EnVision Eye Care
DR. J.A. PARKER & ASSOCIATES

Welcome To Our Office!

(Please Print All Responses)

Today's Date: _____

PATIENT INFORMATION

NAME: ☐ Mr. ☐ Miss ☐ Mrs. ☐ Dr. ☐ Ms. ☐ Fr. _____ Last, _____ First _____ MI _____ (Nickname)

DOB: _____

SSN: _____

ADDRESS: _____

SEX: ☐Male ☐Female

CITY: _____ STATE: _____ ZIP: _____

MARITAL STATUS:

HOME #: _____ CELL #: _____

☐Married ☐Divorced ☐Widowed

EMAIL: _____

☐Domestic Partner ☐Never Married

Preferred Contact Method (select all that apply): ☐Cell ☐Home ☐Email ☐ Text message

EMPLOYMENT STATUS:

☐ Full Time ☐ Part Time
☐ Unemployed ☐ Retired
☐ Student

EMPLOYER/SCHOOL: _____

OCCUPATION/MAJOR: _____

REFERRED BY: ☐ Location ☐ Internet (Yelp, Google, Facebook, etc.) ☐ Other: _____

☐ Insurance list ☐ Patient/Provider Referral: _____

If dependent, please list parent or guardian information: _____

Current Primary Care Physician: _____ Last Visit: _____

INSURANCE

VISION INSURANCE: _____ ID#: _____

What Is Your Relationship To Primary Policy Holder: ☐ Self ☐ Spouse ☐ Dependent

*If not Self, please list primary policy holder's information:

Member Name: _____ Member DOB: _____

Member SSN: _____ Member Employer: _____

PRIMARY MEDICAL INSURANCE: _____ ID#: _____

What Is Your Relationship To Primary Policy Holder: ☐ Self ☐ Spouse ☐ Dependent

*If not Self, please list primary policy holder's information (OR ☐ SAME AS ABOVE):

Member Name: _____ Member DOB: _____

Member SSN: _____ Member Employer: _____

SECONDARY MEDICAL INSURANCE: _____ ID#: _____

SPECTACLE STATUS (PLEASE CHECK **ALL** THAT APPLY)

Date of last eye exam, if elsewhere: _____

☐ I do not currently wear glasses.

☐ I currently wear glasses: ☐ Prescription ☐ Over the counter

When do you wear your glasses? ☐ Full - Time ☐ As – Needed ☐ Mostly for Distance ☐ Reading Only

**If possible, please bring your current glasses with you to the examination.

CONTACT LENS STATUS (PLEASE CHECK **ALL** THAT APPLY)

Are you interested in contacts? ☐ Yes** ☐ No

If YES, please let the staff know!

Have you worn contacts? ☐ Yes ☐ No

Do you currently wear contacts? ☐ Yes ☐ No

Type of contacts recently worn (mark all that apply):

☐Soft ☐RGP ☐Conventional ☐Disposable ☐Toric (For astigmatism)

☐Color Lenses ☐Bifocal/Monovision

Discard how often? _____ Do you sleep in your contacts? ☐ Yes ☐ No (If yes, # of nights in a row: _____)

Are there any specific types of contacts you would like to try?: _____

What lens care system are you using? _____ Please list any lens care solution you have an allergy to: _____

EYE HEALTH HISTORY/HISTORY OF PRESENT ILLNESS (PLEASE MARK ALL CONDITIONS THAT YOU HAVE EXPERIENCED IN THE RECENT PAST.)

Ocular Complaints:
- ☐ Double Vision
- ☐ Flashes
- ☐ Floaters
- ☐ Headaches
- ☐ Vision Loss

Contact Lenses:
- ☐ Excessive Discomfort
- ☐ Dryness
- ☐ Lens Movement
- ☐ Fogging

Vision Complaints:
- ☐ Distance Blurry
- ☐ Near Blurry
- ☐ Computer Blurry
- ☐ Difficulty with reading and/or tracking

Ocular Symptoms:
- ☐ Eye Fatigue
- ☐ Pain
- ☐ Dry, sandy feeling
- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Watery Eyes
- ☐ Infection
- ☐ Photophobia/Light Sensitivity

☐ Other : _____

OCULAR HISTORY & OCULAR FAMILY HISTORY (PLEASE INDICATE IF **ANY** OF THE CONDITIONS APPLY TO YOU OR A BLOOD RELATIVE)

	Self	Family
Bell's Palsy	☐	
Keratoconus	☐	☐
Cataract	☐	☐
Lazy Eye	☐	☐
Eye infection	☐	
Color blindness	☐	☐

	Self	Family
Optic Neuritis	☐	☐
Eye Turn	☐	☐
Glaucoma	☐	☐
Iritis	☐	
Tumor, Ocular	☐	☐
Retinal Disease	☐	☐

	Self	Family
Chalazion/Styes	☐	
Trauma, Ocular	☐	
Macular Degeneration	☐	☐

Other ocular history, please list (i.e. surgery):

_____

_____

ORAL/SYSTEMIC MEDICATIONS (PLEASE LIST **ANY** OVER THE COUNTER AND/OR PRESCRIPTION MEDICATIONS YOU ARE TAKING)

Medication(s):

_____

_____

_____

Known Allergies:

_____

_____

_____

SYSTEMIC FAMILY HISTORY/REVIEW OF SYSTEMS (MARK ALL THAT APPLY)

		Self	Family
Cardio	Cardiovascular Disease	☐	☐
	Elevated Cholesterol	☐	☐
	Hypertension	☐	☐
	Stroke	☐	☐
Consti	Anemia	☐	
	Blackouts	☐	
	Dizziness	☐	
Endo	Diabetes Mellitus	☐	
	Renal Disease	☐	☐
	Thyroid Disease	☐	
Gastro	Colitis	☐	
	Colon Cancer	☐	☐
	Hepatitis	☐	
	Ulcer, Stomach	☐	

		Self	Family
Head	Headaches	☐	☐
	Meniere's Syndrome	☐	☐
	Sinusitis	☐	
Hema	Breast Carcinoma	☐	☐
	Hematologic Disorder	☐	☐
	Sickle Cell	☐	☐
Immun	AIDS	☐	
	HIV	☐	
	Sjogren's Syndrome	☐	☐
Integ	Acne Rosacea	☐	
	Lupus	☐	☐
	Psoriasis	☐	

		Self	Family
Muscu	Arthritis	☐	☐
	Arthritis, Rheumatoid	☐	☐
	Myasthenia Gravis	☐	☐
Neuro	Multiple Sclerosis	☐	☐
	Parkinson's	☐	☐
	Seizure Disorder	☐	☐
Psych	Alzheimer's Disease	☐	☐
	Anxiety Disorder	☐	☐
	Bi-Polar	☐	☐
	Depression	☐	☐
Resp	Asthma	☐	☐
	Lung Cancer	☐	☐
	Sarcoidosis	☐	☐
OB	Pregnant	☐	
	Nursing	☐	

Other Medical History: _____

_____

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A Patient Handout for Vision vs. Medical Insurances

About Your Insurance

There are two types of health insurance that will help pay for your eye care services and products. You may have both and our practice accepts both:

1. Vision care plans (such as VSP, EyeMed, Davis Vision, Spectera, NVA, VCP, etc.)
2. Medical insurance (Anthem/Blue Cross Blue Shield, Medicare, Cigna, United Healthcare, etc.)

- We will use your vision care plan if we are only providing routine vision services to check your acuities, or eye sight. In addition, your vision insurance may also provide you with benefits towards materials such as eyeglasses or contact lenses. Vision plans only cover **basic tests for vision**. They **do not cover medical conditions of the eyes or for treatment of any eye disease**.

- Your medical insurance will be used if you have any eye health condition or systematic problem that has ocular complications. The doctor will determine if these conditions apply to you, but some of these conditions are determined by your medical history (i.e. diabetes).

- If you have both types of insurance plans, it may be necessary for us to bill some services to your medical plan and other services to your vision plan. We will use coordination of benefits for both insurances as necessary.

- We will bill your insurance plan for services if we are a participating provider for your plan. We will try to obtain advanced authorization or verification of your insurance benefits prior to your appointments with our office. In any case, **verification of benefits is not a guarantee of payment**.

- **Our office policy requires payment up front if we are billing your medical insurance for the first time.** Once a billing history has been established, we can then determine how your insurance will provide benefits to you. **Any overpayment for services will be refunded to you via office credit or check once our office receives the payment from your claim.** Co-pays and any services not covered by your insurance are required to be paid at the time of services rendered.

I, _____, have read and agree with these policies.

Printed Name of Patient or Patient's Legal Guardian

_____ _____

Signature of Patient or Patient's Legal Guardian Date

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Signature Acknowledging Receipt of Privacy Practices

I have received a copy of the privacy practices in effect at EnVision Eye Care.

_____	_____
Patient or Patient's Guardian Printed Name	Relationship to Dependent Patient (if applicable)
_____	_____
Signature	Date

Notice of Privacy Policies for EnVision Eye Care

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE FOLLOWING CAREFULLY.

Introduction

At EnVision Eye Care, we are committed to treating our patients with the best care available and, as such, using your protected health information to improve this care. This Notice of Health Information Practices describes the personal information we collect as well as how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective 10/1/02 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit EnVision Eye Care, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care your received,
- Means by which you or a third-party payer can verify that services billed were provided,
- Tool in educating health professionals,
- Source of data for medical research,
- Source of information for public health officials charged with improving the health of this state and the nation,
- Source of data for our planning and marketing,
- Tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy; better understand who, what, when, where, and why others may assess your health information; and make more informed decisions when authorizing disclosure to others.

Your Health Record/Information

Although your health record is the physical property of EnVision Eye Care, the following information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health records provided for in 45 CPR 164.524,
- Amend your health record as provided in 45 CPR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CPR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CPR 164.522, and,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

EnVision Eye Care is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and,
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us or, if you agree, email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue use and disclosure of your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

Example of Disclosures for Treatment, Payment, and Health Operations:

We will use your health information for treatment.

For Example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of the treatment that works best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In this way, the physician will know how you are responding to treatment.

We will use your health information for regular health operations.

For Example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used to continually improve the quality and effectiveness of the healthcare and services we provide.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contacted, we may disclose your health information to our business associate so that they may perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product defects, or post-marketing surveillance information to facilitate product recalls, repairs, or replacement.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement: We may disclose your health information to law enforcement as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney.

For More Information or To Report a Problem

If you have questions and would like additional information, please contact the office's Privacy Officer, Jeffery Herriott, at (912) 927-0707.

If you believe your privacy rights may have been violated, you may file a complaint with the office's Privacy Officer or with the Office for Civil Rights (OCR), U.S. Department of Health and Human Services. There will be no retaliation from us for filing a complaint with either our office's Privacy Officer or the Office for Civil Rights. The address and web page URL for the OCR are listed below:

Office for Civil Rights

U.S. Department of Health and Human Services

200 Independence Ave, S.W.

Room 509F, HHH Bldg.

Washington, D.C. 20201

https://www.hhs.gov/ocr/index.html

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