Lasik Pro
Eye Consultants

PATIENT INFORMATION

Patient's Name: _____ **Date of Birth:** _____/_____/_____

Home Street Address: _____

City/State/Zip Code: _____

***If Child, Parent's Name*:** _____

Home Phone: _____ **Cell:** _____ **Work:** _____

E-MAIL: _____

Sex at Birth: Male Female **Marital Status:** _____

Occupation: _____ **Employer:** _____

Referring Doctor: _____

IN CASE OF AN EMERGENCY, PERSON TO NOTIFY:

Name: _____ ***Phone:*** _____ ***Relationship:*** _____

INSURANCE INFORMATION

Insurance Company: _____

Please complete the following if the insured person is NOT the patient

Policy Holder Name: _____ ***Date of Birth:*** _____

Relationship to the Patient: ***Parent*** ***Spouse***

NAME OF PERSON RESPONSIBLE FOR PAYMENT (IF OTHER THAN PATIENT):

_____

Relationship to the Patient: _____ **Phone Number:** _____

Lifetime Authorization and Assignment of Benefits

I hereby authorize the physicians and staff of Lasik Pro to perform such treatments to me as may be prescribed by my attending physician during any and all my visits to Lasik Pro. I understand that I am financially responsible for all charges arising from services rendered to me by Lasik Pro. I hereby authorize Lasik Pro to file on any and all insurance for any charges that I incur. I request that all payments from any of these insurance's be mailed directly to Lasik Pro. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, or any insurance company, any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature: _____ **Date:** _____

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MEDICAL HISTORY INFORMATION

Patient Name: _____

Who is your family physician? _____

Have you ever been treated/informed you have any of the below?

	Yes	No		Yes	No
Previous Eye Injuries	___	___	High Blood Pressure	___	___
Glaucoma	___	___	Seasonal Allergies	___	___
Cataract	___	___	Diabetes	___	___
Retinal Detachment	___	___	Heart Problems	___	___
Macular Degeneration	___	___	Asthma	___	___
Diabetic Retinopathy	___	___	Emphysema	___	___
Amblyopia	___	___	Arthritis	___	___
Lazy/Cross Eye	___	___	Thyroid Disease	___	___
Dry Eyes	___	___	Hepatitis or Liver Disease	___	___
Corneal Disease	___	___	Kidney Problems	___	___
Uveitis	___	___	Tuberculosis	___	___
Lasik	___	___	Bruise Easily	___	___
RK	___	___	Autoimmune Disease (Lupus, Sjogren's, Rheumatoid)	___	___

List other medical conditions that apply to you _____

Has anyone in your immediate family ever been treated or informed they had any of the following?

	Yes	No	Relative
Glaucoma	___	___	_____
Cataract	___	___	_____
Retinal Detachment	___	___	_____
Macular Degeneration	___	___	_____
Amblyopia	___	___	_____
Lazy/cross eye	___	___	_____

Do you smoke? Yes ___ No___ Packs Per Day ____ Do you drink? Yes ___ No___ How much? _____

Allergies: _____

Eye Medications: _____

Medications: _____

_____

_____

Are you pregnant? ___ Yes ___ No ___ N/A

Have you ever worn contact lenses? _____ **Type:** _____

NOTICE OF PRIVACY PRACTICES

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" mean 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;

disclosures 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 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" 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

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 heath 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 OF 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 at the address below.

To receive confidential communications of health information about you in any manner other than described in our authorization request form. You must make such requests in writing to the address below. 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 at the address below. 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 to the address below. 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.

Contact Person:

Our contact person for all questions, requests or for further information related to the privacy of your health information is:

Christen Chadbourne, Practice Administrator 407-245-3636

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 E mail 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.

Notice Revised and Effective: September 23, 2013

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of **LASIK PRO, P.A**., Notice of Privacy Practices.

Patient name_____ Signature _____Date:_____

Medications and refill policy

Brian Den Beste, O.D. F.A.A.O **Kyle Den Beste, M.D.**

PHARMACY NAME:_____**PHONE:**_____

ADDRESS:_____

- Please be sure that our office has the most up to date list of current medications that you are taking. Please be sure to also have a list readily available at each appointment should our office request it. It is your responsibly to notify our office of any changes or any new medications.

- It is your responsibility to notify the office in a timely manner when refills are necessary. **Approval of your refill may take up to 3-5 business days** so please be courteous and do not wait to call. If you use a mail order pharmacy, please contact us 14 days before your medication is due to run out.

- Refill requests will only be addressed during regular office hours (Monday-Thursday 8am-5pm and Friday 8am-3pm). Requests received on the weekends or holidays will be handled by the office the following business day.

- Please have the name of the medication(s), pharmacy name and phone number available when you call.

- We can only authorize medications prescribed by our office. We will not refill medications prescribed by other doctors.

- It is important to keep your scheduled appointments to ensure that you receive timely refills. Repeated no shows or cancellations will result in a denial of refills. All prescriptions require a follow up appointment every 3-6 months or as determined by the doctor. Before coming in to your next appointment, please be sure to check your medication(s) for refills so we may give you a written prescription at the time of your appointment.

- New symptoms or events require an appointment. Your doctor will not diagnose or treat over the phone.

Patient name (Print):_____

Patient signature: _____

Date: _____

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

(**Please list names**)

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Doctor(s)_____

[ ] Email_____

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Communication preferences

Please call [ ] my home [ ] my work [ ] my cell

Number: _____

Voicemail

[ ] can we leave a detailed message

[ ] can we leave a message asking you to return our call

Other

[ ] _____

[ ] texting ok

Signed: _____ Date: ____/____/_____