong 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 day extension of the 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 to the address listed at the top of this notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or 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 address listed at the top of this notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you one electronically or in paper form already. If you want additional paper copies, send a written request to the office at the address listed at the top 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 and have copies available in our office.

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 want to complain to us, send a written complaint to the office at the address listed on the top of this notice. If you prefer, you can discuss your complaint in person or by phone.

Effective date of notice April 30, 2012