PRIMARY EYECARE
Drs. DiGirolamo + Associates Optometrists

Patient Name: ____

(First) (MI) (Last) (Jr., Sr., etc.) (Preferred Name/Nickname)

Date of Birth: ______/______/______ SSN: ______-_____-_________ Gender (circle) **M F**

Address: ________________________________ Apt/Ste: _______ Marital Status (circle) **S M D W**

City: ________________________ State: _____ Zip ___________ Home Ph: _____________________

Employer : ____ Work Ph: _____________________

Occupation: ____ Mobile: _____________________

Email: ____ ***Required:**

I prefer to be contacted by: ❑ Email ❑ Phone ❑ Postal Height: ______ Weight: _________

Name of Spouse (or Parent, if child): _________________________

Preferred Language: ❑ English ❑ Spanish ❑ Other: ________________________________

Whom may we thank for referring you to our office? ____

If you weren't referred, how did you find out about us?

- ❑ Saw sign/ building
- ❑ Insurance List
- ❑ Yellow Pages
- ❑ Newspaper
- ❑ Website (which? _______________________)
- ❑ Local Search (which?____________________)
- ❑ Other: ______________________________

What is your race?

- ❑ African American
- ❑ American Indian/Alaskan
- ❑ Asian
- ❑ Caucasian
- ❑ Hispanic/Latino
- ❑ Pacific Islander/Hawaiian
- ❑ Other: _________________________

Vision Insurance: ___________________________________

Subscriber Name: _____________________ ID: _____________________ DOB:_________________

Subscriber Address: ____

Primary Medical Insurance: _________________________

Subscriber Name: _____________________ ID: _____________________ DOB:_________________

Patient's Relationship to Subscriber: ____

Do you participate in a flex spending account (circle)? **Yes** **No**

Emergency Contact

Name: ____________________________ Relationship: ___________ Phone: _____________________

Ver. 11_14

Payment Due at Time Services Are Rendered

Authorization to Pay Medical & Optical Benefits Directly to the Attending Physician

For those patients with specific vision insurance for which we are providers (VSP, DavisVision, Anthem, etc):

I hereby authorize my insurance carrier (both primary and secondary carriers) to make payments directly to Primary Eyecare for all medical and optical expense benefits otherwise payable to me for this period of treatment. I also authorize the release of medical records by Primary Eyecare. I understand that I am financially responsible to Primary Eyecare for any and all charges not covered by my insurance benefits.

Contact Lens Medical Management

For your health and safety, we perform annual contact lens evaluations. A separate contact lens fee (starting at $56.00) is charged beyond the comprehensive eye examination. Your doctor determines the fit, health and condition of the eyes with contact lenses. We also evaluate changes in prescription and lens design during this process.

Warning About Eye Dilation

As part of the eye examination, it may be necessary to dilate the pupils of the eye. This may hinder your ability to safely drive and your work may be impaired for up to four or five hours by blurred vision, glare, or light sensitivity. If you do not want your eyes to be dilated, please discuss this with the staff.

Delinquent Accounts

I hereby authorize any necessary medical treatment by the optometrists in the practice of Primary Eyecare, Drs. DiGirolamo & Associates, Optometrists and agree to be responsible for my bill and any reasonable collection fees incurred by Primary Eyecare to collect payment of materials and/or services rendered. I authorize the office of Primary Eyecare to release or obtain any required medical information from my attending physicians or medical facility.

Patient Records

Our practice maintains your patient records for at least 5 years from last date of patient encounter. After that time, our practice may destroy your records in a manner which protects patient confidentiality.

Warning about Pregnancy

If you are pregnant or think you might be, please notify the staff and doctor prior to receiving any eye drops.

_______________________________________ __________________________

Patient's Signature (*required) **Date**

CASE HISTORY

Review of Systems **Name:** **Date: / /**

Please mark the significant health history form below:

Constitutional ❑None
- ❑ Developmental disability
- ❑ Weight Loss
- ❑ Fever
- ❑ Fatigue
- ❑ Trauma
- ❑ Other / Medications

Ears, Nose, Mouth & Throat ❑None
- ❑ Upper respiratory tract infection
- ❑ Other / Medications

Cardiovascular ❑None
- ❑ Heart disease
- ❑ Hypertension
- ❑ Stroke
- ❑ Vascular disease
- ❑ Other / Medications

Respiratory ❑None
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Other / Medications

Gastrointestinal ❑None
- ❑ Crohn's
- ❑ Colitis
- ❑ Ulcer
- ❑ Digestive
- ❑ Other / Medications

Genitourinary ❑None
- ❑ Urinary tract infections
- ❑ Kidney ailments
- ❑ STD: Herpes, Chlamydia, HIV
- ❑ Other / Medications

Musculoskeletal ❑None
- ❑ Fibromyalgia
- ❑ Muscular dystrophy
- ❑ Osteoarthritis
- ❑ Other / Medications

Integumentary ❑None
- ❑ Eczema
- ❑ Rosacea
- ❑ Psoriasis
- ❑ Other / Medications

Neurological ❑None
- ❑ Multiple sclerosis
- ❑ Epilepsy
- ❑ Other / Medications

Psychiatric ❑None
- ❑ Depression
- ❑ Panic disorder
- ❑ Schizophrenia
- ❑ Other / Medications

Endocrine ❑None
- ❑ Type 1 diabetes
- ❑ Type 2 diabetes
- ❑ Thyroid dysfunction
- ❑ Hormonal dysfunction
- ❑ Other / Medications

Blood / Lymphatic ❑None
- ❑ Anemia
- ❑ Leukemia
- ❑ Other / Medications

Allergic / Immunologic ❑None
- ❑ Drug allergy
- ❑ Environmental allergy
- ❑ Rheumatoid arthritis
- ❑ Lupus
- ❑ Other / Medications

ROS Coding: 1 = Problem Pertinent 2-9 = Extended 10-14 = Complete

Social History

PFSH Coding: 1 = Pertinent 2 (3) = Est (New) Complete

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

Do you 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 ❑ Syphilis ❑ HIV ❑ Hepatitis ❑ None

Family History

Is there any family medical history of any of the following? (If yes, please list the relationship to you) ❑ None

❑	Blindness	____________	❑	Corneal Problems	____________
❑	Cataracts	____________	❑	Lazy Eye	____________
❑	Glaucoma	____________	❑	Diabetes	____________
❑	Macular Degeneration	____________	❑	Heart Disease	____________
❑	Retinal Detachment	____________	❑	Other Hereditary Diseases	____________

PATIENT MEDICAL HISTORY

Name of Family Physician: ____

Current Medications (Rx or over the counter):

Current Medication	Reason for taking	Route (oral, injection, etc.)	Dose (mg, etc.)
1			
2			
3			
4			
5			
6			
7			
8			

Are you ***allergic*** to any medications? ❑ Yes ❑ No

Medication Allergy	Reaction

PATIENT EYE HISTORY

Date of last eye exam: ______/______/____________ By Whom? ______________________________

Do you currently wear contact lenses? ❑ Yes ❑ No If so, which kind? ______________________________

Have you ever worn contact lenses? ❑ Yes ❑ No

Do you (check, if "yes"): ❑ Work at a computer? ____Hours/week ❑ Spend time outdoors? ____ Hours/week

Have you ever been diagnosed or treated for the following?

❑ Cataracts ❑ Eye Injury ❑ Iritis/ Uveitis ❑ Retinal Detachment
❑ Corneal Abrasion ❑ Eye Surgery ❑ Lazy Eye ❑ Other Eye Disorders
❑ Eye Infection ❑ Glaucoma ❑ Macular Degeneration

Do you experience, or have you ever experienced?

❑ Blurry Vision ❑ Headaches ❑ Double Vision ❑ Grittiness
❑ Burning ❑ Eye Surgery ❑ Flashes of Light ❑ Itchiness
❑ Tearing ❑ Glaucoma ❑ Floaters/ Spots ❑ Bothered by Glare
❑ Crossed Eye/ Eye Turn ❑ Difficulty Seeing at night

Notice of Privacy Practices

Effective January 1, 2014

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions, please contact our office. We are required by law to: maintain the privacy of your protected health information, give you this notice of our duties and privacy practices regarding health information about you, and follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION:

Described as follows are the ways we may use and disclose health information that identifies you (Health Information, or PHI). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to us and stating that you wish to revoke permission you previously gave us.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.
Payment. We may use and disclose Health Information so that we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment. However, if you pay for your services yourself (e.g. out-of-pocket and without any third party contribution or billing), we will not disclose Health Information to a health plan if you instruct us to not do so.
Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the care you receive is of the highest quality. Subject to the exception above if you pay for your care yourself, we also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operations.
Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you. We will not, however, send you communications about health-related or non health-related products or services that are subsidized by a third party without your authorization.
Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.
Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through an approval process. Even without approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.
Fundraising and Marketing. Health Information may be used for fundraising communications, but you have the right to opt-out of receiving such communications. Except for the exceptions detailed above, uses and disclosures of Health Information for marketing purposes, as well as disclosures that constitute a sale of Health Information, require your authorization if we receive any financial remuneration from a third party in exchange for making the communication, and we must advise you that we are receiving remuneration.
Other Uses. Other uses and disclosures of Health Information not contained in this Notice may be made only with your authorization.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by federal, state or local law.
To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may help prevent the threat.
Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.
Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.
Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.
Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
Lawsuits. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.
Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.
National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.
Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.
Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to our office.
Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our office.
Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our office.
Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our office. **We are not required to agree to all such requests.** If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing, to our office. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.
Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, www.cvilleeyecare.com. To obtain a paper copy of this notice please request it in writing.
Right to Electronic Records. You have the right to receive a copy of your electronic health records in electronic form.
Right to Breach Notification. You have the right to be notified if there is a Breach of privacy such that your Health Information is disclosed or used improperly or in an unsecured way.

CHANGES TO THIS NOTICE: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

I acknowledge that I received a copy of the Dr. J.M. DiGirolamo, PC DBA Primary Eyecare **Notice of Privacy Practices**.

Signed: ___________________________________

Sharing Information with Family and Friends

Primary Eyecare has a Notice of Privacy Practices which describes how we may use and disclose, and how you may access, your protected health information. At times spouses, children or others may call on your behalf. If you would like us to share your protected health information with others, please indicate to whom we may disclose this information.

If you do not let us know whom we may speak to, we will NOT discuss your protected health information with them.

I, ________________________________, Date of Birth ________________________, give my permission to Primary Eyecare to discuss my medical care and/or to leave messages with the following people:

Full Legal Name	Relationship to Patient	Phone Number
Full Legal Name	Relationship to Patient	Phone Number
Full Legal Name	Relationship to Patient	Phone Number
Full Legal Name	Relationship to Patient	Phone Number

____ ____________________

Patient Signature Date