

Heart Disease/High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SOCIAL HISTORY

Have you ever tried to wear contact lenses?

Yes No If YES, how long have you worn them? _____

Do you currently wear glasses?

Yes No If YES, how long have you had the current prescription? _____

Do you drink alcohol? Yes No If YES... Occasional 1 per day 2-3 per day 4+ per day

Do you smoke? Yes No If YES... Occasional 1/2 pack/day 1 pack per day 1+ pack/day

Have you ever had a blood transfusion? Yes No

History reviewed. No Changes Additions as noted above _____

Signature: _____ **Date:** _____



COMMERCIAL INSURANCE

I authorize Morris Eye Group, dba: Eyecare Solutions Inc., a medical corporation, to submit a claim to my medical/vision insurance carrier or its intermediaries for all covered services or products provided by the practice. **I understand that I am responsible for any Deductible, Co-Insurance, Co-Payment and any Non-Covered Services.** I understand that it is the policy of Eyecare Solutions, Inc. to collect for these items at time of service. I understand that it is my responsibility to update my insurance file whenever I change insurance carriers. I understand that failing to provide current carrier information makes me immediately responsible for balances that other wise would have been paid by my medical/vision carrier. I understand that if I join an **HMO** I will inform the providers of Eyecare Solutions, Inc. prior to scheduling any care such that the staff can identify my eligibility for care with this practice.

Medical Insurance Company: _____
Policy/Group Number: _____

Vision Insurance Company: _____
Policy/Group Number: _____

Date: _____

Signature: _____

This assignment of benefits shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original.

PRIVACY PRACTICES ACKNOWLEDGEMENT

I hereby acknowledge that I received, read and understand the Notice of Privacy Practices that are implemented by Morris Eye Group, Eyecare Solutions, Inc AMG. I understand that the physicians and employees of the practice will make reasonable efforts to protect my privacy and keep my patient information confidential and secure.

Patient Print Name: _____ Date: _____

Signature of Patient: _____ Date: _____



PRACTICE POLICIES CONCERNING CONTACT LENSES

New Patients and New Contact Lens Wearers:

To be fit for contact lenses we require that our patients complete all three components of the eye examination: medical exam, refraction, and contact lens measurements. In some instances, due to patient preference and time constraints, a separate second appointment with our contact lens specialist may be necessary. Even if one is an experienced contact lens wearer all three components of the examination must be completed. To reiterate, there are three separate professional examination fees: medical, refraction, and contact lens. In some instances, patients may have medical and/or vision insurance that may be applicable to these fees. Patients are provided with their contact lenses during their initial fitting. Professional fees are payable when the products are ordered. The fees for different contact lens products vary and our opticians can review these costs and answer any other questions regarding contact lenses.

We recommend that all of our contact lens patients have a pair of glasses on hand. You may purchase glasses from our practice or any other vendor you choose. After your refraction you will be given a copy of your glasses prescription. This prescription is good for two years. Additionally, wearing sunglasses is an important product to one's eyes from UV rays. Sometimes contact lenses make one more sensitive to bright light. If you only wear contact lenses occasionally, then you will need a pair of prescription sunglasses.

Contact lenses are medical devices that are placed on the eye. It is important that we determine that they are properly fit, that they are not compromising corneal health, and that there are no other problems related to the wearing time or infection. Once ordered, our opticians will spend time educating you on insertion, removal, proper care and your own specific wearing regimen. Once dispensed, we will be seeing you for a series of follow-up appointments over the next 90 days to confirm that you are correctly fit.

After 90 days, you may order replacement lenses from us or any other vendor of your choice. We will be happy to provide you with a contact lens

prescription once we are confident you are correctly fit. Contact lens prescriptions are good for one year.

Established Patients and Long-Time Contact Lens Wears:

If you currently wear contact lenses we recommend an annual medical eye examination to ensure the health of the eye and the fit of the lenses. Moreover, from year to year there is often a change in vision and there may need to be a correction made in your contact lens or glasses prescriptions. If there is a significant change in your refraction, a second contact lens examination may be required by our contact lens specialist. Fees for these services may be applied to any form of insurance that provides you benefits for this care. The process for fitting and dispensing an updated pair of contact lenses is identical to the initial process described previously. Once this process is complete, we would once again be pleased to have you reorder your lenses through our dispensary or provide you with your contact lens prescription to be used with any other vendor.

BASIC DO'S AND DON'TS

- DO use only solutions recommended by your doctor.
- DO check for lens damage before each wear.
- DO replace you contact lens case once a month to avoid infection.
- DO keep all of your follow-up appointments and annual eye exams.
- DO wear sunglasses with proper UV protection.
- DO have a spare pair of glasses on hand.
- DO carry your prescriptions when traveling.
- DO call us if you have questions or problems.
- DO call to reorder before you run out of disposable lenses.

- DON'T wet your lenses with you saliva.
- DON'T rub your eyes when wearing you lenses.
- DON'T insert a lens from a packet that is damaged.
- DON'T forget to clean and disinfect non-disposable lenses.

Please sign below that you have read and understand our practice policies regarding contact lenses. Thank you.

Signature of Patient (or responsible party)

Date

**Morris Eye Group
EyeCare Solutions, Inc. AMG**

NOTICE OF PRIVACY PRACTICES

**As Required by the Privacy Regulations Created as a Result of the
Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

We understand that information about you and your health is confidential. We are committed to protecting the privacy of this information. This notice will tell you about the ways in which we may use and disclose health information about you, as well as certain obligations we have regarding the use and disclosure of health information. It also will describe your rights regarding your health information.

Our primary responsibility is to safeguard your personal health information. We must give you this notice of our privacy practices, and follow the terms of the notice currently in effect. We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice and you may request a copy of our most current Notice at any time.

WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe ways in which we may use and disclose your health information. We have not listed every use or disclosure within the categories below, but all permitted uses and disclosures will fall within one of the following categories. In addition, there are some uses and disclosures that will require specific authorization.

1. TREATMENT. We will use and disclose your health information to provide, coordinate or manage your health care and any related services. We may disclose health information about you to the doctors, ophthalmic assistants, opticians or other allied health personnel in our practice who are involved in taking care of your medical needs. Additionally, we may share your health information with other providers involved in coordinating your care, such as your primary care physician, subspecialty physicians and pharmacists. We may also disclose your health information to family members involved in your care.

2. PAYMENT. We may use and disclose your health information to check eligibility, bill and collect payment from you, an insurance company, a third party or a collection agency. This may include the disclosure of health information to obtain prior authorization for treatment, procedures and optical products from your insurance plans.

3. HEALTH CARE OPERATIONS. We may use and disclose your health information to operate our medical practice. Examples of these activities are quality assurance activities, medical staff education, provider credentialing, contractual obligations with health maintenance organizations or other insurance carriers as well as our own and business planning.

4. APPOINTMENT REMINDERS. We may contact you to remind you to remind you of an appointment.

5. TREATMENT OPTIONS. We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

6. HEALTH-RELATED BENEFITS AND SERVICES. We may contact you to tell you about benefits or services that we provide.

7. RELEASE OF INFORMATION TO INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE. We may release medical information to a friend, family member or any individual that you choose that is involved in your care, or who assists in taking care of you. We may also give information to someone who helps pay for your care.

8. DISCLOSURES REQUIRED BY LAW. We will use and disclose your health information when we are required to do so by federal, state or local law.

SPECIAL SITUATIONS: We may use or disclose health information about you without your verbal or written permission.

1. Public Health Risks. We may disclose your health information for public health required by law to prevent or control disease, injury or disability; to report births and deaths; to report child and adult abuse or neglect; to report reactions to medications, problems with products or other adverse events; to notify people of recalls of products they may be using; to notify those who may have been exposed to a disease or who may be at risk for contracting or spreading a disease or condition.

2. Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law such as audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, governmental programs and compliance with Civil rights laws.

3. Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute.

4. Law Enforcement. If asked to do so by law enforcement, and as authorized or required by law, we may release medical information to identify or locate a suspect, fugitive, material witness, or missing person; about a suspected victim of a crime, about a death suspected to be the result of criminal conduct, criminal conduct conducted while at our practice; and in case of medical emergency, to report a crime, the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

5. Coroners, Medical Examiners and funeral Directors. We may disclose health information to a coroner or medical examiner, for example, to identify a deceased person or determine the cause of death.

6. Organ and Tissue Donation. We may disclose your health information to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation.

7. Research. We may use and disclose your health information for research purposes as permitted by law. On occasion, we contact our patients regarding their interest in participating in certain research studies. Enrollment in those studies can only occur after each patient has been informed about the study, had an opportunity to ask questions and indicated a willingness to participate by signing a separate consent form.

8. Serious Threat To Health and Safety. We may use and disclose your health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone able to help stop or reduce the threat.

9. Military and Veterans. If you are or were a member of the armed forces, we may release medical information about you to military command authorities as authorized or required by law.

10. National Security. We may disclose your health information to federal officials for intelligence, counterintelligence and national security activities as required by law.

11. Inmates. If you are an inmate of a correctional institution or under the custody of law enforcement officials, we may release information about you to the correctional institution as authorized or required by law.

12. Workers' Compensation. We may release your health information for Workers' Compensation or similar programs as authorized or required by law.

13. Disaster Relief Efforts. We may disclose your health information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding your health information.

1. Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a particular manner or at a certain location. For example, you may ask that we only contact you at work or home or by mail. In order to request a specific type of communication you must make a written request to our office addressed to, "The Privacy Official", specifying the requested method of contact, or the location where you wish to be contacted. If we agree with your request, we will comply. We will accommodate reasonable requests. You do not need to give a reason for your request.

2. Request Restrictions. You have the right to request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or

disclosure of your health information you must make your request in writing to, “The Privacy Official”. Your request must describe in a clear and concise fashion the information you wish restricted; whether you are requesting to limit our practice’s use, disclosure or both; and to whom you want the limits to apply.

3. Inspect and Request a Copy of Your Health Record. You have the right to inspect and obtain a copy you’re your health record, including your medical and billing records. You must submit your request in writing. As allowed by State Law, we charge a fee for the costs of photocopying, handling and postage. We may deny your request under special circumstances. If you are denied access to your health information, you may request that the denial be reviewed by another licensed health care professional chosen by us to review the denial.

4. Amendment. You may request an amendment to your health care record if you feel the information is incorrect or incomplete. You may request an amendment for as long as the information is kept by or for our practice. Your request must be made in writing to, “The Privacy Officer” and it must include a reason that supports the request. We will deny your request if you fail to submit your request and the supporting reason in writing. Also, we may deny your request if you ask us to amend information that in our opinion: accurate and complete, not part of the health record kept by our practice; not part of the health record which you would be permitted to inspect and copy; not created by our practice.

5. Accounting of Disclosures. You may request an accounting of disclosures to others of your health record. The accounting will provide information about disclosures made for the purposes other than treatment, payment, health care operations, disclosures excluded by law or those you have authorized. In order to obtain an accounting of disclosures, you must submit your request in writing to, “The Privacy Official”. All requests for an “accounting of disclosures” must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge but our practice may charge you for additional lists within the same 12-month period. We will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to Obtain a Copy of Our Notice of Privacy Practices. You are entitled to receive a paper copy of our notice of privacy practices at any time.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, please submit your complaint, in writing to, “The Privacy Official”. You will not be penalized for filing a complaint.

8. Revoke Your Authorization. You have the right to revoke your authorization for the use or disclosure of your health information except to the extent that action has already been taken. All revocations must be in writing, addressed to, “The Privacy Official”. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization.

If you have any questions regarding this notice, contact our Privacy Officer at (760) 631-3500.

