West Seattle Vision

New Patient Information Form- please print clearly

Today's Date: _____ **Male / Female / Other:** _____ **Pronouns:** _____

Full Legal Name: _____ **Preferred Name:** _____

Address: _____ **City, State, Zip:** _____

Social Sec #: _____ **Birthdate:** _____ **Age:** _____

Hm phone: _____ **Wk phone:** _____ **Cell:** _____

Best way to contact you: Hm Wk Cell Email **Marital Status:** Single Married Divorced Widowed **Hobbies:** _____

Occupation: _____ **Email:** _____

Can we text your cell? Y / N

Emergency Contact: _____ **Phone #:** _____

Who may we thank for referring you to us? _____

Responsible Party (if different from above)

Name of person responsible for account if not the patient: _____

Address: _____ **City, State, Zip:** _____

Hm phone: _____ **Wk phone:** _____ **Cell:** _____

Employer: _____ **Relationship to patient:** _____

Medical Insurance Information

Insurance: _____ **Group #:** _____ **ID #:** _____

Subscriber's Name: _____ **Subscriber's Last 4 of Social Sec #** _____

Patient's relationship to subscriber: Self Spouse Child Other: _____

Subscriber's Employer: _____ **Subscribers Date of Birth:** _____

Please read and sign below

We will be happy to bill your insurance for you as a *courtesy* provided that you bring your insurance card with you to your visit. You may also submit insurance claims yourself. We must also emphasize that as your eye care providers, our relationship is with you, not your insurance company, with whom we have no legal relationship. While the filing of insurance claims is a courtesy we extend to our patients, all charges (deductible amount, co-insurance, or any balance not paid by your insurance company) are your responsibility from the date the services are rendered. If we are not billing your insurance, you are financially responsible for all services from the date the services are rendered. Questions or concerns regarding charges, insurance coverage or benefits will be addressed with the office manager or any other staff members, not with the doctor.

I acknowledge that I have completed all the information to the best of my knowledge. I authorize the eye doctor to release any information about my records to pertinent third-party payers and/or other health practitioners if needed. **Lastly, I understand that returns and/or exchanges of any eyewear, as seen necessary by a staff member, will be done so by office credit and no refund will be given. Any eyewear returns or exchanges may be subject to a restocking fee.**

X _____ Date: _____

Medical History Questionnaire

Vision History

Are you having difficulties with your vision? YES NO If YES, then what type Distance Intermediate Near Other _____

Do you wear glasses? YES NO If yes, how old is your current pair of daily glasses? _____

How old are your prescription sunglasses? _____ Your backup glasses? _____

How many hours do you spend on the computer and/or any smart screen device? _____

Do you wear contact lenses? YES NO If yes, how old are your contac _____

Type of contact lenses you wear: Gas Permeable Soft Extended Wear Disposable Overnight

If you wear disposable lenses, how often do your replace them? _____

What solution do you use to clean your contact lenses with? _____

Please circle any of the following you have had:

Crossed Eyes Lazy Eye Droopy Eyelid Protruding Eye/s Glaucoma Retinal

Cataracts Eye Infection Eye Injury Eye Surgery

Personal Medical History

List any medications that you take(including over the counter meds, oral contraceptives, aspirin and home remedies)

_____

Do you have any allergies to medications? NO YES If yes, please list medication

_____

Please list all major injuries, surgeries and/or hospitalizations you have had _____

_____

Females, are you pregnant or nursing? NO YES

Please note any general medical history for the following conditions

			If yes, please specify
Respiratory problems (shortness of breath, cough)	NO	YES	
Chronic fatigue, fever, unexpected weight gain/loss	NO	YES	
Ear, nose or throat problems	NO	YES	
Skin conditions (rashes, dryness)	NO	YES	
Musculoskeletal problems (arthritis, muscle pain)	NO	YES	
Heart problems (disease, blood pressure, irregular beat)	NO	YES	
Cancer	NO	YES	
Diabetes	NO	YES	
High Cholesterol	NO	YES	
Kidney Disease	NO	YES	
Liver Disease	NO	YES	
Thyroid Disease	NO	YES	
Neurologic problems (numbness, paralysis, headache)	NO	YES	
Psychiatric problems (depression, anxiety)	NO	YES	

Other _____

Family History

Are there any medical or eye diseases that run in the family (heart disease, diabetes, cancer, glaucoma, macular degeneration)?

YES NO If yes, please specify _____

_____

Contact lens evaluation fees:

In 1994, The Vision Care Customer Assistance Act changed the rules governing how contact lenses are prescribed in the State of Washington. This notice is to help clarify these rules.

Shortly, you will see a practitioner who may perform an evaluation for contact lenses. These tests are not part of your routine eye examination. Most insurance companies do not cover the cost of contact lens services, or will cover only a portion of these costs.

To prescribe contact lenses, tests must be completed to evaluate the effects of the contact lenses have on your overall eye health. If you choose to have your contact lenses prescribed elsewhere, you will receive a copy of your glasses prescription stating "OK for Contact lenses" per the Vision Care Consumer Assistance Act. A contact lens prescription does not exist until you have seen a practitioner for a follow-up visit with the prescribed contacts on and the fitting is deemed complete (Washington State Law RCW 181.95). Federal regulations also apply to contact lens prescriptions.

Contact lens fees are not refundable and do not include the cost of contact lens materials.

Evaluation for current lens wearers: $65-$144

Evaluation for new lens wearers: $116-$285

_____ Yes, I would like to have my contact lenses evaluated today. I understand that after 4 months from today's date if there are any changes to my contact lens prescription, I will be responsible for a new evaluation fee.

_____ No, I do not want to have my contact lenses evaluated today. I understand I cannot order more contact lenses without a valid and current contact lens prescription.

_____ Date:_____

Signature of Patient or Representative (If patient is less than 18 years old)

_____

(Patient name, please print)

Effective 09/23/2013

NOTICE OF PRIVACY PRACTICES SUMMARY

West Seattle Vision Clinic is committed to protecting the confidentiality of your medical information and is required by law to do so. The Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations, and for other purposes that are permitted and required by law. It also describes your rights to access and control your protected health information. We ask for your consent to use and disclose your PHI, as outlined in our Notice of Privacy Practices, by asking you to sign the Consent for Treatment form regarding your care. Generally, unless specifically allowed by state or federal regulations without an authorization, West Seattle Vision Clinic will seek a signed authorization from a consumer or personal representative before disclosing PHI to a third party.

USES AND DISCLOSURES West Seattle Vision Clinic may use or disclose your protected health information as follows:

Uses and Disclosures with Your Permission: Uses and disclosures of PHI will generally only be made with your written permission, called a "Release of Information". You have the right to revoke a Release at any time.

For Treatment: Our office will use and disclose your PHI to provide and coordinate your health care and any related services. We may also disclose your PHI to another health care provider working outside of our office for purposes of your treatment.

For Payment: Our office may use and disclose PHI about your for the purpose of determining coverage, billing, claims management, medical data processing, and reimbursement. The information may be released to an insurance company or a third party payer, or its agent. You may request restriction of this if paying for your own services.

For Health Care Operations: Our office may use and disclose PHI about you in order to support quality improvement and other business activities of our organization. These uses and disclosures are necessary for our operations and ensure the quality of care received by our patients.

Other Uses and Disclosures Provided by Law without Authorizations: Our office may use and disclose PHI about you for other purposes and to other individuals and entities without a signed authorization, as provided by state and federal law. This includes but is not limited to court orders, child abuse reporting, adult protective services reporting, etc.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights regarding your protected health information (PHI):

- -Right to inspect and have a paper/electronic copy
- -Right to request an Amendment
- -Right to a paper copy of Notice
- -Right to be notified of breach of unsecured PHI
- -Right to request confidential communications
- -Right to request restrictions
- -Right to an accounting of certain disclosures

To file a violation complaint with our office, contact our office manager or the Secretary of the Department of Health and Human Services. All complaints must be made in writing. You will not be retaliated against for filing a complaint.

In addition to this summary, you are being offered a full detailed copy of the Notice of Privacy Practices. You may also at any time receive a copy by asking for one when you are at our office or request for one to be mailed to you.

_____ _____

Patient Signature Date

_____

Patient Name