GRAND VISION

New/Returning Patient Routine Exam

PATIENT INFORMATION: (Please Print) Date: _____

(Circle) Mr./Mrs./Ms./Miss/Dr. Last Name: _____First Name: _____MI: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female Social Security #: _____

Email: _____ Marital Status: ☐Single ☐ Married ☐Divorced ☐Widowed ☐ Other

Address: _____Apt # _____City_____State_____ZIP_____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

Ethnicity/Race: (circle) *American Indian/Alaska Native* *Asian* *Hispanic/Latino* *Black/African American* *Native Hawaiian/Pacific Islander* *White/Caucasian* *Other*

Referred By: ☐School Ad ☐Magazine Ad ☐Newspaper ☐Coupon ☐Insurance ☐Walk In ☐Friend or relative

If personally referred, who can we thank for the referral? _____

PATIENT COMMUNICATION:

Please indicate **(circle)** your preferred method of communication for appointment reminders/recalls/product pick-up/etc. ***Text message*** ***Email*** ***Cell Phone*** ***Home Phone*** ***Work Phone***

May we send your emails ☐ or text ☐ messages regarding promotional items/events? **(Circle)** ***YES / NO***

INSURANCE INFORMATION: (If applicable)

Vision Insurance Name: _____ Medical Insurance Name: _____

Medical Insurance Policy # _____ Group # _____

Name of Primary Policy Holder: _____ Secondary Insurance Name: _____

Patient's relation to primary card holder: ☐Self ☐Spouse ☐Child. ***Please fill out section below if patient is not the primary card holder***

RESPONSIBLE PARTY: *(If different than the patient, please complete the following)*

(Circle) Mr./Mrs./Ms./Miss/Dr. Last Name: _____First Name: _____MI: _____

Date of Birth: _____ Gender: ☐Male ☐Female Social Security #: _____

Address : _____Apt # _____City_____State_____ZIP_____

Cell Phone : _____Home Phone: _____ Work Phone : _____

Email Address: _____ Employer: _____

For patients with insurance; in order to process your insurance claim, ***you must present your insurance card or voucher at the time of service.*** Failure to do so may result in denial of your claim. Please understand that you are financially responsible for all charges, whether or not paid by said insurance. **By signing here you are stating that the primary insurance holder is AWARE of the use of his/her policy.**

Patient/Parent/Guardian Signature: _____**Date:** _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES ('NPP'):

I acknowledge that I have received and/or read a copy of Grand Vision Center's notice of Privacy Practices.

Patient/Parent/Guardian Signature: _____ **Date:** _____

Computerized Visual Field Testing:

Computerized visual field testing can help in the early detection of glaucoma, retinal problems, and some neurological diseases and enables us to better diagnose possible causes of headaches. We recommend that patients receive this procedure annually to ensure the most extensive comprehensive examination available. The cost for the visual fields testing is **$20.00**. Do you want computerized visual field testing today**?** ☐ **Yes** ☐ **No**

Patient Signature: _____ Date _____

Optomap™:

Our office is proud to provide our patients with the most highly advanced digital retinal imaging technology available today! Our ability to view your internal retinal health is now dramatically improved with the Optomap. Your doctor is concerned about retinal problems such as macular degeneration, Glaucoma, retinal holes, retinal detachments, and diabetic retinopathy (All of which can lead to partial loss of vision or blindness). **EARLY DETECTION IS CRUCIAL!**

The Optomap provides:

- A digital computerized map of the retina.
- A view of the retinal layers where disease can start.
- The ability to show you your images today during your exam.
- A permanent record for your medical files (year to year screening for potential eye disease, and tracking of diagnosed eye disease).

Because your insurance is designed to only cover a basic eye exam, it does not cover advanced screening tools such as the Optomap. The additional fee is only **$39.**

☐ **Yes - I want this new technology with photos.**

☐ **No - I decline this technology.**

Patient Signature: _____ Date _____

*****Bundle services and save! Computerized Visual Field Testing + Optomap for $49.00*****

Pupil Dilation: (Pupil Enlargement)

Pupil dilation enlarges the size of the pupil temporarily by using an eye drop which allows the doctor a more thorough examination of your retina. Pupil dilation is sometimes used for determining an accurate glasses prescription for younger children. For most individuals, it will blur your near vision for approximately 2-4 hours. Dilation is included in the price of the examination.

Would you like to be dilated today? ☐Yes ☐ No **If No, please sign here :** _____

The Doctors at Grand Vision Center highly recommend a retinal exam yearly to check the internal health of the eye.

Contact Lens Service Policy: (Only applicable with contact lens wearers).

On occasion, our doctors may request you to return for a follow up consultation in order to finalize your contact lens prescription. All of our contact lens fittings include three (3) follow up visits at no charge within 90 days of the original appointment. If you choose to not return for your follow up appointment, please understand that you will be going against the doctor's recommendation and will have the option to sign a contact lens follow up waiver.

Patient Signature: _____ Date _____

Patient Ocular/Medical Questionnaire. Please Answer All Questions.

OCULAR/VISION HISTORY:

Reason for today's visit: _____

Place and Date of Last Eye Exam: _____

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

Are your glasses ☐ Single vision distance ☐ Single vision reading ☐ Progressives/No-line bifocals ☐Lined bifocals ☐ Computer/reading glasses ☐ Safety glasses ☐ Prescription sunglasses ☐OTC readers (power?) _____

Do you wear contact lenses? ☐ No ☐ Yes If yes, what type? ☐ Rigid ☐ Soft ☐ Toric ☐ Multifocal ☐ Monovision ☐Extended Wear ☐Daily Wear Do you wear them ☐Full Time ☐occasionally?

How frequently do you dispose of them? ☐Daily ☐ Every 2 weeks ☐ Every month ☐ Other _____

If you do not currently wear contact lenses, are you interested in wearing lenses? Y/N

Have you had any eye or refractive surgery? **Y/N** If yes, Date _____ Type _____

Are you interested in refractive surgery such as LASIK? **Y/N**

Are you currently experiencing any of the following problems with your eyes? *Please check.*

€ Blurred Vision	€ Floaters in Vision	€ Tearing / Watering
€ Loss of Vision	€ Light Sensitivity	€ Eye Pain / Soreness
€ Loss of Side Vision	€ Dryness	€ Mucous Discharge
€ Distorted Vision	€ Sandy/Gritty Feeling	€ Crusty eyes/lids
€ Double Vision	€ Burning	€ Stye or Chalazion
€ Tired Eyes	€ Itching	€ ***No Symptoms***
€ Flashes of light	€ Redness	

Have you been diagnosed with any of the following conditions? *Please check if applicable.* ***If none, check here:*** ☐

☐ Cataracts	☐ Lazy Eye/Amblyopia	☐ Retinal Detachment	☐ Dry Eye
☐ Glaucoma	☐ Macular Degeneration	☐ Retinal Disease	☐ Other _____

To better assess your lifestyle and to optimize your vision, please check which applies to you. ***If none apply:*** ☐

☐ Sew/Needlepoint	☐ Golfing	☐ Hunting	☐ Wood working
☐ Gardening	☐ Team Sports	☐ Fishing	☐ Water Sports
☐ Computer	☐ Music	☐ Racquet Sports	☐ Swimming
☐ Reading Books	☐ Shooting	☐ Skiing	☐ Other_____

MEDICAL HISTORY:

When was your last physical exam? _____Name of family physician?_____

List any medications you are currently taking and dosages (include oral contraceptives, aspirin, over –the-counter medications): _____

_____

Are you allergic to any medications including eye drops? ☐No ☐Yes *If yes, which ones?* _____

_____

Any other allergies/allergens other than medications? ☐No ☐Yes *If yes, which ones?* _____

_____

Any major surgeries and/or hospitalizations? ☐No ☐Yes *If yes, which ones?* _____

REVIEW OF SYSTEMS: Please check the box beside any problem you currently have, or have had, in the following areas. ***If no problems in any of the following areas, please select this box for 'All Normal'*** ☐

ALLERGIC
- € Allergy /Hay Fever

CARDIOVASCULAR
- € Heart Disease
- € High Blood Pressure
- € High Cholesterol

CONSTITUTIONAL
- € Fever
- € Weight Loss / Gain

ENDOCRINE
- € Diabetes
- € Thyroid Disease

GASTROINTESTINAL
- € Diarrhea / Constipation
- € IBS / Crohn's Disease
- € Ulcers
- € Reflux

GENITOURINARY
- € Kidney Disease
- € Ovarian /Uterine Cancer
- € Prostate Cancer

HEAD: EARS, NOSE, MOUTH, THROAT
- € Sinus Congestion
- € Dry Throat / Mouth
- € Headache

HEMATOLOGIC / LYMPHATIC
- € Anemia
- € Bleeding disorders
- € Cancer

IMMUNOLOGIC
- € HIV/AIDS
- € Shingles (Herpes Zoster)

INTEGUMENTARY (Skin)
- € Cancer
- € Rashes / Eczema
- € Easy Bruising
- € Lupus

MUSCULOSKELETAL
- € Osteo Arthritis
- € Rheumatoid Arthritis
- € Muscle Pain
- € Joint Pain

NEUROLOGICAL
- € Migraines
- € Dizziness
- € Seizures
- € Stroke
- € Multiple Sclerosis

PSYCHIATRIC
- € Anxiety
- € Depression
- € Memory Loss
- € Hallucinations

RESPIRATORY
- € Asthma
- € Bronchitis
- € Emphysema
- € COPD

If you checked any of the above boxes or have a condition not listed, please explain further: _____
_____
_____

SOCIAL HISTORY: (Completely confidential. You may speak to your doctor in private if you wish.)
Do you drive a car? **Y/N**
Do you use tobacco products? **Y/N** If yes, type/amount /how long? _____
Do you consume alcohol? **Y/N** If yes, type/amount/how long? _____
Do you use illicit/street drugs? **Y/N** If yes, type/amount/how long?_____
Have you been exposed to or infected with HIV, Hepatitis or sexually transmitted diseases? **Y/N**
Have you had a blood transfusion? **Y/N**

FAMILY OCULAR/MEDICAL HISTORY: Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions. ***Please check box if no pertinent family history:*** ☐

	Relation to you		Relation to you
Glaucoma	_____	Diabetes	_____
Macular Degeneration	_____	Cancer	_____
Retinal Detachment	_____	Heart Disease	_____
Cataract	_____	High Blood pressure	_____
Blindness	_____	Lupus/autoimmune	_____
Lazy Eye/Amblyopia	_____	Arthritis	_____

Patient /Parent/Guardian Signature: _____ **Date:**_____

GRAND VISION

Notice of Privacy Practices

IN COMPLIANCE WITH THE FEDERAL REGULATIONS OF HIPAA'S PRIVACY RULE, THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Grand Vision Center
1534 S. Grand Parkway
Katy, TX 77494
281-693-3937

Grand Vision South
9550 Spring Green Blvd.
Katy, TX 77494
281.394.7773

www.grandvisionkaty.com
Johan Espitia, Privacy Official

We respect our legal obligation to keep health information that might identify you private. We are obligated by law to provide you with notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reasons we would use or disclose your health information is for treatment, payment, or business operations. We routinely use and disclose your medical information within the office on a daily basis. We do not need specific permission to use or disclose your medical information in the following matters, although you have the right to request that we do not.

Examples of how we might use or disclose health information for treatment purposes might include:

Setting up or changing appointments including leaving messages with those at your home or office who may answer the phone or leaving messages on answering machines, voice mails or emails; calling your name out in a reception room environment; prescribing glasses, contact lenses, or medications as well as relaying this information to suppliers by phone, fax or other electronic means including initial prescriptions and requests from suppliers for refills; notifying you that your ophthalmic goods are ready, including leaving messages with those at your home or office who may answer the phone, or leaving messages on answering machines, voice mails or emails; referring you to another doctor for care not provided by this office; obtaining copies of health information from doctors you have seen before us; discussing your care with you directly or with family or friends you have inferred or agreed may listen to information about your health; sending you postcards or letters or leaving messages with those at your home who may answer the phone or on answering machines, voice mails or emails reminding you it is time for continued care; at your request, we can provide you with a copy of your medical records via email transmission.

At your request, we may not disclose health care information for services you paid for out of pocket. This only applies to those encounters related to the care you want restricted.

Examples of how we might use or disclose health information for payment purposes might include:

Asking you about your vision or medical insurance plans or other sources of payment; preparing and sending bills to your insurance provider or to you; providing any information required by third party payors in order to insure payment for services rendered to you; sending notices of payment due on your account to the person designated as responsible party or head of household on your account with fee explanations that could include procedures performed and for what diagnosis: collecting unpaid balances either ourselves or through a collection agency, attorney, or district attorney's office

Examples of how we might use or disclose health information for business operations might include:

Financial or billing audits; internal quality assurance programs; participation in managed care plans; defense of legal matters; business planning; certain research functions; informing you of products or services offered by our office; compliance with local, state, or federal government agencies request for information; oversight activities such as licensing of our doctors; Medicare or Medicaid audits; providing information regarding your vision status to the Department of Public Safety, a school nurse, or agency qualifying for disability status

USES AND DISCLOSURES FOR OTHER REASONS NOT NEEDING PERMISSION

In some other limited situations, the law allows us to use or disclose your medical information without your specific permission. Most of these situations will never apply to you but they could.

- When a state or federal law mandates that certain health information be reported for a specific purpose
- For public health reasons, such as reporting of a contagious disease, investigations or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices
- Disclosures to government or law authorities about victims of suspected abuse, neglect, domestic violence, or when someone is or suspected to be a victim of a crime
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative hearings
- Disclosures to a medical examiner to identify a deceased person or determine cause of death or to funeral directors to aid in burial
- Disclosures to organizations that handle organ or tissue donations
- Uses or disclosures for health related research
- Uses or disclosures to prevent a serious threat to health or safety of an individual or individuals
- Uses or disclosures to aid military purposes or lawful national intelligence activities
- Disclosures of de-identified information
- Disclosures related to a workman's compensation claim

- 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 and disclosures

- Disclosure of information needed in completing form from a school related vision screening, information to the Department of Public Safety, information related to certification for occupational or recreational licenses such as pilots license.
- Disclosures to business associates who perform health care operations for Grand Vision and who commit to respect the privacy of your information. We also require a business associate to require any sub-contractor to comply with our privacy policies.
- Unless you object, disclosure of relevant information to family members or friends who are helping you with your care or by their allowed presence cause us to assume you approve their exposure to relevant information about your health

USES OR DISCLOSURES TO PATIENT REPRESENTATIVES

It is the policy of Grand Vision for our staff to take phone calls from individuals on a patients behalf requesting information about making or changing an appointment; the status of eyeglasses, contact lenses, or other optical goods ordered by or for the patient. Grand Vision staff will also assist individuals on a patient's behalf in the delivery of eyeglasses, contact lenses, or other optical goods. During a telephone or in person contact, every effort will be made to limit the encounter to only the specifics needed to complete the transaction required. No information about the patient's vision or health status may be disclosed without proper patient consent. Grand Vision staff and doctors will also infer that if you allow another person in an examination room, treatment room, dispensary, or any business area within the office with you while testing is performed or discussions held about your vision or health care or your account that you consent to the presence of that individual.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written *Authorization for Release of Identifying Health Information*. The content of this authorization is determined by federal law. The request for signing an authorization may be initiated by Grand Vision or by you as the patient. We will comply with your request if it is applicable to the federal policies regarding authorizations. If we ask you to sign an authorization, you may decline to do so. If you do not sign the authorization, we may not use or disclose the information we intended to use. If you do elect to sign the authorization, you may revoke it at any time. Revocation requests must be made in writing to the Privacy Officer named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your personal health information.

You may ask us to restrict our uses and disclosures for purposes of treatment (except in emergency care), payment, or business operations. This request must be made in writing to Privacy Officer named at the beginning of this Notice. We do not have to agree to your request, but if we agree, must honor the restrictions you ask for.

You may ask us to communicate with you in a confidential manner. Examples might be only contacting you by telephone at your home or using some special email address. We will accommodate these requests if they are reasonable and if you agree to pay any additional cost, if any, incurred in accommodating your request. Requests for special communication requests must be made to the Privacy Officer named at the beginning of this Notice.

You may ask to review or get copies of your health information. There are a very few limited situations in which we may refuse your access to your health information. For the most part we are happy to provide you with the opportunity to either review or obtain a copy of your medical information. All requests for review or copy of medical information must be made in writing to the Privacy Officer named at the beginning of this Notice. While we usually respond to these requests in just a day or so, by law we have fifteen (15) days to respond to your request. We may request an additional thirty (30) day extension in certain situations.

Health care information you request copies of may be delivered to you in electronic format. The e-formats Grand Vision has approved as secure and protects the integrity of your health care information include secure email, an authorized Electronic Health Information system and media supplied by Grand Vision.

You may ask us to amend or change your health care information if you think it is incorrect or incomplete. If we agree, we will make the amendment to your medical record within thirty (30) days of your written request for change sent to the Privacy Officer named at the beginning of this Notice. We will then send the corrected information to you or any other individual you feel needs a copy of the corrected information. If we do not agree, you will be notified in writing of our decision. You may then write a statement of your position and we will include it in your medical record along with any rebuttal statement we may wish to include.

You may request a list of any non-routine disclosures of your health information that we might have made within the past six (6) years (or a shorter period if you wish). Routine disclosures would include those used your treatment, payment, and business operations of Grand Vision. These routine disclosures will not be included in your list of disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you must pay for them in advance at a fee of $25.00 per list. We will usually respond to your written request (made to the Privacy Officer named at the beginning of this Notice) within thirty (30) days but we are allowed one thirty (30) day extension if we need the time to complete your request.

You may obtain additional copies of this Notice of Privacy Practices from our business office or online at our website address shown at the beginning of this Notice.

CHANGING OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to substantially change the Notice. We reserve the right to change this Notice at any time. If we change this Notice, the new privacy practices will apply to your existing health information as well as any additional information generated in the future. If we change this Notice, we will post a new Notice in our office and on our website.

COMPLAINTS

If you think that anyone at Grand Vision has not respected the privacy of your health information, you are free to complain to the Privacy Officer named at the beginning of this Notice. We are more than happy to try to resolve any concern you may have in writing. If we cannot resolve your concern at that level, you may also file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights or the Texas Attorney General's Office. We will not retaliate against you if you make such a complaint.