LAST NAME:_____FIRST & MIDDLE NAME:_____

ADDRESS:_____

CITY:_____ ST:_____ ZIP:_____

DATE OF BIRTH:_____/_____/_____ AGE:_____ SEX:_____

SOCIAL SECURITY #:_____

SPOUSE'S/PARENT'S NAME:_____

CELL PHONE:_____ EMAIL:_____

FINANCIAL INFORMATION:

PAYMENT IS DUE AT TIME SERVICES ARE RENDERED AND/OR MATERIALS ORDERED. IF PAYING BY CASH, PLEASE BE PREPARED TO HAVE CORRECT CHANGE, AS WE DO NOT KEEP CASH ON HAND.

PLEASE CIRCLE TODAY'S METHOD OF PAYMENT:

CASH CHECK DEBIT/CREDIT CARD CARECREDIT

STATEMENT TO PERMIT PAYMENT OF MEDICARE & ALL OTHER INSURANCE BENEFITS TO PROVIDER, PHYSICIANS, AND PATEINT:

I HEREBY REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE OR ANY OTHER INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF FOR ANY SERVICES FURNISHED TO ME BY J. BART BRADY,O.D. OR AUTUMN ADAMS, O.D., DOING BUSINESS AS GLOBL EYE CARE, INCLUDING PHYSICIAN SERVICES. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS OR ANY OTHER THIRD PARTY INSURANCE CARRIER, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR BENEFITS FOR RELATED SERVICES. HOWEVER, I AGREE TO ACCEPT RESPONSIBILITY FOR ANY SERVICES PERFORMED THAT ARE DENIED COVERAGE BY MEDICARE OR ANY OTHER INSURANCE.

I HAVE READ AND UNDERSTAND THE PRECEDING POLICIES AND ANSWERED THE QUESTIONS TO THE BEST OF MY KNOWLEDGE.

_____ _____

PATIENT OR GUARDIAN SIGNATURE DATE

DILATION POLICY: Dr. Brady and Dr. Adams consider dilation an important part of a complete eye examination. The purpose of pupil dilation is to enable the doctor to examine the inside of the eye more thoroughly. It also helps to detect/monitor eye diseases such as cataracts, glaucoma, and retinal disorders, and systemic diseases such as hypertension and diabetes. It may be necessary for patients showing signs of eye disease and young children to be dilated at today's visit. Eye drops are used to dilate the pupils, which causes temporary sensitivity to lights and difficulty with reading or near work for an hour or more. If you have a reason that you cannot be dilated today, you may re-schedule the dilation for another time (however, an additional office visit fee may apply). Dr. Adams and Dr. Brady recommend dilation **every year** for patients **under the age of 9, over the age of 50, and for all patients with a systemic disease like diabetes**. Dilation is strongly recommended for **ALL new patients. Pupil dilation does NOT require an additional fee and is INCLUDED in the exam fee.**

PLEASE CHECK ONE:

_____ I would like pupil dilation today for a comprehensive examination.

_____ I do not want my pupils dilated and understand that refusing this procedure will make early detection of eye diseases more difficult.

Please note that patients that continue to refuse dilation year after year will be dismissed from the practice.

Patient Signature: _____ Date: _____

Visual Field Screening Testing Consent: Our office has an instrument, much like a VR (virtual reality) headset, which enables us to provide a more thorough peripheral visual field analysis. Visual Field Screening can assist in early detection of glaucoma, retinal problems, and neurological diseases (such as optic nerve disease). The fee for this procedure is **$20** and is generally NOT covered by insurance companies. This procedure is recommended for all patients over the age of 14.

PLEASE CHECK ONE:

___ I DO want the Visual Field Screening

___ Though it may be in my best interest, I DO NOT want the Visual Field Screening

Retinal Photo Testing Consent: As part of your eye exam, we recommend a special diagnostic procedure called Retinal Imaging. This procedure consists of capturing an image of the inside of your eye. This is not an X-Ray or Ultrasound procedure and nothing will touch your eye. We are simply taking a digital picture. This permanent record is very valuable in assessing the current health of your eye and the specific structures of your eye such as the retina, optic nerve, macula and blood vessels. It will also serve as a baseline from which to compare, as we follow your health in subsequent years. The fee for this procedure is **$30** and is generally NOT covered by insurance companies. This procedure is recommended for all patients over the age of 14.

PLEASE CHECK ONE:

_____ Yes, I want to have retinal photos taken of my eye.

_____ No, I DO NOT wish to have retinal photos taken.

Patient Signature: _____ Date: _____

Date:_____ Name:_____ Age:_____ Gender:_____

Name of Primary Care Physician:_____ Weight:_____ Height:_____

Date of Last Eye Exam: _____ What is your birth order? 1st 2nd 3rd 4th 5th >5; only; twin: Id/Fra. Are you pregnant? _____

Social: Have you/do you use tobacco? Y/N Do you drink alcohol? Y/N Do you use illegal drugs? Y/N

Have you had a blood transfusion? Y/N Do you have any STDs? Y/N

Medical: Please circle all that apply to you and/or any members of your immediate family, and then list who has the condition. (i.e. Self, Mother, Father, Sister, Brother, MGM, MGF, PGM, PGF, Aunt, Uncle)

Cardiovascular:
Blood Pressure Problems
Heart Disease
High Cholesterol

Endocrine:
Diabetes
Thyroid Disease
Pituitary Disease

Respiratory:
Asthma
Emphysema
Tuberculosis

Allergic/Immune:
Autoimmune Disease
Seasonal Allergies
HIV Status/Chronic Infection

Integumentary:
Rashes/Sores
Lumps/Bumps/Acne
Dry Skin

Nervous System:
Stroke
Multiple Sclerosis
Seizures

Mental Health:
Depression
Behavioral Disorder
Alzheimer's

Head/Ear/Nose/Throat:
Hearing Problems/Impaired
Sinus Disease
Dry Mouth/Swallowing

Gastrointestinal:
Ulcer/Heartburn/Acid Reflux
Liver Disease/Hepatitis
Gallbladder Disease

Blood/Lymph:
Bleeding Abnormalities
Swollen Lymph Nodes
Anemia

Genitourinary:
Kidney Disease
Urinary Infection

Musculoskeletal:
Arthritis
Osteoporosis

Cancer/Other:

List Your Surgeries:

Ocular/Eye History:

Glaucoma Cataracts Macular Degeneration Retinal Disease
Blindness Amblyopia Strabismus Eye Surgery/Lasik Other

Do you currently take medication(s)? Y/N

List your medication(s):
List your medication usage:
Do you have medication allergies? Y/N
List your medication allergies:

Are you interested in contact lenses? Y/N

Have you ever had: Flashes/Floaters? Y/N Double Vision? Y/N Dry Eyes? Y/N
Eye/Head Injury? Y/N Headaches? Y/N Glasses/Contacts? Y/N

**For subsequent visits/exams: I certify that the above information has been reviewed and/or updated.

Initials: _____ Date: _____ Initials: _____ Date: _____ Initials: _____ Date: _____

Global Eye Care
4101 S. 1st St.
Cabot, AR 72023
(501) 941-4321

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the ***Notice of Private Practices***.

I understand that I may request in writing that you restrict how my private information is used of disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship To Patient/Self: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Notice of Privacy Practices
(Medical)

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.

The Health Insurance Portability & Accountability Act of 1996 ('HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used, "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care provider. An example of this would include a physical exam.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to

agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of you protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will past and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA or
To file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775