

# One Source Vision Care, LLP

## Confidential Patient Information

**Patient Name:** Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Date \_\_\_\_\_

Birth date \_\_\_\_\_ Age \_\_\_\_\_ Sex:  male  female

Telephone # \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

E-mail address (if you want to receive our monthly newsletter): \_\_\_\_\_

**Guardian Name** (person responsible for this account if patient is a minor):

Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Relationship \_\_\_\_\_

Birth date \_\_\_\_\_ Age \_\_\_\_\_ Sex:  male  female

Telephone # \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

## Financial Policy

Your clear understanding of our Financial Policy is important to our professional relationship. Therefore, we wish to clarify the following points.

1. I acknowledge that I am fully responsible for all costs incurred during my treatment at One Source Vision Care, LLP.
2. Payment is due at the time of service.
3. I understand that as a service, One Source Vision Care, LLP will file my insurance claims, but they do require a copy of my insurance card to insure accurate information for processing.
4. I understand that my insurance is a contract between me and the insurance company and One Source Vision Care, LLP (If my insurance does not pay in 60 days), I will be responsible for payment of the charges incurred.
5. I agree to pay One Source Vision Care, LLP (in full) within 30 days of notification of nonpayment by my insurance carrier.
6. I understand that I will be responsible for services deemed "not medically necessary" by my insurance company.
7. Parents and guardians are responsible for full payment on unaccompanied minors.
8. I agree that payment of insurance benefits be made on my behalf to One Source Vision Care, LLP for any services furnished me by One Source Vision Care, LLP.
9. I understand that a Collection Agency may be used to collect unpaid balances. I further agree to pay any and all legal and collection costs on my account.
10. I understand there is a \$20.00 service fee for all returned checks.
11. I have received a copy of One Source Vision Care, LLP's Privacy Practices for review and to keep for my records.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

(Patient/Parent or Guardian if minor)

# One Source Vision Care, LLP

## Confidential Ocular/Medical History

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Reason For Today's Visit? \_\_\_\_\_

### Check If You Are Experiencing The Following:

<input type="checkbox"/> Blurred Distance Vision	<input type="checkbox"/> Distorted Vision	<input type="checkbox"/> Light Sensitivity	<input type="checkbox"/> Halos
<input type="checkbox"/> Blurred Near Vision	<input type="checkbox"/> Transient Vision Loss	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Excessive Tearing
<input type="checkbox"/> Visual Discomfort	<input type="checkbox"/> Loss of Central or Side Vision	<input type="checkbox"/> Burning	<input type="checkbox"/> Sudden Vision Loss
<input type="checkbox"/> Eye Strain	<input type="checkbox"/> Blind Spots	<input type="checkbox"/> Foreign Body Sensation	<input type="checkbox"/> Drooping Eyelids
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Night Blindness	<input type="checkbox"/> Floaters	<input type="checkbox"/> Migraine Headaches

Other \_\_\_\_\_

### Personal Ocular History

Date of your last eye exam (approximate)? \_\_\_\_\_

Do you wear eyeglasses?  No  Yes If yes, how old is your present pair? \_\_\_\_\_

Do you wear contact lenses?  No  Yes If yes, do you wear?  Soft  Gas Permeable  Hard

Check if you have you been diagnosed with:

<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Amblyopia	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Retina Detachment	<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Strabismus
<input type="checkbox"/> Other _____		

Have you had previous Eye Disease, Eye Injury or Eye Surgery?  No  Yes If yes, explain: \_\_\_\_\_

### Personal Medical History: (Check those at apply to you)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Depression
<input type="checkbox"/> Lupus	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Asthma/Emphysema	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Sarcoidosis	<input type="checkbox"/> Stroke	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Lung Disease
<input type="checkbox"/> Giant Cell Arteritis	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Anemia	

Other \_\_\_\_\_

### Please List All Medications You Are Currently Taking:

\_\_\_\_\_

Long Term Use of: (please circle) Antibiotics Steroids Aspirin NSAIDS Insulin

Known Drug Allergies: \_\_\_\_\_

### Personal Social History:

Occupation \_\_\_\_\_

Do you use tobacco products?  No  Yes: If yes, frequency?  Rarely  Moderate  Frequently  Heavy

Do you drink alcohol?  No  Yes: If yes, frequency?  Rarely  Moderate  Frequently  Heavy

**Personal Review of Systems** (Check those that apply to you)

**Constitutional:**

- Weight Loss/Gain
- Chronic Fatigue
- Fever/Chills
- Other \_\_\_\_\_

**Ears/Nose/Throat:**

- Loss of Hearing
- Sinus Congestion
- Nosebleeds
- Dry Throat/Mouth
- Other \_\_\_\_\_

**Vascular/Cardiovascular:**

- Diabetes
- Chest Pain
- Irregular Heart Beat
- High Blood Pressure
- Vascular Disease
- Other \_\_\_\_\_

**Respiratory:**

- Asthma
- Wheezing
- Chronic Bronchitis
- Shortness of Breath
- Other \_\_\_\_\_

**Genitourinary Tract:**

- Incontinence
- Painful Urination
- Difficult Urination
- Frequent Urination
- Kidney Disease
- Other \_\_\_\_\_

**Hematological:**

- Low Blood Count
- Easy Bruising
- Bleeding Problems
- Anemia
- Other \_\_\_\_\_

**Allergy/Immunity:**

- Environmental Allergies
- Seasonal Allergies
- Hayfever
- Other \_\_\_\_\_

**Musculoskeletal:**

- Rheumatoid Arthritis
- Painful Joints
- Muscle Pain
- Other \_\_\_\_\_

**Neurological:**

- Numbness/Weakness
- Loss of Memory
- Headache
- Dizziness
- Seizures
- Other \_\_\_\_\_

**Psychiatric:**

- Depression
- Other \_\_\_\_\_

**Endocrine:**

- Swollen Glands
- Thyroid Disease
- Other \_\_\_\_\_

**Integumentary:**

- Skin Disorders
- Other \_\_\_\_\_

**Gastrointestinal:**

- Constipation
- Diarrhea
- Other \_\_\_\_\_

**Family Ocular/Medical History** (Please note any blood relatives that have the following conditions)

		RELATIONSHIP TO YOU		
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____		_____
<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____		_____
<input type="checkbox"/> Blindness	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____		_____
<input type="checkbox"/> Retinal Detachment	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____		_____
<input type="checkbox"/> Eye Disease (Describe to Dr.)	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____		_____
<input type="checkbox"/> Misaligned Eyes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____		_____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____		_____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____		_____
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____		_____
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____		_____
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____		_____
<input type="checkbox"/> Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	_____		_____
<input type="checkbox"/> Other _____		_____		_____

For Office Use Only:

Personal Ocular History, Medical History, Medications, KDA, Social History, Review of Systems and Family Ocular/Medical History were reviewed with patient or guardian by:

Dr. \_\_\_\_\_ Date \_\_\_\_\_

# One Source Vision Care, LLP

## 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.**

**PLEASE REVIEW IT CAREFULLY.**

### **OUR PRACTICE DUTIES**

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies that are outlined in this notice.

### **RIGHT TO REVISE PRIVACY PRACTICES**

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulation. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

### **USES AND DISCLOSURES**

We use and disclose health information about you for various reasons.

**FOR TREATMENT.** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

**FOR PAYMENT.** Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

**FOR HEALTHCARE OPERATIONS.** Your health information may be used as necessary to support the day-to-day activities and management of One Source Vision Care. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

**PERSONS INVOLVED IN CARE.** We may use or disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or to notify or assist with payment for your healthcare, but only if you agree that we may do so.

**FOR LAW ENFORCEMENT.** Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting, such as abuse, neglect or domestic violence. We may also disclose your information under certain circumstances for national security.

**FOR PUBLIC HEALTH REPORTING.** Your health information may be disclosed to public health agencies, State or Federal, as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

**FOR OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION.** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit your request of revocation of authorization using our form. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us or your decision to revoke your authorization.

**ADDITIONAL USES OF INFORMATION.** Appointment reminders. Your health information will be used by our staff to contact you or send you appointment reminders.

**INFORMATION ABOUT TREATMENTS.** Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health related products and services that we believe may interest you.

**YOUR INDIVIDUAL RIGHTS.** You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Certain of these issues must be in writing and you must use our form.

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that request to inspect or copy protected health information be submitted in writing using our form. You may obtain a form to request access to your record by contacting the receptionist. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

You have the right to express complaints to us or to Health and Human Services. If you believe that your privacy rights have been compromised. Please let us know of your concerns in writing.

You will not be penalized or otherwise retaliated against for filing a complaint.

**QUESTIONS OR COMPLAINTS.** If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

One Source Vision Care, LLP  
966A Aigner Drive  
Boonville, Indiana 47601  
Attn: HIPPA Privacy Officer