



“Protecting your family’s eyesight for life”

Dear Patient,

Welcome to Family EyeCare Clinic. Thank you for trusting your family’s visual needs to our family. Enclosed, please find forms that you can review and complete in the comfort and privacy of your home.

At the time of your visit please bring your insurance cards for medical and vision plans. All co-pays must be paid on the day of services. Please **arrive 10 minutes prior** to your appointment so your personal information may be up-dated in our medical records system for the Doctor’s review.

We look forward to seeing you soon.

Your friends at Family EyeCare Clinic

Daily Double

\$75.00 off a 2nd pair of single vision or lined bifocal eyeglasses

or

\$100 off a 2nd pair of progressive eyeglasses when purchased 30 days within original purchase.

Visit us at:

www.feweb.org

Willoughby
37131 Euclid Ave
(440) 946-8809
(across from YMCA)

Painesville
77 Normandy Dr
(440) 352-0616
(behind Painesville Commons)



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Date _____ Referred by _____

Name _____ Sex M or F

Address _____

City _____ State _____ Zip Code _____

Phone number _____ E-mail _____

Daytime Phone Number _____ Cell Phone Number _____

Social Security Number _____ Date of Birth _____ Age _____

EMPLOYER INFORMATION

Employer: _____ Title: _____

Work Phone Number _____

Contact in emergency

Name _____ Relationship: _____

Phone number: _____

If patient is a minor, please complete the following:

Guardian: _____ Relationship: _____

Phone number: _____

Insurance Information:

Primary medical (hospitalization) insurance company _____

Name of insured: _____

Relationship to insured: Self Spouse Dependent

ID# _____

Is your insurance in a group plan? yes no

If yes, what is the Employer or Group number? _____

Vision Insurance: _____

How will you settle your account today? Cash Check Credit Card Financing

Family EyeCare Clinic Financial Policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Professional fees are due when services are rendered. We accept American express, Discover, Visa, MasterCard and Care credit.
2. When glasses or contacts are purchased through insurance, the balance is due in full when the order is placed.
3. **Keep in mind that your insurance policy is basically a contract between you and your insurance company.** As a service to you, we will file your insurance claim if you assign the benefits to the doctor—in other words, if you agree to have your insurance company pay the doctor directly.
4. **If your insurance company does not pay the practice within 45 days, you are responsible for all fees due.** If we later receive a check from your insurer, we will refund any overpayment to you. **WE DO NOT PROCESS SECONDARY INSURANCES.**
5. If you are insured by a plan that we do not accept, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. **Therefore, our charges for your care are due at the time of service.**
6. Not all-insurance plans cover all services. In the event your insurance plan determines a service to be “not covered,” you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

I have read and understand the practice’s financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

X _____ /_____/_____

Signature of patient (or responsible party, if minor) Date

Please print the name of the patient

Notice of Privacy Practices for Protected Health Information

This notice is being provided to you as a requirement of the federal Health Insurance Portability and Accountability Act (HIPAA). This notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created in or received by your health care provider, and that relates to your past, present or future physical health or condition. Each time you visit a hospital, physician or other healthcare provider, 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. Understanding what is in your medical record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

1 - How Medical Information about You May Be Used and Disclosed

We may use and disclose protected health information about you to provide you with medical treatment or services. We may disclose this information to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you. For example, we may disclose information to people outside of our office when scheduling tests, arranging consultations with other physicians, phoning in prescriptions, etc.

1.1 - For Treatment

We may use and disclose protected health information about you to provide you with medical treatment or services. We may disclose this information to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you. For example, we may disclose information to people outside of our office when scheduling tests, arranging consultations with other physicians, phoning in prescriptions, etc.

1.2 - For Payment

We may use and disclose protected health information to obtain reimbursement for the health care provided to you. We may also use this information to obtain prior authorization for proposed treatment or to determine whether your plan will cover the treatment. We will also share this information with our billing service as needed to facilitate their efforts towards reimbursement from you or your insurance company.

1.3 - For Healthcare Operations

We may use and disclose protected health information to support functions of our practice related to treatment and payment such as case management and quality assurance. In addition, we may use your health information to evaluate staff performance, to help us decide what additional services we offer, and other management and administrative activities.

1.4 - Appointment Reminders

We may contact you to remind you that you have an appointment or need a referral for an appointment.

1.5 - Treatment Issues

We may call you with test results, to tell you about treatment options or alternatives, or to respond to your phone call and answer questions about your treatment.

1.6 - Health-Related Benefits and Services

We may use and disclose medical information to tell you about health-related benefits, services or medical education classes that may be of interest to you.

1.7 - Individuals Involved in Your Care or Payment for Your Care

Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care.

1.8 - Emergencies

We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably possible after the delivery of your treatment.

1.9 - Communication Barriers

We may use or disclose your protected health information if we have attempted to obtain consent from you but are unable to do so due to substantial communication barriers and we determine that your consent to receive treatment is clearly inferred from the circumstances.

1.10 - Required by Law

We may use or disclose your protected health information when required by federal, state or local law. The disclosure will be limited to the relevant requirements of the law.

1.11 - Public Health Risks

We may use or disclose your protected health information for public health reasons in order to prevent or control disease, injury or disability; or to report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

1.12 - Communicable Diseases

We may disclose your protected health information, if required by law, to a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading the disease or condition.

1.13 - Health Oversight Activities

We may disclose protected health information to federal or state agencies that oversee our activities.

1.14 - Legal Proceedings

We may disclose protected health information in response to a court or administrative order or in response to a subpoena, discovery request or other lawful process.

1.15 - Law Enforcement

We may release protected health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process subject to all applicable legal requirements.

1.16 - Workers Compensation

We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

1.17 - Military Activity and National Security

If you are, or were, a member of the armed forces or part of the National Security and Intelligence communities we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

1.18 - Business Associates

There may be some services provided in our organization through contracts with Business Associates. Examples include our billing services, answering services, web services, etc. When these services are contracted, we may disclose some of your protected health information to our Business Associate so that they can perform their job. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

1.19 - Other Uses and Disclosures of Health Information

Other uses and disclosures of your protected health information will be made only with your written authorization unless otherwise permitted or required by law as described above. You may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance on the use or disclosure indicated on the authorization.

2 - Your Health Information Rights

You have the right to inspect and obtain a copy of your protected health information. This means you may inspect and obtain a copy of your medical and billing records. A reasonable copying charge may apply. This request must be made in writing.

2.1 - Right To Inspect and Copy Your Protected Health Information

You have the right to inspect and obtain a copy of your protected health information. This means you may inspect and obtain a copy of your medical and billing records. A reasonable copying charge may apply. This request must be made in writing.

2.2 - Right To Request a Restriction on Uses and Disclosures of Your Protected Health Information

You have the right to request a restriction on your protected health information. This means you may ask us to restrict or limit disclosure of any part of your protected health information. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or payment for your care. You must state the specific restriction requested and to whom you want the restriction to apply. However, this request is subject to our approval. If the physician believes it is in your best interest to permit use and disclosure of your information, it will not be restricted. If the physician does agree to the requested restriction, we may not use or disclose your protected health information unless it is needed to provide emergency treatment.

2.3 - Right To Request To Receive Confidential Communications

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. You must make this request in writing and your request must specify how or where you wish to be contacted. We will not ask you the reason for your request.

2.4 - Right To Request Amendments To Your Protected Health Information

You have the right to request a correction to your protected health information. This means you may request an amendment of your medical record if you believe the health information we have about you is incorrect or incomplete. You must make this request in writing. Forms are available for this purpose and can be obtained from us. We may deny your request for an amendment if we feel it is inaccurate, or if the amendment you are requesting is part of the record that was not created by us. If we deny your request for amendment, you have the right to have your request and our denial added to your medical record.

2.5 - Right To Receive An Accounting

You have the right to receive an accounting of disclosures of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operation, or for disclosures that occurred prior to April 14, 2003. You must make this request in writing and this request must include a time frame, which may not be longer than 6 years or may not include dates prior to April 14, 2003.

2.6 - Right To Obtain A Paper Copy Of This Notice

You have the right to obtain a paper copy of this notice from us.

2.7 - Right To Register A Complaint

You have the right to register a complaint if you feel your privacy rights have been violated. If you believe your privacy rights have been violated, you may file a complaint with our office. You may also file a complaint with the Secretary of the Department of Health & Human Services. You will not be penalized for filing a complaint.

3 - Changes To This Notice

We reserve the right to change this notice and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date at the top. You are entitled to a copy of the notice currently in effect. This notice will be posted on our website.

4 - Contacting Our Privacy Officer

Contact details for our office can be found

HYPERLINK "https://secure.patientwire.com/practice_domain=feweb.org/contact/"

5 - Effective Date

This notice is effective April 14, 2003.

Acknowledgement in receipt of Notice of Privacy Practice

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 healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the Notice of Privacy Practices from Family EyeCare Clinic.

Patient/ Guardian Signature: _____

Life Style Assessment form

Please take a moment so we can better understand your visual needs.

Employer? _____ Occupation? _____

Main reason for exam today? _____

How many hours do spend reading daily? _____ How many hours do you spend on the computer? _____

Check one:

Do you work in Bright Light _____ Medium Light _____ Low Light _____

Do your eyes feel tired or strained at the end of the workday? no yes

Do you experience sensitivity to light? no yes

Does glare bother you? no yes

Do you experience difficulty with nighttime vision, like glare? no yes

Do you wear your glasses all day? no yes

Do you need bifocal correction, but dislike having a line on your lens? no yes

Do you have allergies to metal or silicone? no yes

Do you have interest in contact lenses? no yes

Do you have children? no yes

Do you have family members in need of eye care? no yes

Do you have more than one pair of prescription eyeglasses? no yes

Do you have interest in non-surgical approach to vision correction? no yes

Do you think you would benefit from thinner and lighter lenses? no yes

What is your primary form of vision correction? glasses contact lenses none

If you wear contacts, do you have: Current pair of prescription glasses

Sunglasses (purchased at a boutique, department/optical)

How often do you replace your contact lenses? daily every two weeks monthly other _____

Do you sleep in your contact lenses? yes no If yes, how often do you remove them? _____

What do you like about your contact lenses? _____

What don't you like about your contact lenses? _____

What contact lens solution do you use? _____

What do you like about your glasses? _____

What don't you like about your glasses? _____

Do you need glasses for: Computers Trades Safety Sports/hobbies

Leisure Activities: 1 Fitness 2 Sportsman 3 Art/Crafts 4 Computer 5 Outdoor leisure 6 Music 7 Indoor leisure
8 home/car repair 9 Competitive sports

Medical History Questionnaire

Name: _____

Primary Care Physician _____

Phone number _____

Last Eye Exam _____

Last eye doctor _____

Review of systems

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

	NO	YES	?		NO	YES	?
Constitutional	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Vascular			
Fever, Weight loss/gain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Integumentary (skin)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	High Blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Neurological				Gastrointestinal			
Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seizures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Constipation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eyes				Genitourinary			
Blurred Vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Genitals/ Kidney	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Burning/itching	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Bones/Joints/Muscles			
Cataract	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dry/tearing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Glaucoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Lymphatic/Hematological			
Loss of vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Bleeding problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Allergic/immunological	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Endocrine				Psychiatric	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thyroid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Respiratory			
Ears, Nose, Throat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Allergies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Emphysema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sinus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	FAMILY MEDICAL Hx:			
Hearing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Glaucoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you drink alcohol?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Macular Degeneration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you use tobacco?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Blindness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you use recreational drugs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pregnant?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hypertension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do you use vitamins?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Lazy Eye	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				Cataract	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				Rosacea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Medication

List any allergies

—

List all major surgeries and hospitalization

Patient or guardian signature

Date

Doctor's signature
