Checklist for Your Eye Doctor Appointment at Lifetime Eyecare Associates

Have you ever left the doctor's office and thought of a dozen questions you meant to ask? We all do that!

We hope this checklist will help make visit to the eye doctor your best ever.

When you call to make an appointment:

- Describe any vision problems you are having.
- Ask if you will be able to drive yourself home and if the eye examination will temporarily affect your vision?
- Ask how much the exam will cost and if your insurance is accepted.

Before you go for your examination

Make a list of the following:

- Signs or symptoms of eye problems you have noticed (flashes of light, difficulty seeing at night, temporary double vision, loss of vision, etc.)
- Eye injuries or eye surgery you have had (approximate dates, hospitals where treated, etc.)
- Prescription and over-the-counter drugs you are taking.
- Questions you have about your vision.
- Your general health condition (allergies, chronic health problems, operations, etc.)
- Family history of eye problems (glaucoma, cataracts, etc.)

Take along the following:

- Your glasses, prescription sunglasses and/or contact lenses.
- A list of prescription(s) and over-the-counter drugs you are currently taking.
- Vision insurance information
- Medical or health insurance card(s) or your membership certificate.

During the examination

- Ask questions about anything that seems unclear to you, such as the names and purposes of tests you may undergo.
- Ask if there are any changes since your last exam.

Find out when you should return for your next exam.

MEDICAL HISTORY QUESTIONNAIRE

Date____/____/_____

Personal Information

Name Dr. Mr. Mrs. Ms. _____

Date of Birth _____ **Age**_____ **Sex** □ **Male** □ **Female** **SSN** _____

Home Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone # (____**)**_____ **Work Phone # (**____**)**_____ **Cell Phone # (**____**)**_____

Marital Status □ **single** □ **divorced** □ **widowed** □ **married** **Spouse's Name**_____

Email Address: _____

Occupation _____ **Employer / School** _____

Guardian (if under 18) _____ **Relationship** _____

Address (if different) _____ **City** _____ **State** _____ **Zip**_____

How did you hear about us? □ **Yellow Pages** □ **Direct Mail Location** □ **Insurance Book**

□ **Recommendation** **Who may we thank for referring you to us?** _____

Medical History

Date of Last Eye Exam ____/____/_____ **Are you Pregnant and/or nursing?** □ no □ yes

List any and all medications you take: (including oral contraceptives, aspirin, otc meds, and home remedies)

_____

Do you have any allergies? If yes explain:_____

_____

List any surgeries, hospitalizations, and major injuries you have had: _____

_____

Check the eye conditions you have experienced:

□ crossed eyes □ lazy eye □ drooping eyelid □ prominent eyes
□ glaucoma □ retinal disease □ cataracts □ macular degeneration
□ other eye diseases (please list) _____

Do you wear glasses? □ no □ yes If yes, how old are your current pair of lenses?_____
Do you wear contacts? □ no □ yes if yes, how old are your current pair of lenses? _____
Type of contact lenses: □ rigid □ soft □ extended wear □ other Are they comfortable? □ yes □ no

Family History

Please note if any family member (parents, grandparents (maternal or paternal), siblings, children) **has had any of the following diseases**

Disease	Relationship	Disease	Relationship
Blindness		Arthritis	
Cataract		Cancer	
Crossed eyes		Diabetes	
Glaucoma		Heart Disease	
Macular Degeneration		High Blood Pressure	
Retinal Detachment		Kidney Disease	
Eye Disease		Lupus	
		Thyroid	

Do you currently or have you ever had any problems in the following areas. Please indicate all that apply:

Problem	No	Yes	Problem	No	Yes
Loss of Vision	□	□	Asthma	□	□
Blurred Vision	□	□	Chronic Bronchitis	□	□
Double Vision	□	□	Sinus Congestion	□	□
Dryness	□	□	Cancer	□	□
Distorted Vision/Halos	□	□	Diabetes	□	□
Loss of Side Vision	□	□	Heart Disease	□	□
Mucous Discharge	□	□	Kidney Disease	□	□
Redness	□	□	High Blood Pressure	□	□
Gritty Feeling	□	□	Anemia	□	□
Itching	□	□	Thyroid	□	□
Burning	□	□	Lupus	□	□
Foreign Body Sensation	□	□	Urinary System	□	□
Excess Watering/Tearing	□	□	Immune System	□	□
Glare/Light Sensitivity	□	□	Skin Rash/Irritation	□	□
Eye Pain or Soreness	□	□	Headaches	□	□
Chronic Infection of Eyelid	□	□	Seizures	□	□
Styes or Chalazion	□	□	Psychological Dysfunction	□	□
Flashes/Floaters in Vision	□	□	Arthritis	□	□
Tired Eyes	□	□			

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

_____

_____

Do you. . . (check box if answer is yes)

- □ Work at a computer
- □ Think you might benefit from thinner, lighter lenses
- □ Have an interest in a “test drive” of the latest contact lens designs
- □ Spend time outdoors
- □ Have prescription sunglasses
- □ Prefer not to wear your glasses at times
- □ Want information on Laser Vision Correction Surgery
- □ Have problems with glare and halos at night
- □ Enjoy sports that need eye protection
- □ Enjoy outdoor recreation such as golf, tennis, or fishing
- □ Drive and have visual difficulties with glare during the day or night

Social History

This information is kept strictly confidential. If you prefer, you may discuss this section directly with your doctor.

□ Yes, I would prefer to discuss this section directly with my doctor.

Do you drive? □ No □ Yes If yes, do you have visual difficulty when driving? (describe)

_____

Do you use tobacco products? □ No □ Yes If yes, for how long? _____

How much: □ occasional □ 1/2 pack or less/day □ 1-2 packs/day □ 3-4 per day □ more

Do you drink Alcohol? □ No □ Yes If yes, amount/how many years? _____

How often: □ occasional □ 1-2 per day □ 3-4 per day □ more

Do you use illegal drugs? □ No □ Yes If yes, how long? _____

Have you ever been exposed to or infected with: □ Gonorrhea □ Hepatitis □ HIV □ Syphilis

Reviewed by: _____ _____

Doctor’s signature Date

HIPAA PRIVACY ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____(print full legal name of patient or patient's legal representative), have been presented with the Notice of Privacy Practice of Lifetime Eyecare Associates, and have been offered a copy of such policy to keep for my records.

☐ I hereby acknowledge that I have been provided with a copy of the policy

☐ I hereby decline a copy of the Policy. I understand that although I have not received a copy of the policy, an optometrist of *Lifetime Eyecare Associates* may still provide treatment for me.

_____

Signature of patient or legal representative *Date*

PATIENT FINANCIAL RESPONSIBILTY

Patient Name _____

Insurance _____

Insurance plans vary greatly in their coverage, even within the same insurance company. Your insurance plan may not pay for all your vision care costs. It will only pay for a percentage of covered items and services when all the rules are met. We make every attempt to find out what your insurance will cover before services are provided; however, only after the claim has been processed can we be sure of the actual coverage provided.

Payments for services not covered by insurance are due at the time of service. Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not *Lifetime Eyecare Associates*.

You are responsible to pay for:

- All co-pays
- All deductible amounts
- Your percentage of covered items and services
- Any items and services which your insurance company identifies as "non-covered"

We will, in most cases, file your insurance claim as a service to you. However, if your insurance company has not paid within 60 days, you will be responsible for the charges in full. Should your account become delinquent and need to be turned over to collections, there will be a 15% fee added to the outstanding balance.

I understand and agree to the conditions outlined above.

_____

Signature of patient or legal representative *Date*

Please provide the following information for insurance purposes:

Primary Insured's *(not insurance company name)*

Name _____

SSN ____/____/____ DOB ____/____/____

Address _____

Secondary Insurance Member *(not insurance company name)*

Name _____

SSN ____/____/____ DOB ____/____/

Address _____

Lifetime Eyecare Associates

NOTICE OF PRIVACY PRACTICES

Jeremy R Burns, O.D.
2428 Reidville Road
Spartanburg, SC 29301

Office 864.576.7225 **Fax 864.576.7226**

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.

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 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" mean those administrative and managerial functions that we have to do 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. We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not 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 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;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence; ses 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 on a post card, and/or leave you a reminder message on your home 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 the 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 contact person named at the beginning of this Notice.

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 contact person at the address, fax or E Mail shown at the beginning 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 E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning 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 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 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 contact person at the address, fax or E mail shown at the beginning 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 ask us. We will send the corrected information to persons who we know got the wrong information, and 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 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 for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past 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 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 office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning 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, have copies available in our office, and post it on our Web site.

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 contact person at the address, fax or E mail shown at the beginning of this Notice. 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 at the address or phone number shown at the beginning of this Notice.