PATIENT REGISTRATION AND HISTORY FORM ~ FAMILY EYE HEALTH ASSOCIATES

PATIENT INFORMATION:

Name (Last, First, MI)_____ Date:_____

Address:_____City_____State_____Zip_____

Home Phone_____ 2nd Phone_____ ❒Work ❒Cell

E-Mail_____

Gender: ❒M ❒F Birthdate_____ Age_____

Occupation_____ Employer_____

In case of emergency, contact_____

Relationship_____ Phone_____

If you are a new patient, who may we thank for referring you?_____

INSURANCE INFORMATION:

Insurance #1

Insurance holder_____ Relationship_____Date of Birth_____

Insurance Company_____Policy #_____

Insurance #2

Insurance holder_____ Relationship_____Date of Birth_____

Insurance Company_____Policy #_____

HEALTH HISTORY:

Do you have or have you had any of the following?:

❒ AIDS/HIV
❒ Rheumatoid arthritis
❒ Asthma
❒ Hay fever/allergies
❒ Heart disease
❒ Heart attack. When?_____
❒ High blood pressure
❒ High Cholesterol
❒ Rosacea
❒ Stroke. When?_____
❒ Carotid Artery Disease
❒ Thyroid disease (Hyper/Hypo)
❒ Multiple sclerosis (MS)
❒ Migraines
❒ Anxiety/Depression
❒ Cancer: Where?_____

Other conditions:

Are you diabetic? ❒Y ❒N If YES please fill out this section:

How many years?_____ How do you control it? ❒Diet ❒Medication ❒Insulin

Average blood sugar reading?_____ Your last Hemoglobin A1C reading (if known)?_____

Do you see a specialist for your diabetes? ❒N ❒Y If so, who?_____

Are you pregnant or nursing? ❒Y ❒N

Do you smoke? ❒Never ❒Currently ❒Quit.

May we access your online medication information? ❒Y ❒N

Please list your current medications(Name/mg/how often):

_____
_____
_____
_____

Please list your allergies:

_____
_____
_____
_____

Name & Address of Primary Care Doctor:

_____

_____

_____

Name & Address of Pharmacy:

_____

_____

_____

EYE HEALTH HISTORY:

If you are a new patient, when was your last eye exam_____ Doctor_____

Do you wear (check all that apply):
- ❒ Glasses for distance only
- ❒ Glasses for reading only
- ❒ Bifocals or progressive lenses
- ❒ Contact lenses

Are you interested in:
- ❒ New glasses
- ❒ Contact lenses
- ❒ Laser vision correction

If you wear contacts, please fill out this section:

How many hours per day do you wear contacts?___ How often do you replace your contacts? _____

What brand of contacts do you wear?_____

Describe any problems with your contacts? _____

Have you had the following:
- ❒ Cataracts
- ❒ Macular Degeneration
- ❒ Eye surgery (Please describe)_____
- ❒ Eye injuries (Please describe)_____
- ❒ Crossed or lazy eye
- ❒ Glaucoma

Do you have any of the following symptoms:
- ❒ Blurry vision
- ❒ Eye strain
- ❒ Poor color vision
- ❒ Poor night vision
- ❒ Seeing haloes
- ❒ Double vision
- ❒ Bloodshot eyes
- ❒ Burning eyes
- ❒ Itching eyes
- ❒ Discharge from eyes
- ❒ Watering eyes
- ❒ Dry eyes
- ❒ Seeing spots, floaters, or flashes
- ❒ Temporary vision loss

Have your parents or siblings had any of the following? If so, please list who:

- ❒Glaucoma_____
- ❒Macular degeneration_____
- ❒Blindness_____
- ❒Retinal detachment_____
- ❒Diabetic eye disease_____

Please remember to bring all glasses and contact lenses to your appointment, including contact lens boxes.

Please bring all insurance cards, including vision and medical insurance.

Thank you and we look forward to seeing you!

FAMILY EYE HEALTH ASSOCIATES, LLC

2374 Post Road, Suite 104
Warwick, Rhode Island 02886
Ph (401) 921-0098 ~ Fax (401) 921-0073
www.FamilyEyeRI.com

Date_____

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the notice of Privacy Practices and have been provided an opportunity to review it.

Name_____ Birthdate_____

Signature of patient/parent/guardian/personal representative:_____

INSURANCE INFORMATION

There are two types of health insurance that will help pay for your eye care services and optical products. You may have both types and Family Eye Health Associates accepts most insurance plans in both categories: 1) Vision plans (such as VSP, EyeMed and others) and 2) Medical insurance (such as Blue Cross/Blue Shield, Medicare and others).

· Vision plans only cover routine vision wellness exams, along with eyeglasses and contact lenses. Vision plans do not cover medical eye care (the diagnosis, management or treatment of eye health problems).

· Medical insurance must be used for medical eye care.

· If you have both types of insurance plans it may be necessary for us to bill some services to one plan and some services to the other. We will follow a procedure called coordination of benefits to do this properly and to minimize your out-of-pocket expense.

· If some fees are not paid by your insurance, we will bill you for them, such as deductibles, co-pays or non-covered services as allowed by the insurance contract.

Please provide your insurance cards to our staff member so we can make a copy. We need to have your medical insurance card or Medicare card on file in case we should need it in the future for billing your insurance.

I have read and accept the policies stated above. I certify that I assign directly to Family Eye Health Associates, LLC all insurance benefits, if any, otherwise payable to me for services rendered. ***I understand that I am financially responsible for all charges whether or not paid by insurance.*** I authorize the use of my signature on all insurance submissions. Family Eye Health Associates, LLC may use my health care information and may disclose such information to Medicare or other insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of patient/parent/guardian/personal representative:_____

Printed name of patient/parent/guardian/personal representative:_____

Relationship to patient_____

NOTICE OF PRIVACY PRACTICES

Family Eye Health Associates, LLC
John C. Sellechio, O.D. ~ Janice M.Gardner, O.D.
2374 Post Road, Suite 104, Warwick, RI 02886
Phone: (401) 921-0098
Fax: (401) 921-0073
Web: www.FamilyEyeRI.com
Office Contact: Kim Johnson

Effective date of notice: January 1, 2015

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights. You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices. You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures. We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests

- Respond to lawsuits and legal actions

Your Rights. When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- Get an electronic or paper copy of your medical record. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct your medical record. You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- Get a list of those with whom we've shared information. You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting us.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices. For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures. How do we typically use or share your health information? We typically use or share your health information in the following ways:

- Treat you. We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.
- Run our organization. We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.
- Bill for your services. We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- Help with public health and safety issues
- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety
- Do research. We can use or share your information for health research.
- Comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Respond to organ and tissue donation requests. We can share health information about you with organ procurement organizations.
- Work with a medical examiner or funeral director. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- Address workers' compensation, law enforcement, and other government requests We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

❖ Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

❖ We are required by law to maintain the privacy and security of your protected health information.
❖ We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
❖ We must follow the duties and privacy practices described in this notice and give you a copy of it.
❖ We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.