Patient's Insurance Information and Signature Authorization

Name: _____ Date: _____
First Initial Last

Preferred Name / Nickname: _____

SSN: _____ Date of Birth: _____ Age: _____ Male / Female _____

Local Address: _____
Street Apartment No. City State Zip

Out-of-town Address: _____

Phone: _____ Work Phone: _____ Cell Phone: _____Email: _____

Occupation: _____ Employer: _____

Marital Status: □ Single □ Married □ Widowed □ Divorced

Spouses Name: _____

Primary Insurance Carrier: _____ (please present your card for copying)

Insured's name: _____ Insured's Employer Name: _____

Insured's Relationship to patient: □ Self □ Spouse □ Parent □ Other: _____

Policy Number: _____ Group Number: _____ Effective Date: _____

Secondary Insurance Carrier: _____ (please present your card for copying)

Insured's name: _____ Insured's Employer Name: _____

Insured's Relationship to patient: □ Self □ Spouse □ Parent □ Other: _____

Policy Number: _____ Group Number: _____ Effective Date: _____

Other Insurance Carrier: _____ (please present your card for copying)

Insured's name: _____ Insured's Employer Name: _____

Insured's Relationship to patient: □ Self □ Spouse □ Parent □ Other: _____

Policy Number: _____ Group Number: _____ Effective Date: _____

LIFETIME MEDICARE B AND / OR INDEPENDENT INSURANCE SIGNATURE AUTHORIZATION

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is full and correct. I authorize the holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare or independent insurance claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services rendered to Jeffrey D. Phillips, O.D., P.A. OR authorize Jeffrey D. Phillips, O.D., P.A. to submit a claim to Medicare or independent insurance company for payment on my behalf. I request that payment of any authorized MEDIGAP benefits be made on my behalf to Jeffrey D. Phillips, O.D., P.A. for any services rendered to me. I authorize any holder of medical information about me to release to my insurance company any information needed to determine these benefits or the benefits payable for related services. I understand that I am personally responsible for all co-payments of my insurance contract. If my insurance fails to pay for physician services rendered to me by Jeffrey D. Phillips, O.D., P.A., I agree to be personally responsible for payment.

Patient's Signature: _____ Date: _____

MEDICAL HISTORY / Review of Systems: *Please complete blanks below and mark any conditions that apply to you.*

Name:_____ **Date:** _____

Your Primary Care Physician's Name: _____ and their phone: (_____) _____
Were you REFERRED to us by another DOCTOR? Y N
Dr's Name_____ Phone (___) _____
Their Address_____

List your ALLERGIES to medicine or any other substance

_____
_____
_____
_____

List your MEDICATIONS Vitamins, Pills and Supplements you take and what they are for:

_____
_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY:
List *anyone in your family who has these disorders.*
Diabetes _____
High Blood Pressure _____
Stroke_____
Heart Disease _____
Macular degeneration _____
Glaucoma _____
Other _____

SURGERIES: Please list any surgeries you have had, and during what month and year.

_____
_____
_____
_____
_____

SOCIAL HISTORY: (Circle the best answer)

Tobacco Use? Current / Former / Never
When did you quit? 1 2 3 4 5 6+ years ago
Alcohol Use? None / Rarely / Daily / Frequent
Narcotic use? None / Rarely / Daily / Frequent

Birth Order: 1 2 3 4 5
Were You: Only child? / Fraternal twin? / Identical twin?
History of Blood Transfusion Y N
Approximate: Height _____ Weight _____

Cardiovascular
___ Heart Attack
___ High Blood Pressure
___ Congestive Heart Failure
___ Elevated Cholesterol
___ Stroke
Other_____

Constitutional
___ Appetite Loss/ Excess
___ Dizziness
___ Fainting
___ Fatigue
___ Nausea
___ Poor Sleep
___ Thirst Excess
Other_____

Endocrine
___ Diabetes
___ Hypoglycemia
___ Hepatitis
___ Thyroid Disorder
___ Pituitary Disorder
Other _____

Gastrointestinal
___ Reflux Disorder (GERD)
___ Nausea
___ Weight Gain/ Loss
___ Gallbladder / stones
___ Colon Cancer
___ Crohn's Disease
Other_____

Genitourinary
___ Kidney Disease/Infection
___ Bladder Disease/ Infection
___ Uterine Cancer
___ Sexually Transmitted Disease
___ Prostate Enlarged / Cancer
___ Kidney Disorder
___ Kidney Stones
___Prostate Disorder
Other_____

__ Head
__ Headaches / Migraines
__ Dental disorder
__ Hearing Loss
__ Seizures
Other _____

Hematologic /Lymphatic
___ Breast Cancer
___ Hodgkin's Lymphoma
___ Sickle Cell Disease
___ Leukemia
___ Bleeding Disorder
___ Temporal Arteritis
___ Peripheral Vascular Disease
Other _____

Immunologic / Infectious
___ Cancer
___ HIV
___ Bacterial Infection
___ Viral Infection (Herpes etc)
___ Mononucleosis
___ Lyme Disease
___ Sarcoid
___ Sjogren's Syndrome
Other_____

Integumentary/Skin
___ Albinism
___ Dermatitis
___ Lupus
___ Raynaud's
___ Rosacea
___ Scleraderma
___ Skin Cancer
___ Urticaria (hives)
Other_____

Musculoskeletal
___ Arthritis
___ Down's Syndrome
___ Gout
___ Marfan's Syndrome
___ Muscular Dystrophy
___ Myasthenia Gravis
___ Osteoporosis
___ Paget's Disease
___ Scoliosis
___ Skeletal Disorder
Other _____

Neurologic
___ Alzheimer's
___ Brain Tumor / Damage
___ Cerebral Palsy
___ Epilepsy
___ Multiple Sclerosis
___ Myasthenia Gravis
___Seizures
___ Neuralgia / fibromyalgia
___Parkinson's
Other _____

Psychiatric
___ Attention Deficit (ADD)
___ Anorexia
___ Autism
___ Anxiety
___ Bipolar
___ Dementia
___ Depression
___ Insomnia
___ Memory Loss
___ Mood Disorder
___ Schizophrenia
Other _____

Respiratory
___ Cough
___ Asthma
___ Bronchitis
___ Pneumonia
___ Cystic Fibrosis
___ Emphysema
___ Tuberculosis
Other _____

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:

Jeffrey D. Phillips, OD
Clair Bugbee

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: September 23, 2013

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Jeffrey Phillips, O.D. and Susan Phillips, O.D., Notice of Privacy Practices.

Date _____

Patient name_____

Signature _____

Some serious eye diseases, such as diabetic retinopathy, retinal detachment, or malignant tumors (which can result in blindness, loss of an eye, or death) can only be detected by wide-field examination of the retina inside the eye. We have two methods available for this examination: dilated pupillary examination and OPTOS retinal imaging.

Florida law presently requires dilation of the pupil for a patient's first comprehensive eye examination unless there are medical reasons for it not to be performed or unless the patient chooses not to have dilation. A patient can choose OPTOS retinal imaging as an alternative to dilation. If you are considering OPTOS imaging, please ask a staff member to present the features, benefits and costs to you before making your selection below.

Informed Consent for Retinal Examination

I agree to indemnify, hold harmless and waive and release from any and all claims, legal actions and attorney fees, which may arise as a result of my choice or failure to comply with the recommendation of Lifetime Vision Care and their employees, officers, directors and agents. I am aware that choosing pupillary dilation carries a very small risk of complication including angle closure glaucoma, and will accept medically necessary treatment if complications arise.

Please check one:

❏ I choose pupillary dilation

❏ I will be responsible for rescheduling my dilation.
(If more than one month later, office visit charges will apply)

❏ I choose OPTOS retinal photography (additional fees will apply)

❏ I refuse dilation at this time. (You may change this at any time)

Printed Name: _____ Date: _____

Signature: _____ (Parent or guardian if a minor.)

Informational Safety Statement

Lifetime Vision Care is required to inform all patients that **Polycarbonate** plastic is the safest, most impact resistant material for eyeglass lenses. Your lifestyle, including your activities, should be considered when ordering eyewear for yourself or your family.

I have read the above safety statement: _____
Signature