PROVISION LASER EYE CENTER MEDICAL HISTORY

Date: _____ Name: _____
Date of Birth: _____ Phone: _____ Height_____ Weight_____
Primary Physician: _____ Address: _____
Endocrinologist: _____ Address: _____
Pharmacy Address: _____ Pharmacy Phone : _____

EYE HISTORY: Have you or do you currently have any of the following:

☐**NONE** ☐Cataract Surgery (approx. date _____)
☐Glaucoma ☐Macular Degeneration ☐Dry Eyes ☐Floaters / Flashing lights
☐Blurred Vision ☐Eye pain, aching or burning ☐Retinal Detachment ☐LASIK surgery
☐Itching, tearing, redness ☐Trouble seeing road signs ☐Difficulty with glare or halos around lights
Do you wear contact lenses? ☐Yes ☐No ☐Soft Lenses ☐ Hard Lenses

REVIEW OF SYSTEMS: Check all that apply or check NONE

NEUROLOGICAL: ☐**NONE** ☐Stroke (date _____) ☐Temporary Vision Loss ☐Tremor ☐Alzheimers
RESPIRATORY: ☐**NONE** ☐Asthma ☐COPD ☐Emphysema ☐Shortness of Breath ☐Bronchitis
☐Chronic Cough
EAR, NOSE, THROAT: ☐**NONE** ☐Swollen Glands ☐Vertigo ☐Seasonal Allergies ☐Sinus Problems
ENDOCRINE: ☐**NONE** ☐Diabetes ☐Insulin Dependent ☐Hypothyroid ☐Hyperthyroid A1C _____
CARDIOVASCULAR: ☐**NONE** ☐Heart attack (date _____) ☐Irregular Heartbeat ☐Angina ☐HBP
☐Pacemaker (date_____) ☐Chest Pain ☐Heart valve abnormality ☐Aortic stenosis
GASTROINTESTINAL / SKIN: ☐**NONE** ☐Ulcers ☐Hernia ☐Lesions ☐Rash ☐ Gerd
GENITOURINARY: ☐**NONE** ☐Kidney Stone ☐Kidney Failure ☐Hernia ☐Liver Problems ☐ Prostate Cancer
MUSCULOSKELETAL: ☐**NONE** ☐Joint Pain ☐Muscle Weakness ☐Back Pain ☐Arthritis
HEMATOLOGIC / LYMPHATIC: ☐**NONE** ☐Blood Disorder ☐Anemia ☐Leukemia ☐Hepatitis ☐Cancer _____
PSYCHIATRIC: ☐**NONE** ☐Depression ☐Anxiety ☐Panic Attacks
OTHER: _____

Do you use any eye drops? ☐Yes ☐No If yes, please list: _____
CURRENT MEDICATIONS: ☐**NONE**

Name	Dosage	Name	Dosage

ALLERGIES / REACTION ☐**NONE**

Allergic to latex? ☐Yes ☐No **Allergic to eggs?** ☐Yes ☐No
Do you smoke cigarettes? Yes ☐No
Drink Alcohol? ☐Yes No

Hobbies / Activities: _____ Occupation: _____
Do you live: ☐Alone ☐With spouse ☐Care center ☐Other:_____

SURGERIES: Please list all past surgical procedures and approximate date ☐**No previous surgeries**

Surgery	Date	Surgery	Date

FAMILY HISTORY: ☐NONE ☐Glaucoma ☐Cataracts ☐Diabetes ☐Retinal Detachment ☐Macular Degeneration

PROVISION
LASER EYE CENTER

Dry Eye Questionnaire (DEQ5)*

1. Questions about **EYE DISCOMFORT**:
   a. During a typical day in the past month, **how often** did your eyes feel discomfort?
      - 0 Never ☐
      - 1 Rarely ☐
      - 2 Sometimes ☐
      - 3 Frequently ☐
      - 4 Constantly ☐
   b. When your eyes felt discomfort, **how intense was this feeling of discomfort** at the end of the day?

Never have it	Not at All Intense				Very Intense
0 ☐	1☐	2☐	3☐	4☐	5☐

2. Questions about **EYE DRYNESS**:
   a. During a typical day in the past month, **how often** did your eyes feel dry?
      - 0 Never ☐
      - 1 Rarely ☐
      - 2 Sometimes ☐
      - 3 Frequently ☐
      - 4 Constantly ☐
   b. When your eyes felt dry, **how intense was this feeling of dryness** at the end of the day, within two hours of going to bed?

Never have it	Not at All Intense				Very Intense
0☐	1☐	2☐	3☐	4☐	5☐

3. Questions about **WATERY EYES**:
   During a typical day in the past month, **how often** did your eyes look or feel excessively watery?
   - 0 Never ☐
   - 1 Rarely ☐
   - 2 Sometimes ☐
   - 3 Frequently ☐
   - 4 Constantly ☐

PROVISION LASER EYE CENTER REGISTRATION

Name:_____
Last First Middle

Address:_____

City:_____State:_____Zip:_____

Phone (H):_____(W)_____(Cell)_____

Northern Address:_____

City:_____State:_____Zip:_____

Email Address: _____Employer: _____

Sex M F Single ____ Married ____ Widowed ____

Social Security #:_____Date of Birth:_____

Spouse:_____

Social Security #_____Date of Birth:_____

If minor, who is responsible for bill?_____

Address:_____City:_____Zip:_____

Social Security #:_____Date of Birth:_____

Whom may we thank for referring you:_____

Primary Insurance:_____

Secondary Insurance:_____

Contact in case of emergency:_____Phone:_____

I consent to treatment, diagnostic, and/or therapeutic services ordered by Provision Laser Eye Center. I authorize payment by my insurance company/companies on my behalf for services provided. I certify the information given by me under Title XVIII of the Social Security Act is accurate. I understand I am responsible for any unpaid balance including deductibles, co-pays, and any non-covered services.

X_____ _____
Patient Signature or Responsible Party Date

PROVISION
LASER
EYE
CENTER

Dear Patient,

Our medical providers are participating in a program that encourages the adoption of electronic medical records. This technology is designed to reduce healthcare costs, while improving the overall quality of your care. As part of this program, we are asked to record the following demographic information about our patients. Please be assured, your privacy is 100% protected.

Thank you for your assistance!

Primary Language

English ____

Spanish ____

Other ____

Race

White ____

Hispanic ____

Black ____

Asian ____

Am. Indian ____

Other ____

Ethnicity

Caucasian ____

Hispanic ____

Other ____

Venice Health Park • 1191 Jacaranda Blvd. • Venice, FL 34292 • (941) 493-0311 • Fax: (941) 492-4655

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form (electronically, on paper, or orally) are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information (PHI) is used. HIPAA provides penalties for covered entities that misuse protected health information. As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

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

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would be referring you to a retina specialist.
- Payment means such activities as obtaining reimbursement for services, confirming coverages, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and or veifying coverage prior to a surgery.
- Health Care Operations include business aspects of running the practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentially to the furthest extent possible.

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

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

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care options
- Disclosures that constitute a sale of PHI under HIPAA
- Other uses and disclosures not described in this notice

  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:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of PHI by alternative means or at alternative locations.
- The right to inspect and copy your PHI
- The right to amend your PHI
- The right to receive an accounting of disclosures on your PHI
- The right to obtain a paper copy of this notice from us upon request
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed

If you have paid for services "out of pocket", in full, and you request that we do not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make such disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of September 10, 2014 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office.

You have the right to file a formal, written complaint with the office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information, in person or in writing.

Patient Signature: _____ Date: _____

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EYE
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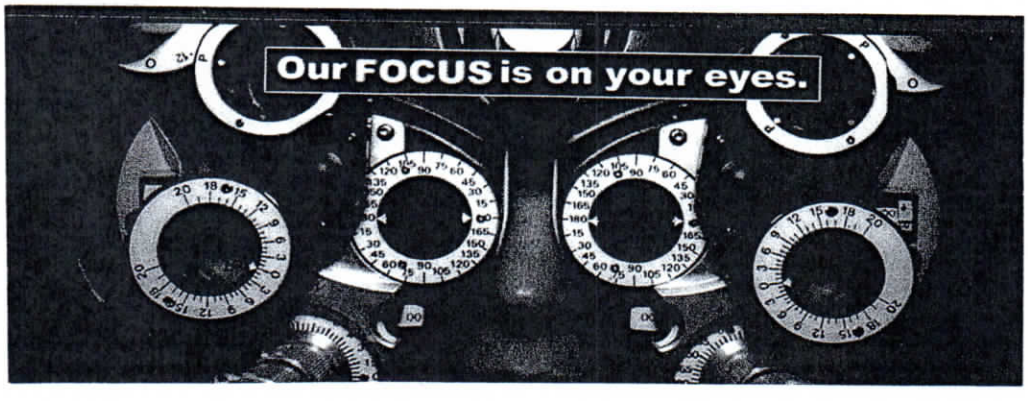
Medicare and most insurance companies do not pay for refractions. The cost of the refraction is $50. Payment is expected at the time of service.

A refraction is the only way to determine your best corrected vision. It is a necessary component of the eye exam that is used to determine your prescription for glasses, legal driving limits, and evaluate for diseases of the eye.

A common question that is asked is "if I am happy with my vision, why do I need a refraction?" Subtle changes in your "best corrected vision" (that may or may not be noticeable to you) help identify new diseases or progression of known diseases of the eye such as cataracts, macular degeneration, glaucoma, and dry eye. This leads to earlier and more successful treatment.

Please sign below to indicate that you have been informed of this non-covered service.

Signature Date



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PATIENT
RELEASE OF INFORMATION
CONSENT

I authorize the following person(s) permission to discuss my appointment, billing, and/or medical information specific to myself:

Name of Person: _____

Relationship: _____

Phone: _____

Secondary Name if Applicable: _____

Relationship: _____

Phone: _____

No one at this time _____

X _____

Patient Signature Date

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