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NOTICE OF PRIVACY

Norma Tucker, HIPAA Coordinator 459-2641

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.

EFFECTIVE DATE OF NOTICE: 01/01/2003

We respect our legal obligation to keep private any health information that identifies you. 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;
- 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 relating to worker's compensation programs;
- 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;

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.

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 this office.

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 this office 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 this office 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 this office 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 this office 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 this office 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 this office 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 number listed above, or you can discuss your complaint in person.

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.

PATIENT INFORMATION

Please check the information on this report for accuracy. Please make corrections and fill in any missing information. Thank you for your cooperation.

NAME:					
ADDRESS:					
CITY:		STATE:		ZIP:	
HOME PHONE:				CELL:	
WORK PHONE:					
BIRTHDATE:				MARITAL STATUS:	
SOCIAL SECURITY NUMBER:					
OCCUPATION / GRADE:					
EMPLOYER / SCHOOL:					
EMAIL ADDRESS:					

INSURANCE INFORMATION

INS. CO.	ID NUMBER	SUBSCRIBER	SUBSCRIBER ID	SUBSCRIBER BIRTHDATE
VISION				
MEDICAL				

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICIES

I acknowledge that I received a copy of the Notice of Privacy Practices for this office.

Guardian

X _____ DATE

INSURANCE AUTHORIZATION

I request that payment of authorized Insurance benefits for any services furnished me, be made on my behalf to:

I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

I understand that I am responsible for charges not paid by the insurance plan.

X _____ DATE

Date: _____ Date Of Last Eye Exam: _____
 Patient: _____ Birthdate: _____
 Address: _____ Age: _____
 Referred By: _____ Sex: _____
 Emergency Contact: _____ Emergency Contact Telephone: _____

REVIEW OF HEALTH SYSTEMS ◆ (ROS)

◆ **EYES** Have you had or do you have any of the following?

Glaucoma:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:
Cataracts:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:
Dry Eyes:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain:
Other eye problems:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Description:

Please describe any problems with the following health systems:

◆ GASTROINTESTINAL <input type="checkbox"/> No Problem <input type="checkbox"/> Ulcer <input type="checkbox"/> Colitis <input type="checkbox"/> Heartburn <input type="checkbox"/> Diarrhea <input type="checkbox"/> Other: _____ Meds: _____	◆ NEUROLOGICAL <input type="checkbox"/> No Problem <input type="checkbox"/> Epilepsy <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Headaches <input type="checkbox"/> Numbness <input type="checkbox"/> Other: _____ Meds: _____	
◆ EARS/NOSE/THROAT <input type="checkbox"/> No Problem <input type="checkbox"/> Upper Respiratory Infection <input type="checkbox"/> Sinusitis <input type="checkbox"/> Chronic colds <input type="checkbox"/> Other: _____ Meds: _____	◆ CONSTITUTIONAL <input type="checkbox"/> No Problem <input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Trauma <input type="checkbox"/> Other: _____ Meds: _____	
◆ CARDIOVASCULAR <input type="checkbox"/> No Problem <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Vascular Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Chest Pain <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Other: _____ Meds: _____	◆ MUSCULOSKELETAL <input type="checkbox"/> No Problem <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Joint Pain <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Other: _____ Meds: _____	
◆ RESPIRATORY <input type="checkbox"/> No Problem <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Wheezing <input type="checkbox"/> Coughing <input type="checkbox"/> Other: _____ Meds: _____	◆ INTEGUMENTARY (SKIN) <input type="checkbox"/> No Problem <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema <input type="checkbox"/> Rashes <input type="checkbox"/> Acne <input type="checkbox"/> Cancer <input type="checkbox"/> Excessive Dryness <input type="checkbox"/> Other: _____ Meds: _____	
◆ ALLERGIC/IMMUNE <input type="checkbox"/> No Problem <input type="checkbox"/> Allergies: _____ <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Drug allergies: _____ <input type="checkbox"/> Lupus <input type="checkbox"/> HIV <input type="checkbox"/> Meds: _____	◆ ENDOCRINE (GLANDS) <input type="checkbox"/> No Problem <input type="checkbox"/> Thyroid Dysfunction <input type="checkbox"/> Hormonal Dysfunction <input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Type 2 Diabetes <input type="checkbox"/> Meds: _____	
◆ BLOOD / LYMPH <input type="checkbox"/> No Problem <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Other: _____ Meds: _____	◆ PSYCHIATRIC (MENTAL) <input type="checkbox"/> No Problem <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Other: _____ Meds: _____	◆ GENITOURINARY <input type="checkbox"/> No Problem <input type="checkbox"/> STD <input type="checkbox"/> Bladder Infection <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Other: _____ Meds: _____

PAST, FAMILY, & SOCIAL HISTORY ★ (PFSH)

★ **PATIENT PAST HISTORY**

Have you had any eye operations? Yes No Date: _____ Type: _____
 Have you had an eye injury? Yes No Date: _____ Type: _____
 Have you had a retinal detachment? Yes No Date: _____ Treatment: _____
 Name of family doctor: _____
 List any eye medications you are currently taking: _____

★ **SOCIAL HISTORY**

Do you use alcohol? Yes No Amount: _____
 Do you use tobacco? Yes No Amount: _____
 Do you use other substances? Yes No What: _____
 Describe any special visual needs: _____

★ **FAMILY HISTORY** Do any family members have any of the following problems:

High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____	Macular Degeneration <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____
Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____	Retinal Detachment <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____
Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____	Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____
Other eye condition <input type="checkbox"/> Yes <input type="checkbox"/> No Relation _____ Description: _____	

Patient Signature: _____

Date Reviewed _____ Changes _____

No Changes _____
 No Changes _____
 No Changes _____
 No Changes _____

FOR OFFICE USE ONLY

◆ ROS ELEMENTS PP=1 Ext=2-9 Comp= 10-14
 ★ PFSH AREAS 1 2 3

Dr. Init	Review Date	ROS Elements	PFSH Areas
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____