

## Welcome to Terrezza Optical

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: Hispanic or Latino Not Hispanic or Latino

Language Spoken: \_\_\_\_\_ Special Needs: \_\_\_\_\_

Emergency Contact Name and Number: \_\_\_\_\_

Do you currently wear any vision correction? Glasses Contacts Both Neither

\_\_\_\_\_ Effective April 1, 2015 all prescription lens sales are final. No refunds may be given. Remakes for any reason must be within 90 days of original date of service and are limited to one remake. (Refund Policy available upon request.)

\_\_\_\_\_ I authorize the release of any information necessary to process my claim to insurance carrier(s) listed above. I understand that it is my responsibility to know my coverage and that any balance not paid by insurance company after 60days is my responsibility. (HIPPA Notice of Privacy Practices available upon request.)

\_\_\_\_\_ I voluntarily consent for a physician to perform reasonable and necessary medical examination, testing and treatment for any condition which has brought me to seek care at this practice or one that has been identified.

Patient/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>Date</b> _____ <b>Name</b> _____ <b>Primary Dr :</b> _____ <b>Primary Dr Ph #</b> _____ <b>Pharmacy :</b> _____ <b>Pharmacy Ph#</b> _____ <b>Please list medications you are currently taking: None</b> _____ _____ _____	<b>Do you have:</b>			<b>Do you :</b>		
	General Allergies?	<b>Y</b>	<b>N</b>	Have Glaucoma?	<b>Y</b>	<b>N</b>
	Sinus Problems ?	<b>Y</b>	<b>N</b>	Have Cataracts?	<b>Y</b>	<b>N</b>
	Headaches?	<b>Y</b>	<b>N</b>	High Blood Pressure?	<b>Y</b>	<b>N</b>
	Eye pain?	<b>Y</b>	<b>N</b>	Diabetes?	<b>Y</b>	<b>N</b>
	Dry Eyes ?	<b>Y</b>	<b>N</b>	Do you take insulin?	<b>Y</b>	<b>N</b>
	Eye redness?	<b>Y</b>	<b>N</b>	Have HIV?	<b>Y</b>	<b>N</b>
	Eyes burn?	<b>Y</b>	<b>N</b>	Work with a computer?	<b>Y</b>	<b>N</b>
	Eyes itch?	<b>Y</b>	<b>N</b>	Play sports in which safety Is a factor?	<b>Y</b>	<b>N</b>
	Eyes water?	<b>Y</b>	<b>N</b>	Drive an excessive amount ?	<b>Y</b>	<b>N</b>
<b>Drug Allergies: None Known</b>	Eye mucous?	<b>Y</b>	<b>N</b>	Have a problem with sunlight?	<b>Y</b>	<b>N</b>

<b>Patient Ocular History</b> ☼ NONE ☼ Glasses ☼ Contact Lenses ☼ Glaucoma RT LT ☼ Retinal Detachment ☼ Macular Degeneration ☼ Retinitis Pigmentosa ☼ Iritis / Uvetitis ☼ Cataracts ☼ Crossed eyes/ Strabismus ☼ Ocular migraines ☼ field loss ☼ photophobia ☼ redness ☼ itching ☼ burning ☼ recurrent styes ☼ Eye Surgery RT LT ☼ Flashes ☼ Floaters ☼ Recurring styes  <b>Family Ocular History</b> ☼ Glaucoma ☼ Retinal detachment ☼ Macular degeneration ☼ Retinitis Pigmentosa ☼ Blindness for any reason  <b>Constitutional</b> ☼ NONE ☼ Developmental disability ☼ weight loss ☼ fever ☼ fatigue ☼ trauma ☼ Involved in motor vehicle accident	<b>Cardiovascular</b> ☼ NONE ☼ heart disease ☼ High blood pressure ☼ stroke ☼ vascular disease ☼ Congestive Heart Failure ☼ Family History ☼ Surgery  <b>Ear, nose, mouth &amp; throat</b> ☼ NONE ☼ Upper resp tract inf ☼ Ear infection ☼ sore throat ☼ runny nose ☼ trouble swallowing ☼ Family History ☼ Surgery  <b>Respiratory</b> ☼ NONE ☼ cigarette smoker ☼ asthma ☼ bronchitis ☼ emphysema ☼ Tuberculosis ☼ Lung cancer ☼ Family History ☼ Surgery  <b>Muskuloskeletal</b> ☼ NONE ☼ fibromyalgia ☼ muscular dystrophy ☼ osteoarthritis	<b>Integumentary</b> ☼ NONE ☼ eczema ☼ rosacea ☼ psoriasis ☼ Family History ☼ Surgery  <b>Neurological</b> ☼ NONE ☼ multiple sclerosis ☼ epilepsy ☼ head injury ☼ stroke _____ ☼ Alzheimer's ☼ Fainting/ Blackouts ☼ Dizziness ☼ Family History ☼ Surgery  <b>Gastrointestinal</b> ☼ NONE ☼ Crohn's ☼ colitis ☼ ulcer ☼ digestive ☼ hiatal hernia ☼ gallbladder ☼ Hepatitis ☼ pancreatitis ☼ Family History ☼ Surgery  <b>Genitourinary</b> ☼ NONE ☼ STD – viral, herpetic, chlamydia ☼ Kidney Disease ☼ Prostate Cancer ☼ Cervical/Uterine/ Ovarian Cancer	<b>Genitourinary(cont)</b> ☼ Pregnant ☼ Family History ☼ Surgery  <b>Psychiatric</b> ☼ NONE ☼ depression ☼ panic disorder ☼ schizophrenia ☼ Bipolar disorder ☼ Family History ☼ Surgery  <b>Endocrine</b> ☼ NONE ☼ non-insulin diabetes ☼ insulin diabetes ☼ thyroid dysfunction ☼ hormonal dysfunction  <b>Hematological/ Lymphatic</b> ☼ NONE ☼ anemia ☼ Ig volume blood loss ☼ leukemia ☼ Family History ☼ Surgery  <b>Allergic/ Immunologic</b> ☼ NONE ☼ drug/allergy ☼ environmental allergy ☼ HIV / AIDS ☼ rheumatoid arthritis ☼ lupus ☼ Family History ☼ Surgery
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## Vision Eye Exams vs. Medical Eye Exams

***Regular eye examinations are important to maintain your vision for your lifetime. It is important that you be aware of your insurance benefits and how they apply to your visit. We have prepared this sheet to help you understand how your visit is submitted to your health insurance or vision insurance for today's visit. Benefits may vary based upon the reason for your visit.***

**Routine Eye Examinations** A “routine eye exam” takes place when you come for an eye examination without any underlying medical condition which affects the eye. The doctor screens the eyes for disease and will check your vision. Examples that will necessitate your visit being submitted as a vision exam include:

- Comprehensive eye exam
- Glasses / Contact Lenses

**Medical Eye Examinations** Exams for medical care which are for evaluation of a medical-related complaint or follow up of an existing condition are examples of an eye examination that would be billed to your medical insurance. Any additional testing done to document your medical condition would be billed to your medical insurance. Examples that will necessitate your visit being submitted as a medical exam include but may not be limited to:

- Diabetes mellitus
- Dry or redness of eyes
- Allergies
- Floaters and/or flashing lights
- Glaucoma
- High risk medications (auto immune, systemic illness treatment)
- Cataracts
- Macular degeneration
- Vitreous degeneration

*The purpose of your visit will determine which insurance benefit will be used. If your doctor determines that your problem falls under the category of a “medical eye examination”, your visit may be billed as a medical exam instead of a routine vision exam, which will be subject to co-pays and deductibles according to your medical insurance plan.*

# Model HIPAA Notice of Privacy Practices

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 about this notice, please contact 850-983-8447.

## OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

## HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

**For 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.

**For Payment.** We may use and disclose Health Information so that we or others 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 about you so that they will pay for your treatment.

**For Health Care Operations.** We may use and disclose Health Information for health care operations 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 obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

**Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services.** We may use and disclose Health Information to contact you 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.

## SPECIAL SITUATIONS:

**As Required by Law.** We will disclose Health Information when required to do so by international, federal, state or local law.

**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.

**Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

**Lawsuits and Disputes.** 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 certain very 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.

Effective January 1, 2016

**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 WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES**

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

#### **YOUR RIGHTS:**

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

**Right to an Electronic Copy of Electronic Medical Records.** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

**Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

**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. You may obtain a copy of this notice by contacting our office as stated below

#### **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 in the top right-hand corner.

#### **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. To file a complaint with our office, contact as stated below. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

You may contact our office at:

Gene Terrezza, O.D.

113 Palafox Place Pensacola FL, 32502

Office Line: 850-434-2060 Fax Line: 850-434-1830

The Plans may change the terms of this Notice at any time. If the Plans change this Notice, the Plans may make the new Notice terms effective for all of your PHI that the Plans maintain, including any information the Plans created or received before we issued the new Notice. If the Plans change this Notice, the Plans will make it available to you.