OFFICE FOR CIVIL RIGHTS

YOUR HEALTH INFORMATION PRIVACY RIGHTS

Most of us feel that our health information is private and should be protected. That is why there is a federal law that sets rules for health care providers and health insurance companies about who can look at and receive our health information. This law, called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), gives you rights over your health information, including the right to get a copy of your information, make sure it is correct, and know who has seen it.

Get It.

You can ask to see or get a copy of your medical record and other health information. If you want a copy, you may have to put your request in writing and pay for the cost of copying and mailing. In most cases, your copies must be given to you within 30 days.

Check It.

You can ask to change any wrong information in your file or add information to your file if you think something is missing or incomplete. For example, if you and your hospital agree that your file has the wrong result for a test, the hospital must change it. Even if the hospital believes the test result is correct, you still have the right to have your disagreement noted in your file. In most cases, the file should be updated within 60 days.

Know Who Has Seen It.

By law, your health information can be used and shared for specific reasons not directly related to your care, like making sure doctors give good care, making sure nursing homes are clean and safe, reporting when the flu is in your area, or reporting as required by state or federal law. In many of these cases, you can find out who has seen your health information. You can:

- **Learn how your health information is used and shared by your doctor or health insurer.** Generally, your health information cannot be used for purposes not directly related to your care without your permission. For example, your doctor cannot give it to your employer, or share it for things like marketing and advertising, without your written authorization. You probably received a notice telling you how your health information may be used on your first visit to a new health care provider or when you got new health insurance, but you can ask for another copy anytime.
- **Let your providers or health insurance companies know if there is information you do not want to share.** You can ask that your health information not be shared with certain people, groups, or companies. If you go to a clinic, for example, you can ask the doctor not to share your medical records with other doctors or nurses at the clinic. You can ask for other kinds of restrictions, but they do not always have to agree to do what you ask, particularly if it could affect your care. Finally, you can also ask your health care provider or pharmacy not to tell your health insurance company about care you receive or drugs you take, if you pay for the care or drugs in full and the provider or pharmacy does not need to get paid by your insurance company.
- **Ask to be reached somewhere other than home.** You can make reasonable requests to be contacted at different places or in a different way. For example, you can ask to have a nurse call you at your office instead of your home or to send mail to you in an envelope instead of on a postcard.

If you think your rights are being denied or your health information is not being protected, you have the right to file a complaint with your provider, health insurer, or the U.S. Department of Health and Human Services.

Patient Questionnaire Form

TODAY'S DATE _______/ _______/_______

FIRST _________________________________ MI ______ LAST _____________________________________

DATE OF BIRTH _____/_____/______ AGE _______ [ ] MARRIED [ ] DIVORCED [ ] SINGLE [ ] WIDOWED

STREET ADDRESS ____ APT/LOT/ROOM/SUITE ________

CITY _________________________ STATE _______ ZIP ____________ GENDER: [ ] MALE [ ] FEMALE

HOME PHONE ________________________ CELL PHONE ______________________ SSN ______-______-_______

EMPLOYER _________________________________ ADDRESS ____

CITY _________________________ STATE _______ ZIP _____________ WORK PHONE ______________________

HOW DID YOU HEAR ABOUT US? ____

IS THIS YOUR FIRST EYE EXAM? [ ] YES [ ] NO IF NO, WHEN WAS YOUR LAST EYE EXAM? _________________

WHAT IS YOUR REASON FOR TODAY'S VISIT ____

HAVE YOU WORN GLASSES BEFORE? [ ] YES [ ] NO HOW OLD ARE YOUR CURRENT GLASSES? ____________

HAVE YOU WORN CONTACT LENSES BEFORE? [ ] YES [ ] NO HOW OLD ARE YOUR CONTACTS? ____________

PATIENT MEDICAL HISTORY

NAME OF PRIMARY CARE PHYSICAN ____

NAME OF FACILTY ____ PHONE _____________________________

PHARMACY NAME____________________________ LOCATION___________________ PHONE___________________

Have "you" ever had or been diagnosed for any of the following? Please circle "Y" for yes or "N" for no.

Y / N	Blurred Vision	**Y / N**	Headaches	
Y / N	Glaucoma	**Y / N**	Heart Disease	
Y / N	Cataracts	**Y / N**	Hepatitis	
Y / N	Flashing Lights	**Y / N**	HIV/ AIDS	
Y / N	Double Vision	**Y / N**	Sinus Problems	
Y / N	Wavy Vision	**Y / N**	High Blood Pressure	**Date of Onset:** _____________
Y / N	Burning Eyes	**Y / N**	Kidneys	
Y / N	Increased Tearing	**Y / N**	Thyroid	
Y / N	Macular Degeneration	**Y / N**	Cancer	**Date of Onset:** _____________
Y / N	Retinal Detachment	**Y / N**	Diabetes **Type:** ______	**Date of Onset:** _____________

Please list any other health conditions: ____

Is there any "family history" of the following? Please circle "Y" for yes or "N" for no.

Y / N Diabetes Who? __________________________________
Y / N Macular Degeneration Who? __________________________________
Y / N High Blood Pressure Who? __________________________________
Y/ N Glaucoma Who? __________________________________

Eye procedures and/or surgeries (please include date of procedure): ____

____

Current Medications: ____

Eye Medications: ____

Allergies: ____

INSURANCE INFORMATION

PRIMARY INSURANCE____ ID #________________________________

NAME OF POLICY HOLDER____

POLICY HOLDER'S DATE OF BIRTH _____/_____/_____ POLICY HOLDER'S SSN_______-_______-_______

RELATIONSHIP TO PATIENT: [ ] SPOUSE [ ] CHILD [ ] OTHER _______________________

SECONDARY INSURANCE_____________________________________ ID #________________________________

NAME OF POLICY HOLDER____

POLICY HOLDER'S DATE OF BIRTH _____/_____/_____ POLICY HOLDER'S SSN_______-_______-_______

RELATIONSHIP TO PATIENT: [ ] SPOUSE [ ] CHILD [ ] OTHER _______________________

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NOTICE OF PRIVACY POLICY- PATIENT ACKNOWLEDGEMENT

I, ____________________________________ hereby authorize **Parkway Family Eye Clinic, Inc.** to furnish information to insurance carrier(s) concerning my diagnosis and treatment. I authorize **Parkway Family Eye Clinic, Inc.** and affiliated business associates to contact me regarding appointments, payments, and billing inquiries. I also, authorize **Parkway Family Eye Clinic, Inc.** to disclose health information needed for providing exam records, visual aids, and medications. If we need to disclose your health information outside of our office for any of these reasons, we usually will not ask you for permission if someone other than you requests health information related to the information above. I acknowledge that I have received and reviewed a copy of The Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPPA).

BENEFIT ASSIGNMENT/ RELEASE OF INFORMATION

I hereby assign all medical and/or routine benefits to include medical, optical materials, and routine vision benefits to which I am entitled, including Medicare and private insurance and third party payers to **Douglas A. Anania, O.D., D.B.A. Parkway Family Eye Clinic, Inc.** A photocopy of this assignment is to be considered as valid as the original. I hereby authorize the release of all information, including Medical Records to the Health Care Financing Administration or Insurance Company, as needed, to determine the level of benefits as necessary, to secure payment for related services.

I acknowledge that I have read and understand the information in the statements above. I also acknowledge that, I was given an opportunity to ask *Parkway Family Eye Clinic, Inc.* and staff any questions about anything I do not understand.

Print Patient Name ____ Date ____________________

Patient/ Guardian Signature____________________________________ Relationship to Patient __________________

PUPIL DILATION

Pupil dilation allows the doctor to examine the retina for retinal detachments, holes, tumors (benign or malignant), leaking blood vessels, and/or other retinal problems. Pupil dilation is important for patients: **(1)** with high unusual prescriptions for their glasses, **(2)** with a history of head or eye injuries, **(3)** with diabetes, and **(4)** where the examination findings are suspicious for cataracts, glaucoma, or other eye problems. The most common side effects of the drops used in the dilating process are increased light sensitivity and reduced ability to focus at near. Distance vision is usually not significantly affected, so you should be able to drive. If you do not have sunglasses with you, a temporary pair will be provided. The effects of dilation generally last from 3 to 4 hours. If any redness or blurred vision occurs, please call our office immediately and discuss your problem with the doctor. Signing this, releases the doctor of any liability that may occurs as a result of the pupil dilation.

I understand the importance of pupil dilation in a complete eye examination and [ ] I do [ ] I do not give my permission for dilating drops to be instilled in my eyes.

Patient/ Guardian Signature____ Date ___________________

Relationship to Patient ____________________________