**BLUE OAKS EYECARE**
**Optometric Corporation**

# WELCOME TO OUR OFFICE!

## Receipt of Notice of Privacy Policies & Consent Form

Last Name: _____ First Name: _____ Gender: M F

Social Security #: _____ Date of Birth: _____ Text Messages: YES NO

PLEASE CIRCLE PLEASE CIRCLE

Primary Phone (Home/Cell/Work/Other): _____ Other Phone (Cell/Work/Other): _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Please inform us if you DO NOT want patient communications via email

Would you like us to communicate examination results and records through email? YES NO

Employer: _____ Occupation: _____ Last Eye Examination Date: _____

Vision Insurance Carrier: _____ Vision Insurance ID: _____

Medical Insurance Carrier: _____ Medical Insurance ID: _____

Primary Care Physician (PCP) Name: _____ City: _____ State: _____

Other Family Members who are Patients: _____ Referred by: _____

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The ***Notice of Privacy Practices*** you have been given describes these uses and disclosures in detail. You may refer to this notice any time before you sign this form. As described in our ***Notice of Privacy Practices*** the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated if our privacy practices change. You can get an updated copy here at the office. When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our ***Notice of Privacy Practices.*** You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our ***Notice of Privacy Practices,*** we are not obligated to agree to these suggested restrictions. If you do agree, however, the restrictions are binding on us. Our ***Notice of Privacy Practices*** describes how to ask for restriction.

**It is the patient's or insured's responsibility to provide accurate insurance information. We will gladly bill your insurance for you; however, it is the responsibility of the patient or insured member to pay any non-covered balances.**

**I have read and understood this document. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the *Notice of Privacy Practices* from the office of Blue Oaks Eyecare, Optometric Corporation**.

_____ _____ _____

**Signature** **Print Name** **Date**

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____

**Relationship to Patient** **Source of Authority**

BLUE OAKS EYECARE
Optometric Corporation

# Medical History Questionnaire

Name: _____ Today's Date: _____/_____/_____

Name of Medical Doctor: _____ Doctor's Phone: _____

Last Medical Exam: _____/_____/_____ Last Eye Exam: _____/_____/_____

## Medical History

Do you have any allergies to medications? ☐ No ☐ Yes

_____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications, and home remedies):_____

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____List any eye conditions/surgeries that you have had, such as: LASIK, crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury:_____

_____

Are you pregnant and/or nursing? ☐ No ☐ Yes

Do you wear glasses? ☐ No ☐ Yes If yes, how old are your present pair of lenses? _____

Do you wear contact lenses ☐ No ☐ Yes If yes, how old are your current pair of contacts? _____

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Other: _____ Are they Comfortable? ☐ No ☐ Yes

## Family History

Please note any family history (parents, grandparents, siblings, children, living or deceased-please specify **Maternal or Paternal** side) for the following conditions:

| DISEASE/CONDITION | NO | YES | RELATIONSHIP TO YOU |
|---|---|---|---|
| Blindness | ☐ | ☐ | _____ |
| Cataract | ☐ | ☐ | _____ |
| Crossed Eyes | ☐ | ☐ | _____ |
| Glaucoma | ☐ | ☐ | _____ |
| Macular Degeneration | ☐ | ☐ | _____ |
| Retinal Detachment/Disease | ☐ | ☐ | _____ |
| Arthritis | ☐ | ☐ | _____ |
| Cancer | ☐ | ☐ | _____ |
| Diabetes | ☐ | ☐ | _____ |
| Heart Disease | ☐ | ☐ | _____ |
| High Blood Pressure | ☐ | ☐ | _____ |
| Kidney Disease | ☐ | ☐ | _____ |
| Lupus | ☐ | ☐ | _____ |
| Thyroid Disease | ☐ | ☐ | _____ |
| Other: _____ | ☐ | ☐ | _____ |

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Optometric Corporation

# Medical History Questionnaire

**Social History** *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer*

☐ Yes, I would prefer to discuss my Social History information directly with my doctor (check box)

Do you drive? ☐ No ☐ Yes If yes, do you have visual difficulty when driving? ☐ No ☐ Yes

Do you use tobacco products? ☐ No ☐ Yes If yes, type/amount/how long: _____

Do you use drink alcohol? ☐ No ☐ Yes If yes, type/amount/how long: _____

Do you use illegal drugs? ☐ No ☐ Yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

## Review of Systems

Do you currently, or have you had any problems in the following areas:

| SYSTEM | NO | YES |
|---|---|---|
| **CONSTITUTIONAL** | | |
| Fever | ☐ | ☐ |
| Cough | ☐ | ☐ |
| Weight Loss | ☐ | ☐ |
| Weight Gain | ☐ | ☐ |
| **NEUROLOGICAL** | | |
| Headaches | ☐ | ☐ |
| Migraines | ☐ | ☐ |
| Seizures | ☐ | ☐ |
| **OCULAR** | | |
| Dryness | ☐ | ☐ |
| Mucous Discharge | ☐ | ☐ |
| Redness | ☐ | ☐ |
| Sandy or Gritty Feeling | ☐ | ☐ |
| Itching | ☐ | ☐ |
| Burning | ☐ | ☐ |
| Sties or Chalazion | ☐ | ☐ |
| Foreign Body Sensation | ☐ | ☐ |
| Excess Tearing/Watering | ☐ | ☐ |
| Glare/Light Sensitivity | ☐ | ☐ |
| Eye Pain/Soreness | ☐ | ☐ |
| Chronic Infection of Eye/Lid | ☐ | ☐ |
| Flashes in Vision | ☐ | ☐ |
| Floaters in Vision | ☐ | ☐ |
| **ENDOCRINE** | ☐ | ☐ |
| Thyroid/Other Glands | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Diabetes Suspect | ☐ | ☐ |
| Gout | ☐ | ☐ |

| | NO | YES |
|---|---|---|
| **EARS, NOSE, MOUTH, THROAT** | | |
| Allergies/Hay Fever | ☐ | ☐ |
| Sinus Congestion | ☐ | ☐ |
| Runny Nose | ☐ | ☐ |
| Post Nasal Drip | ☐ | ☐ |
| Sneezing | ☐ | ☐ |
| Dry Throat/Mouth | ☐ | ☐ |
| **RESPIRATORY** | | |
| Asthma | ☐ | ☐ |
| Chronic Bronchitis | ☐ | ☐ |
| Emphysema | ☐ | ☐ |
| **VASCULAR/CARDIOVASCULAR** | | |
| Heart Pain | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ |
| Vascular Disease | ☐ | ☐ |
| Elevated Cholesterol | ☐ | ☐ |
| **GENITOURINARY** | | |
| Kidney Disorder | ☐ | ☐ |
| Bladder Disorder | ☐ | ☐ |
| **MUSCULOSKELETAL** | | |
| Rheumatoid Arthritis | ☐ | ☐ |
| Muscle Pain | ☐ | ☐ |
| Joint Pain | ☐ | ☐ |
| **PSYCHIATRIC** | | |
| Depression | ☐ | ☐ |
| Bipolar Disorder | ☐ | ☐ |
| Anxiety Disorder | ☐ | ☐ |
| **LYMPHATIC/HEMATOLOGIC** | | |
| Anemia | ☐ | ☐ |

**If you answered YES to any of the above or have a condition not listed, please explain:** _____

_____

_____

_____ _____

**Doctor's Signature** **Date**

**1422 Blue Oaks Blvd. Suite #150, Roseville, CA 95747 | (916) 783-3937 (EYES)**

**BLUE OAKS EYECARE**
**Optometric Corporation**

# Contact Lens Policy

At Blue Oaks Eyecare Optometric Corporation, we provide exceptional **individually** tailored contact lens services based on your overall health, eye health, visual needs, and eyeglass prescription. If you are interested in contact lenses or currently wear contact lenses, our doctors will discuss contact lens fitting and prescription options with you.

**What is a contact lens fitting?**

A contact lens fitting is a **separate** service from the comprehensive eye examination and requires additional testing in order for our doctors to prescribe contact lenses. This requires more of the doctor's time and expertise and as such, **charges apply for <u>each</u> fitting that is done**. Contact lens fittings must be done within **90 days** of a comprehensive eye exam and any changes must be done within **30 days** of your fitting.

**For your contact lens fitting we:**

1. Evaluate the health of your eyes, paying close attention to the cornea, eyelids and conjunctiva to assess how contact lens wear will affect your eye health.
2. Determine the proper contact lens material and prescription based on your vision needs, eyeglass prescription, corneal health, and curvature.
3. Examine the contact lens on your eye to ensure proper alignment with the cornea and eye lids.
4. Measure your vision with the contact lenses and make adjustments as needed.

Contact lens fittings have different levels of difficulty depending on **the type of contact lenses needed** to suit your visual requirements and eye health. Our contact lens fitting fees range from $60-$240, depending on the contact lens fitting level and if training or follow ups are required.

*** Please ask our staff or doctor if you have any questions about these fees <u>before</u> being fitted ***

**What is a contact lens prescription?**

Contact lenses are medical devices that can only be dispensed with a prescription. A contact lens prescription is different and separate from an eyeglass prescription because they are placed on your eyes and have different corrective properties. Contact lens prescriptions expire after **one year** (or sooner if the doctor determines a medical reason for a shorter expiration date).

Contact lenses must be regarded with the same caution you would use for prescription medications because they can cause adverse effects as well. If you experience any side effects, take out your contact lenses and call your eye doctor.

**Potential symptoms include but not limited to:**

- Irritated, red eyes
- Worsening pain in or around the eyes—even after contact lens removal
- Light sensitivity
- Sudden blurry vision
- Unusually watery eyes or discharge

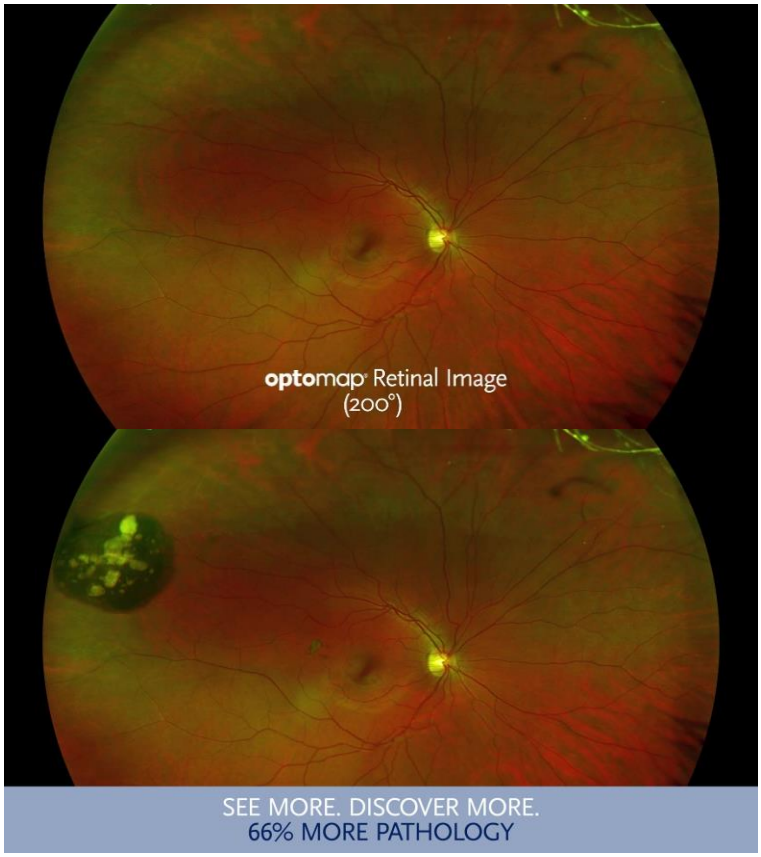
Your eyes go through gradual changes in size, shape and physiological requirements (such as oxygen requirements) while wearing contact lenses. These changes can affect the health of the cornea and need to be monitored at least every year. The federal government requires contact lens prescriptions to expire after a set period of time for these reasons.

**Contact Lens Policy Acknowledgement**

**Print Name:** _____ **Signature:** _____ **Date:** _____

**1422 Blue Oaks Blvd. Suite #150, Roseville, CA 95747 | (916) 783-3937 (EYES)**

# optomap® Advanced Ocular Screening




**Opto**map non-invasively captures an instantaneous, ultra-widefield digital image of the retina, revealing important information for the comprehensive evaluation of systemic and ocular health. The image, which is captured in less than half a second, enhances clinical care, patient satisfaction, and practice efficiency. **Opto**map can help aid in the detection and diagnosis of serious eye conditions such as:

- Diabetic Retinopathy
- Retinal Detachments
- Macular Degeneration
- Melanomas

An **Opto**map is performed as part of a comprehensive eye exam. It is a useful tool which helps the doctor discover retinal disease and assist in the diagnosis of eye conditions, but is NOT a direct replacement of dilation.

An **Opto**map should be performed annually regardless of symptoms, thereby allowing doctors to observe subtle changes occurring as their patients age.

There is an additional charge for an **Opto**map of $42. Ask a member of our staff for more details.

☐ Yes, I would like to get an **Opto**map screening. I understand this is NOT a replacement of dilation.

☐ No, I understand the benefits and risks and decline the scan.

_____ _____ _____

Name Signature Date

# BLUE OAKS EYECARE, OPTOMETRIC CORPORATION
# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY.** Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice).
We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

## *USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION*

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we must carry out in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

## *OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT*

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA.

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for heath care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

## *SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION*

The following are some specific uses and disclosures we may not make of your health information **without** your authorization:

**Marketing activities:** We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent to such payment.

**Sale of health information:** We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.

**Psychotherapy notes.** Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

### *YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES*

Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization. You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.
We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law. We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).
Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

### *YOUR INDIVIDUAL RIGHTS*

You have many rights concerning the confidentiality of your health information. You have the right:

- **To request restrictions on the health information we may use and disclose for treatment, payment and health care operations.** We are not required to agree to these requests. To request restrictions, please send a written request to us at the address below.
- **To receive confidential communications of health information about you in any manner other than described in our authorization request form**. You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.
- **To inspect or copy your health information.** You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.
- **To amend health information.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:
    - was not created by us, unless the person that created the information is no longer available to make the amendment,
    - is not part of the health information kept by or for us,
    - is not part of the information you would be permitted to inspect or copy, or
    - is accurate and complete.
- **To receive an accounting of disclosures of your health information.** You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).
- **To designate another party to receive your health information.** If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

***Contact Person:***
Our contact person for all questions, requests or for further information related to the privacy of your health information is:

Kristie Trang, O.D.

***Complaints:***
If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown above. If you prefer, you can discuss your complaint in person or by phone.

***Changes to This Notice:***
We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

Notice Revised and Effective: October 7, 2013