Welcome

eye studio AT ANTHEM

Last Name_____
First (Legal) Name _____ MI_____
Preferred Name _____
Street _____
City_____State_____Zip _____
Preferred Phone _____
Alternate Phone _____
Patient's SSN _____
Date of Birth _____Age _____
Employer (or School) _____
Occupation (or Grade) _____
Email Address _____

Are you having any specific problems with your eyes?_____

When was your last eye exam? _____
By Whom? _____

Have you or a family member had?	Patient	Mother's Family	Father's Family
Blindness	❑	❑	❑
Cataracts	❑	❑	❑
Corneal Problems	❑	❑	❑
Diabetes	❑	❑	❑
Glaucoma	❑	❑	❑
Heart Disease	❑	❑	❑
Lazy Eye	❑	❑	❑
Macular Degeneration	❑	❑	❑
Retinal Problems	❑	❑	❑
Dry Eyes / Grittiness	❑		
LASIK, PRK, or ICL	❑		

Other eye concerns or injuries_____

Have you ever tried contact lenses? ❑ Yes ❑ No
Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?_____
Solutions used_____
Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Who may we **thank** for referring you to us?
❑ Friend/ Family/ Dr. Whom? _____
❑ Saw Sign / Building / Location
❑ Web Page: Which Web Site? _____
❑ Insurance List
❑ Other_____

Do you have...(check if answer is yes)
❑..difficulty seeing the road or other cars?
❑..prescription sunglasses?
❑..interest in lighter weight lenses?
❑..interest in glasses that place less pressure on your head?
❑..interest in trying the latest contact lenses?
❑..difficulty finding the clearest spot in your bifocals or progressives?
❑..family members in need of eye care?
❑..prescription computer glasses?

Do you use a .. ❑desktop computer? ❑laptop computer? ❑ipad/tablet?
How many hours per day do you use a computer, tablet, or smart phone?___
During or after using a computer, do you have any of the following...
❑Blurry vision? ❑Double vision? ❑Dry, tired, burning, or sore eyes?
❑Headaches? ❑Neck pain, shoulder pain, back pain, or bodily fatigue?

Family Dr. Name_____
Address or Phone Number _____
Date of Last Physical Check-up_____
Please list any surgeries you have had_____
_____
Do you use cigarettes/tobacco? ❑ Yes ❑ No
Do you use alcohol or other substances? ❑Sometimes ❑Frequently ❑Never
Are you pregnant or nursing? ❑ Yes ❑ No
Please list **medications** including vitamins, aspirin, eye drops, and birth control. **OR** we can **photocopy your medication list**

_____
_____
_____
_____

Please list any **medication allergies**_____

Have you had trouble with?		
❑Allergies / Sinus	❑Arthritis	❑Blood / Lymph
❑Endocrine / Thyroid	❑Cancer	❑Respiratory / CPAP
❑Ear / Nose / Throat	❑Digestive	❑High Cholesterol
❑Eczema / Skin	❑Fatigue	❑Frequent Headaches
❑Genitourinary	❑Kidney	❑High Blood Pressure
❑Throat Infections	❑Muscle / Bone	❑Unusual weight change
❑Neurological	❑Psychological	❑Crossed eye / Eye turn
❑Tearing / Burning	❑Eye Itchiness	❑Flashes of light
❑Floaters	❑Iritis / Uveitis	❑Sunlight Sensitivity
❑Double Vision	❑Eye infection	

Medical Insurance		**Vision Insurance**
_____	Insurance Company	_____
_____	ID #	_____
_____	Group #	_____
_____	Subscriber Name	_____
_____	Subscriber SSN	_____
_____	Subscriber D.O.B.	_____
_____	Subscriber Employer	_____

Acknowledgment of Receipt: I acknowledge that I have received the Notice of Privacy Practices with an effective date of January 28, 2008, and I understand that I may contact the privacy officer if I have any questions regarding this Notice. **X**_____ **(date) X**_____

Assignment and release: I certify that I and/or my dependent(s) have insurance as declared and assign directly to Korman Optometry Ltd. all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. Korman Optometry Ltd. may use my health care information and may disclose such information to the named 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. **X**_____ **(date) X**_____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY KORMAN OPTOMETRY LTD. AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

effective date: January 28, 2008

UNDERSTANDING YOUR PATIENT HEALTH INFORMATION (PHI):

Understanding what is in your health record and how your health information is used will help you to ensure its accuracy, allow you to better understand who, what, when, where and why others may access your health information, and assist you in making more informed decisions when authorizing disclosure to others. When you visit us, we keep a record of your symptoms, examination, test results, diagnoses, treatment plan, and other medical information. We also may obtain health records from other providers. In using and disclosing this protected health information (PHI) we will follow the Privacy Standards of the Federal Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Part 464. The law allows us to use and disclose PHI without your specific authorization for treatment, payment, operations and other specific purposes explained on the next page. This includes contacting you for appointment reminders and follow-up care. All other uses and disclosures require your specific authorization.

YOUR HEALTH INFORMATION RIGHTS: You have the right to:

- Request a restriction on the uses and disclosures of PHI as described in this notice, although we are not required to agree to the restriction you request. You should address your request in writing to the Privacy Officer. We will notify you within 30 days if we cannot agree to the restriction.
- Obtain a paper copy of this Notice and upon written request, inspect and obtain a copy of your health record for a fee of $.20 per page and the actual cost of postage per **NRS 629.061**, except that you are not entitled to access to, or to obtain a copy of, psychotherapy notes and information compiled for legal proceedings.
- Amend your health record by submitting a written request with the reasons supporting the request to the Privacy Officer. In most cases, we will respond within 30 days. We are not required to agree to the requested amendment.
- Obtain an accounting of disclosures of your health information, except that we are not required to account for disclosures for treatment, payment, operations, or pursuant to authorization, among other exceptions.
- Request in writing to the Privacy Officer that we communicate with you by a specific method and at a specific location. We will typically communicate with you in person; or by letter, e-mail, fax, and/or telephone.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

OUR RESPONSIBILITIES: The law requires us to:

- Maintain the privacy of PHI and provide you with notice of our legal duties and privacy practices with respect to PHI.
- Abide by the terms of the notice currently in effect. We have the right to change our notice of privacy practices and we will apply the change to all of your protected health information, including information obtained prior to the change.
- Post notice of any changes in our privacy policy in the lobby and make a copy available to you upon request.
- Use or disclose your health information only with your authorization except as described in this notice.
- Follow the more stringent law in any circumstance where other state or federal law may further restrict the disclosure of your health information.

FOR MORE INFORMATION OR TO REPORT A PROBLEM, you may contact the designated Privacy Officer, Dr. Shana Korman, in writing at 2870 Bicentenial Parkway, Suite 130, Henderson, NV 89044 or by calling 702-459-3937. If you feel your rights have been violated, you may file a complaint in writing with the Privacy Officer. If you are not satisfied with the resolution of the complaint, you may also file a complaint with the Secretary of Health and Human Services. Filing a complaint will not result in retaliation.

We may use or disclose your protected health information for treatment, payment and operations, and for purposes described below:

Treatment: We will use and exchange information obtained by a physician, nurse practitioner, nurse or other medical professionals, staff, trainees and volunteers in our office to determine your best course of treatment. The information obtained from you or from other providers will become part of your medical records. We may also disclose your health care information to other outside treating medical professionals and staff as deemed necessary for your care. For example, we may disclose your health information to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment.

Payment: We may send a bill to you or to your insurance carrier. The information on or accompanying the bill may include information that identifies you, as well as that portion of your PHI necessary to obtain payment.

Health Care Operations: Members of the medical staff, trainees, medical students, a Risk or Quality Improvement team, or similar internal personnel may use your information to assess the care and outcomes of your care in an effort to improve the quality of the healthcare and service we provide or for educational purposes. For example, an internal review team may review your medical records to determine the appropriateness of care. There may also be times in which our accountants, auditors or attorneys may be required to review your health information to meet their responsibilities.

Other uses and disclosures not requiring authorization

- Business Associates: There are some services provided to our organization through contracts with business associates, such as laboratory and radiology services. We may disclose your health information to our business associates so that they can perform these services. We require the business associates to safeguard your information to our standards.
- Notification: We may disclose limited health information to friends or family members identified by you as being involved in your care or assisting you in payment. We may also notify a family member, or another person responsible for your care, about your location and general condition.
- Legally Required Disclosures, Public Health & Law Enforcement: We may disclose PHI as required by law, or in a variety of circumstances authorized by federal or state law. For example, we may disclose PHI to government officials to avert a serious threat to health or safety or for public health purposes, such as to prevent or control communicable disease (which may include notifying individuals that may have been exposed to the disease, though in such circumstance you will not be personally identified), to an employer to evaluate whether an employee has a work related injury, and to public officials to report births and deaths.
- We may disclose PHI to law enforcement such as limited information for identification and location purposes, or information regarding suspected victims of crime, including crimes committed on our premises. We may also disclose PHI to others as required by court or administrative order, or in response to a valid summons or subpoena.
- Information Regarding Decedents: We may disclose health information regarding a deceased person to: 1) coroners and medical examiners to identify cause of death or other duties, 2) funeral directors for their required duties and 3) to procurement organizations for purposes of organ and tissue donation.
- Research: We may also disclose PHI where the disclosure is solely for the purpose of designing a study, or where the disclosure concerns decedents, or an institutional review board or privacy board has determined that obtaining authorization is not feasible and protocols are in place to ensure the privacy of your health information. In all other situations, we may only disclose PHI for research purposes with your authorization.
- Marketing: We may contact you with information about treatment alternatives or other health related benefits and services that may be of interest to you.
- Fund raising: We may contact you as part of a fund raising effort.
- Directory information: We may disclose limited information regarding your name and location for directory purposes to those persons who ask for you by name or to members of the clergy. You may request that we not include your name in the directory.

Disclosures requiring authorization

All other disclosures of protected health information will only be made pursuant to your written authorization, which you have the right to revoke at any time, except to the extent we have already relied upon the authorization.