EYE CARE CENTER
Caring for Your Total Vision Health

Dr. Cynthia G. Neff and Associates
Optometrists

332 4th Street, Freeport, PA 16229
Phone: 724-295-5127 • Fax: 724-295-5130

451 Hyde Park Road, Leechburg, PA 15656
Phone: 724-842-2020 • Fax: 724-845-2800

www.freeporteyecarecenter.com

WELCOME TO OUR OFFICE

(PLEASE PRINT)

Today's Date _____ Date of Last Exam _____

Name _____

Street _____

City _____ State ____ Zip Code _____

Home Phone _____

Cell Phone _____

Work Phone _____

E-mail Address _____

Social Security Number _____

Date of Birth _____ Age ____ Sex: M ___ F ___

Employer (or School) _____

Occupation (or Grade) _____

Vision Insurance _____

Insured's Name _____

Insured's Date of Birth _____

Do you participate in a flexible spending account? YES NO

What is the major purpose of this visit? _____

_____

Any problems with your present contact lenses or glasses?

_____

PATIENT'S MEDICAL HISTORY

Allergies	☐ No	☐ Yes		Arthritis	☐ No	☐ Yes	
Asthma	☐ No	☐ Yes		Cancer	☐ No	☐ Yes	
Skin Disorder	☐ No	☐ Yes		Diabetes	☐ No	☐ Yes	
Eye Diseases	☐ No	☐ Yes		Heart Diseases	☐ No	☐ Yes	
Eye Injury	☐ No	☐ Yes		High Blood Pressure	☐ No	☐ Yes	
Eye Surgery	☐ No	☐ Yes		Kidney	☐ No	☐ Yes	
Lazy Eye	☐ No	☐ Yes		Nerves	☐ No	☐ Yes	
Cataracts	☐ No	☐ Yes		Other	☐ No	☐ Yes	
Glaucoma	☐ No	☐ Yes					

CURRENT MEDICATIONS

Name of Medication _____

_____

_____

_____

Allergy to Medication _____

Are you currently under the care of a physician? ☐ No ☐ Yes

Name of Physician _____

FAMILY MEDICAL HISTORY

			Relationship
Blindness	☐ No	☐ Yes	_____
Cataracts	☐ No	☐ Yes	_____
Glaucoma	☐ No	☐ Yes	_____
Diabetes	☐ No	☐ Yes	_____
Heart Disease	☐ No	☐ Yes	_____
Other	☐ No	☐ Yes	_____

Do you…

Work at a computer for long periods?	☐ No	☐ Yes
Have more than one pair of glasses	☐ No	☐ Yes
Want information on thinner, lighter lenses?	☐ No	☐ Yes
Wear bifocals	☐ No	☐ Yes
(if yes, are you bothered by head tilting, restricted areas of vision correction, etc.?)	☐ No	☐ Yes
Have times when you would rather not wear your glasses?	☐ No	☐ Yes
Send time outdoors? (how much?)	☐ No	☐ Yes
Have prescription sunglasses?	☐ No	☐ Yes
Have problems with glare or reflection particularly when driving at night?	☐ No	☐ Yes
Have family members in need of eyecare?	☐ No	☐ Yes
Want to change your look with different styles of eyewear?	☐ No	☐ Yes
Have you ever worn/are you currently wearing contacts?	☐ No	☐ Yes

What kind _____ Solution used _____

Are you interested in contact lenses? ☐ No ☐ Yes

Do you experience…

- ☐ Burning
- ☐ Itching
- ☐ Nausea
- ☐ Watery Eyes
- ☐ Tearing
- ☐ Dryness
- ☐ Eye Strain
- ☐ Reading problems
- ☐ Glare or reflection
- ☐ Uncomfortable contacts lenses
- ☐ Trouble working up-close
- ☐ Other:
- ☐ Spots
- ☐ Soreness
- ☐ Flashes of light
- ☐ Headaches
- ☐ Redness
- ☐ Double vision
- ☐ Uncomfortable glasses
- ☐ Sudden loss of vision
- ☐ Sensitivity to light
- ☐ Fainting or dizziness
- ☐ Blurry distance vision
- ☐ Blurry near vision
- ☐ Gritty feeling in eyes
- ☐ Objects floating in vision
- ☐ Trouble seeing at night
- ☐ Trouble reading or learning at work, school, or activity

How did you first hear about our office?

Friend or Relative…Who? _____

Another Health Care Practitioner…Who? _____

Yellow Pages…Which directory? _____

Website _____ Cart Ad _____ Table Ad _____ Other _____

Civic Group or Community Event…Which? _____

Previous Patient…Who? _____

NOTICE OF PRIVACY PRACTICES

Member
American Optometric Association

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY.

Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice).

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health 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 disclose your 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" means those administrative and managerial functions that we must carry out in order to run our office. 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.

OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. Not all of these situations will apply to us; some may never come up at our office at all. 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;
- disclosure 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 proceeding, 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" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA;
- [specify other uses and disclosures affected by state law].

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for health care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

SPECIFIC USES AND DISCLOSURES OR INFORMATION REQUIRING YOUR AUTHORIZATION

The following are some specific uses and disclosures we may not make of your health information without your authorization:

Marketing activities. We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent to such payment.

Sale of health information. We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.

Psychotherapy notes. Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

- Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization.
- You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.
- We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.
- We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right:

- **To request restrictions on the health information we may use and disclose for treatment, payment and health care operations.** We are not required to agree to these requests. To request restrictions, please send a written request to us.
- **To receive confidential communications of health information about you in any manner other than described in our authorization request form.** You must take such requests in writing. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.
- **To inspect or copy your health information.** You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.
- **To amend health information.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:
  - was not created by us, unless the person that created the information is no longer available to make the amendment,
  - is not part of the health information kept by or for us
  - is not part of the information you would be permitted to inspect or copy, or
  - is accurate and complete
- **To receive an accounting of disclosures of your health information.** You must make such requests in writing. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).
- **To designate another party to receive your health information.** If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

Complaints:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or 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 want to complain to us, send a written complaint to the office contact person at the address, fax or email shown above. If you prefer, you can discuss your complaint in person or by phone.

Changes to this Notice:

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

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PERSONAL REPRESENTATIVE LIST

Name _____ Birthdate _____

Please list below anyone with whom you authorize this office staff to discuss your personal health information. This list may be edited by you at any time. ie. Family members, caretakers, etc.
Do not include physicians, attorneys insurance co or employers.

_____ _____ _____

_____ _____ _____

_____ _____ _____

I have read the notice of privacy practices of Cynthia G. Neff, OD and Associates and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and health care operations.

Patient X _____ Date _____

If you are signing as personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to patient _____ Print name _____

Source of authority _____

Insured's or authorized person's signature. I authorize payment of medical and vision benefits to the above physician or supplier for services provided.

Signature X _____ Date _____