

WELCOME TO WOODLANDS EYECARE!

Patient Information

Name: _____ Date of Birth: _____ Age: _____

Home #: _____ Work #: _____ Cell #: _____

Address: _____ City: _____ Zip Code: _____

Marital Status: _____ Spouse's Name: _____ Hobbies: _____

Employer: _____ Occupation: _____

Social Security #: _____ Driver's License #: _____

How did you hear about our office? _____

Medical & Eye History

List all medications & the dosages you are currently taking: _____

List any medication/drug allergies: _____

List any environmental allergies: _____

EYE CONDITIONS

Cataracts	_____ Me	_____ Family
Glaucoma	_____ Me	_____ Family
Macular Degeneration	_____ Me	_____ Family
Eye Surgery	_____ Me	_____ Family
Eye Trauma	_____ Me	_____ Family

MEDICAL CONDITIONS

Diabetes	_____ Me	_____ Family
High Blood Pressure	_____ Me	_____ Family
Heart Disease	_____ Me	_____ Family
Breathing Difficulty	_____ Me	_____ Family
Headaches	_____ Me	_____ Family
Infectious Disease	_____ Me	_____ Family

Do you wear glasses? Yes or No

Do you wear contacts? Yes or No

If Yes, what brand? _____

Hours worn each day? _____

Solution(s)? _____

Date of Last Eye Exam: _____

Doctor's Name: _____

Have you had surgery? Yes or No

If Yes, what kind & when? _____

Have you had any major illness? Yes or No

If Yes, what kind & when? _____

Please continue to the second side to complete your Insurance information

Patient's Name: _____

Billing Information

Responsible Party: _____ Relationship to Patient: _____

Address, if different: _____

Phone #, if different: _____ Work #, if different: _____

Insurance Information

Insurance Company: _____ Phone #: _____

Address: _____ City: _____ Zip Code: _____

Name of Insured: _____ Relationship to Patient: _____

Subscriber #: _____ Group #: _____

Please read this carefully, then sign & date below:

- **This document is to serve as my signature on file. I authorize payment of benefits to Woodlands Eyecare.**

- **I understand that any monies not paid by my insurance company (for any reason) will be my responsibility. I agree to submit payment for any remaining balance to Woodlands Eyecare upon notification.**

- **The Contact Lens Exam is a separate exam for ensuring proper fit of your contacts & evaluating your vision with the contacts & may not be covered by your insurance.**

- **If insurance does not apply, I understand that I will be held responsible & liable for all services & materials.**

- **All fees are due at the time services are rendered.**

Signature of Patient/Guardian: _____ Today's Date: _____

Notice of Privacy Practices
Woodlands Eyecare
5246 Highway 377, Suite #1
Krugerville, Texas 76227
(Phone) 940.365.0440

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

General Rule

We respect our legal obligation to keep health information, that identifies you, private. The law obligates us to give you notice of our privacy practices.

Generally, we can only use your health information in our office or disclose it outside of our office, without your written permission, for purposes of treatment, payment or healthcare operations. In most other situations, we will not use or disclose your health information unless you sign a written authorization form. In some limited situations, the law allows or requires us to disclose your health information without written authorization.

Uses or Disclosures of Health Information

Examples of how we use information for treatment purposes:

- When we set up an appointment for you.
- When our technician or doctor tests your eyes.
- When the doctor prescribes glasses or contact lenses.
- When the doctor prescribes medications.
- When our staff helps you select and order glasses or contact lenses.
- When we show you low vision aids.

We may disclose your health information outside of our office for treatment purposes, for example:

- If we refer you to another doctor or clinic for eye care or low vision aids or services.
- If we send a prescription for glasses or contacts to another professional to be filled.
- When we provide a prescription for medication to a pharmacist.
- When we phone to let you know that your glasses or contact lenses are ready for pickup.

Sometimes we may ask for copies of your health information from another professional that you may have seen before.

We may use your health information within our office or disclose your health information outside of our office for payment purposes.

Some examples are:

- When our staff asks you about health or vision care plans that you may belong to, or about other sources of payment for our services.
- When we prepare bills to send to your or your health or vision care plan.
- When we process payment by credit card and when we try to collect unpaid amounts due.
- When bills or claims for payment are mailed, faxed, or sent by computer to you or your health or vision plan.
- When we occasionally have to ask a collection agency or attorney to help us with unpaid amounts due.

We use and disclose your health information for healthcare operations in a number of ways. Healthcare operations means those administrative and managerial functions that we have to do in order to run our office. We may use or disclose your health information, for example, for financial or billing audits, for internal quality assurance, for personnel decisions, to enable our doctors to participate in managed care plans, for the defense of legal matters, to develop business plans, and for outside storage of our records.

Appointment Reminders

We may call to remind you of scheduled appointments. We may also call to notify you of other treatments or services available at our office that might help you.

Uses & Disclosures without an Authorization

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 happen at our office at all. Such uses or disclosures are:

- A state or federal law that mandates certain health information be reported for a specific purpose.
- Public health purposes, such as contagious disease reporting, investigation of surveillance; and notice to and from the Food and Drug Administration regarding drugs and 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, audits by Medicare or Medicaid, or investigation of possible violations of healthcare laws.
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or court or administrative agencies.

- Disclosure 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.
- Use or disclosures for specialization 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 relating to workers' compensation programs.
- Disclosures to business associates who perform healthcare operations for us and who agree to keep your health information private.

Other Disclosures

We will not make any other uses or disclosures of your health information unless you sign a written authorization form. You do not have to sign such a form. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it.

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 Woodlands Eyecare at the address, fax or e-mail shown at the beginning of this notice.
- You can 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 email 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 Woodlands Eyecare at the address, fax or e-mail shown at the beginning of this notice.
- You can ask to see or to get photocopies of your health information. By law, there are a few limited situation in which we can refuse to permit access or copying. Primarily, however, you will be able to review or have a copy of your health information within 30 days of asking us. 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 required. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we sent you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to Woodlands Eyecare at the address, fax or e-mail shown at the beginning of this notice.
- You can 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 in your health information along with any rebuttal statement that we may write. Once your statement of position and/or 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 Woodlands Eyecare at the address, fax or e-mail shown at the beginning of this notice.
- You can 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), except disclosures for purposes of treatment, payment or health care operations, disclosures made in accordance with an authorization signed by you, 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 health information, send a written request, including your reasons for the amendment, to Woodlands Eyecare 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 in compliance with and 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 website.

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 Woodlands Eyecare 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 Woodlands Eyecare at the address, fax or e-mail shown at the beginning of this notice.

Woodlands Eyecare

5246 Highway 377, Suite #1
Krugerville, Texas 76227
(Phone) 940.365.0440

Consent for Use & Disclosure for Health Information

Section A: Patient Giving Consent

Patient Name: _____ Patient Phone Number: _____

Patient Address: _____

E-mail: _____

Section B: To The Patient - please read the following statements carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to only carry out treatment, payment activities and submissions of insurance.

Notice to Privacy Practices: You have the right to read your Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health care operations. There is a copy posted in our waiting area. Upon request, we can issue you a copy of this policy.

You may obtain a copy from our office by contacting us at the following:

Contact Person: Dr. Coly Marsh

Telephone: 940.365.0440

E-mail: Coly.Marsh@friscoeye.net

Address: 5246 Highway 377, Suite #1, Krugerville, Texas 76227

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any prior action taken on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke the Consent.

Signature:

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your office and disclosure of my protected health information to carry out insurance filing, treatment, and payment activity.

Signature

Date

Personal Representative's Name

Relationship to Patient

You are entitled to a copy of this consent after you sign it, please ask.