

# Oakland Vision Center OPTOMETRY

1960 BROADWAY, OAKLAND CA 94612 • 510-893-5566 • PAGE 1 OF 6

*Welcome! Thank you for choosing our practice for your eye care. We strive to provide personal and caring medial service in an atmosphere of respect and privacy. If you have any questions or concerns, please do not hesitate to ask for help at any time. To help serve you better, please answer the following questions.*

## PATIENT REGISTRATION RECORD

Patient Name (Last, First, Middle)		Date of Birth	<input type="radio"/> Male <input type="radio"/> Female	Marital Status
Home Address		City	Zip Code	
Home Phone		Work Phone	Cell Phone	
Social Security #		Driver's License #	Email	
Employer	Work Address		Occupation / Student	
Name of primary insurance carrier (spouse or parent)		Primary's Social Security #	Primary's Date of Birth	
Name of person to notify in an emergency		Relationship	Phone	
Who referred you to our office?		May we thank them? <input type="radio"/> yes <input type="radio"/> no		

## INSURANCE INFORMATION

Name of Major Medical Insurance (Blue Cross, HealthNet, Kaiser)	Name of Insured (if other than patient)
Medical ID #	Group # (if any)
Vision Plan Name & ID# for Glasses/Contacts (VSP, Eyemed)	

**PLEASE READ & SIGN.** Routine eye exams, refraction (glasses prescription), contact fitting or contact lenses, may not be covered by insurance; In these cases the patient is responsible for payment. A referral is not a guarantee of payment. It is your responsibility to know your coverage. I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits paid and not paid by insurance.

Signed \_\_\_\_\_ Date \_\_\_\_\_

# Oakland Vision Center OPTOMETRY

1960 BROADWAY, OAKLAND CA 94612 • 510-893-5566 • PAGE 2 OF 6

PLEASE ANSWER ALL SECTIONS

Your last eye exam?

Where?

Name of your personal physician?

What city?

Phone number?

Name of your eye doctor (Optometrist or Ophthalmologist)?

What city?

Phone number?

Do you take prescription medication daily? (Please list the names of all your medications including creams, inhalers, sprays & injections)

Any allergies to medications?

What brand of eye drops do you use?

Number of alcoholic drinks per day:

Number of cigarettes per day:

Would you like to see without glasses?

- Yes! I want to try contact lenses.
- Yes! I want more information on laser eye surgery.
- Yes! I want more information on multi-focal cataract surgery.
- OTHER:

Do you experience any of the following . . .

- Dry eyes?
- Computer-related eyestrain/ fatigue?
- Halos while driving at night?
- Sensitivity to sunlight?
- OTHER:

Do you enjoy any of these activities?

- Camping / Hiking
- Traveling
- Sailing / Fishing
- Skiing / Snow Boarding
- Golf
- OTHER:

Any of these run in your family?

- High blood pressure
- Diabetes
- High cholesterol

- Glaucoma
- Macular Degeneration
- Retinal Disorder

- Cataracts
- Lazy Eye
- OTHER:

Do you have or experience?

Y N

- Alcoholic abuse
- Accutane use
- Acne Rosacea
- Asthma
- Blood disorder (Anemia / Leukemia)
- Blurred vision
- Bronchitis / Emphysema
- Bumps on eyelid margin(s)
- Burning sensation in eye(s)
- Cancer
- Computer Eye Strain
- Depression
- Diabetes
- Diabetes when pregnant
- Discharge from eye(s)
- Difficulty breathing
- Digestive problems
- Double vision
- Drug abuse
- Dry eye(s)
- Eye injury

Y N

- Eye surgery
- Feeling of something in eye(s)
- Fatigue
- Fever
- Flashes of light
- Floaters in your vision
- Fluctuating vision
- Gritty/sandy feeling in eye(s)
- Hay fever symptoms
- Headaches
- Heart problems
- Hepatitis
- High blood pressure
- HIV
- Hormonal Dysfunction
- Itchy eye(s)
- Itchy nose
- Joint pain
- Kidney problems
- Lazy eye or eyelid
- Light sensitivity
- Liver problems

Y N

- Lupus
- Menopause
- Migraines
- Muscle pain
- Multiple Sclerosis
- Numbness
- Osteoarthritis
- Pets (dogs or cats)
- Recent weight loss / gain
- Red eye(s)
- Rheumatoid arthritis
- Sarcoidosis
- Schizophrenia
- Sinus Infection
- Sjogren's disease
- Skin problems
- Stroke / Vascular Disease
- Swollen eye(s) or eyelid(s)
- Thyroid problems
- Upper Respiratory Infection
- Watery / Watery Eye(s)
- Watery / Watery Nose

OFFICE USE ONLY:

Updated:

Updated:

Updated:

Updated:

# Oakland Vision Center OPTOMETRY

1960 BROADWAY, OAKLAND CA 94612 • 510-893-5566 • PAGE 3 OF 6

*Thank you for choosing our practice for your eye care. To ensure the privacy, respect and courtesy to our patients, we enforce the following acknowledgements and policies. Please do not hesitate if you have any questions.*

Please Initial that you have read and agree to the following:	
	I have received the HIPPA information from Oakland Vision Center.
	Payment of co-pays, deductibles or any balances not covered by insurance is due at the time of service. <u>If you are being seen today, payment is due TODAY.</u>
	We accept payment by cash, Visa and MasterCard.
	Please no food and drinks allowed in the reception area or in the doctor's office.
	Please turn your cell phones off (or to vibrate mode). No cell phones may be used in the reception area or in the doctor's office.
	This is a smoke-free zone. If at all possible, please avoid smoking before your appointment as the doctor is allergic.
	Restrooms are for patients with appointments only. No exceptions.
	We value your time. We try our very best to stay on schedule, although emergencies sometimes arise. If we are seriously delayed, we will try to notify you beforehand.
	If you are unable to make your appointment for any reason, please feel free to reschedule as soon as possible. This allows us time to give your slot to someone on our waiting list.
	<b>DILATED PUPIL EXAM:</b> Our comprehensive exam includes dilation to detect eye disease. Dilation with eye drops will last approximately 4 hours. You will experience sensitivity to light and blurry near vision. If you did not bring dark glasses, we will provide you with a disposable pair.
	<b>REFRACTION IS NOT A COVERED BENEFIT:</b> Most major medical plans <u>do not</u> cover the refraction portion of the examination. The refraction is how the doctor determines your glasses prescription or determines if your vision is changing. The refraction will be an out-of-pocket expense of \$75.
	<b>GLASSES:</b> Glasses are custom-made for you and only you. There is no return or exchange on glasses (includes the lenses and frame). All our lenses and frames carry a 30 day to 1 year warranty against manufacturer's defect. Damage due to dropping your glasses, etc. is not covered. Payment in full is required before glasses can be ordered.
	<b>CONTACT LENSES:</b> Because contacts are a medical device, we follow a strict return / exchange policy. Please review The Contact Lens Agreement for detailed information.
	As required by law, all minors under the age of 18 must be accompanied by a parent / guardian to see the doctor.

~ We reserve the right to refuse service for any reason. ~

# Oakland Vision Center O P T O M E T R Y

1960 BROADWAY, OAKLAND CA 94612 • 510-893-5566 • PAGE 4 OF 6

**ALL CO-PAYS, DEDUCTIBLES AND PAYMENTS ARE DUE AT THE TIME OF SERVICE.**

**FOR MEDICARE PATIENTS ONLY: SIGNATURE ON FILE**

I request payment of authorized Medicare benefits be made on my behalf to Oakland Vision Center for any services furnished me by the listed provider / supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claims forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. As Medicare Participating Providers, the provider of supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Name (please print)	Provider, Name & Address  OAKLAND VISION CENTER 1960 Broadway Oakland CA 94612
Patient's Signature	
Patient's Medicare #	

**ALL OTHER INSURANCE PLANS / ASSIGNMENT OF BENEFITS**

Patients with insurances please read and sign below. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance and any other health plans to Oakland Vision Center. I am hereby informed that my claim may be billed electronically to my Insurance Carrier or via the Internet.

I understand that my medical records are confidential. I understand that by signing this consent form, I am allowing my medical information to be released upon my insurance company's request, to my insurance company, for the purpose of Health Care Operations (including, but not limited to, provider review functions, claims payment and quality assessment). I also understand that I may revoke this consent by written request, at any time, with this doctor. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

I understand that I have the right to restrict the disclosure of specific information in my medical records if I request such restriction in writing. This assignment/consent will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. I also understand that my request for restriction may be denied if the information restricted is required for Health Care Operations. For additional information on your insurance company's Patient Confidentiality Policy, please refer to their website and/or benefits provider.

I have read the above and foregoing consent for release of information. I do hereby acknowledge that I am familiar with and fully understand the terms and conditions of the consent.

***I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE FINANCIAL POLICY FOR PAYMENT OF FEES AND THAT THE PATIENT IS ULTIMATELY RESPONSIBLE FOR ALL FEES.***

Patient's Signature

Date

## NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Who does this notice apply to?

- ◇ Any business associate with whom we share health information.
- ◇ All employees, staff and other personnel of Oakland Vision Center.

### OUR RESPONSIBILITY TO YOU REGARDING YOUR MEDICAL INFORMATION

We understand that medical information about you is personal. We are committed to protecting the privacy of medical information about you. In an effort to provide the highest quality of medical care and to comply with certain legal requirements, we will and are required to:

- ◇ Keep your medical information private.
- ◇ Provide you with a copy of this notice.
- ◇ Follow the terms of this notice.
- ◇ Notify you if we are unable to agree to a restriction that you have requested.
- ◇ Accommodate reasonable requests made by you for us to communicate health information by alternative means or at alternative locations.

### HOW WE MAY USE & DISCLOSE MEDICAL INFORMATION ABOUT YOU

We may use and disclose medical information about you for your treatment such as sending medical information about you to a specialist as part of a referral; to obtain payment for treatment, such as sending billing information to your insurance company or Medicare.

### EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

■ *We will use your health information for treatment*

For example: Information received by a physician or other member of your healthcare team will be recorded in your record and used to determine your course of treatment. We will also provide your physician or a subsequent healthcare provider with copies of reports to assist him or her in treating you.

■ *We will use your health information for payment*

For example: A bill may be sent to you or an insurance company. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used in your treatment.

■ *We will use your health information for regular healthcare operations (see below)*

### HOW WILL MY INFORMATION BE USED

- ◇ We may contact you for appointment reminders, or tell you about or recommend possible treatment options, alternatives, health-related benefits or series that may be of interest to you.
- ◇ We may release medical information about you to a family member, friend, or any other person involved in your medical care. We may also give information to those you identified as responsible for payment of your care.
- ◇ We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out medical information about you without your prior authorization for the following purposes:
  - **LAW.** We may disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances or in response to valid judicial or administrative orders.
  - **PUBLIC HEALTH.** We may disclose your information to public health or legal authorities charged with preventing or controlling disease, injury, disability, child abuse or neglect, etc. as required by law.
  - **BUSINESS ASSOCIATES.** There are some services provided in our organization through contracts with business associates (i.e. we may disclose medical information about you to a company who bills insurance companies on our behalf to enable that company to help us obtain payment for the healthcare services provided). To protect your health information we require the business associate to properly safeguard your information.
  - **NOTIFICATION.** We may use or disclose information to notify or assist in notifying a family member, personal representative, another person responsible for your care, your location and general condition.
  - **FUNERAL DIRECTORS.** We may disclose health information to funeral directors consistent with applicable law for them to carry out their duties.
  - **ORGAN DONATION.** Consistent with applicable law, we may disclose health information to organ procurement organization or other entities for the purpose of tissue donation and transplant.
  - **FOOD AND DRUG ADMINISTRATION.** We may disclose to the FDA health information relative to adverse events.

NOTICE OF PRIVACY PRACTICES, continued

- **WORKERS' COMPENSATION.** We may disclose health information necessary to comply with laws relating to Workers' Compensation of other similar programs established by law.
- **CORRECTIONAL INSTITUTION.** Should you be an inmate of a correctional institution, we may disclose to the institution or its agent health information necessary for your health and the health and safety of other individuals.
- **STATE REQUIREMENTS.** Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs.

**OTHER USES OF MEDICAL INFORMATION**

In any other situation not covered by this notice, we will ask you for your written authorization before using or disclosing medical information about you. You choose to authorize us to use or disclose your health information; you can later revoke authorization in writing of our decision except to the extent that action has already been taken by us.

**YOUR RIGHTS REGARDING INFORMATION ABOUT YOU**

Although your health record is property of Oakland Vision Center, you have the right to:

- **REQUEST A RESTRICTION,** in writing, on certain uses or disclosures of your medical information for treatment, payment, or health care operations, with the exception of emergency situations. We will consider your request, but we are not legally required to agree to a requested restriction. We will inform you of our decision on your request.
- **OBTAIN A PAPER COPY** of this notice of our privacy practices.
- **INSPECT AND OBTAIN** a copy of your medical information, in most cases.
- **REQUEST IN WRITING,** an amendment to your records if you believe the information in your record is incorrect or important information is missing. We could deny your request to amend a record if the information was not created by us, maintained by us, or if we determine the record is accurate. You may appeal, in writing, a decision by us not to amend a record.
- **OBTAIN AN ACCOUNTING** of disclosure statements who and where your health information has been disclosed for purposes other than treatment, payment, healthcare operations or where you specifically authorized a use or disclosure in the past six (6) years, but not prior to October 1, 2007. The request must be in writing and state the time period desired for the accounting.
- **REQUEST THAT MEDICAL** information about you is communicated to you in a confidential way or at an alternative location. You must specify how or where you wish to be contacted.
- **ALL WRITTEN REQUESTS** or appeals should be submitted to our Privacy Official listed at the bottom of this notice.

**CHANGES TO THIS NOTICE**

Oakland Vision Center has the right to change this notice at any time. We have the right to make the revised or changed notice effective for medical information we receive in the future. The notice will contain the effective date. You may request a copy of the current notice each time your register.

**COMPLAINTS**

If you have questions or would like additional information, or if you believe your privacy rights have been violated, you can contact Oakland Vision Center's Privacy Officer via mail or call (510)893-5566. You may also file a complaint with the U.S. Department of Health and Human Services Office of Civil Rights, 20 Independence Avenue SW, Washington, D.C. 20201. Filing a complaint will not negatively affect the treatment or coverage that you receive.

**PRIVACY OFFICER**

*Name: Tanya N. Gill, OD*

*Address: 1960 Broadway, Oakland CA 94612*