LEGAL FIRST: MI: LAST: **PREFERRED:**

MAILING ADDRESS: CITY: ST: ZIP:

DATE OF BIRTH: / / LAST 4 OF SSN: SEX: **M** / **F** DRIVER'S LICENSE # & STATE:

If you have given us your DL, you may skip this section.

EMPLOYER: OCCUPATION:

❑HOME PHONE: ❑CELL: NAME OF SPOUSE:

Check the box to indicate your preferred phone number.

EMAIL: PRIMARY CARE PHYSICIAN:

REQUIRED FOR MINORS (17 & Under) **– PARENT/LEGAL GUARDIAN INFO**

LEGAL NAME: MAILING ADDRESS:

Of Parent/Legal Guardian *If different than above*

DATE OF BIRTH: / / LAST 4 OF SSN: DRIVER'S LICENSE # & STATE:

Of Parent/Legal Guardian

RELATIONSHIP TO MINOR: PHONE NUMBER:

INSURANCE INFORMATION *If you have given your cards to our technicians, you may skip this section.*

PRIMARY MEDICAL: **SECONDARY** MEDICAL:

Please list only the name of the insurance provider.

Do you have an additional or embedded vision benefit? YES / NO **VISION** BENEFIT:

Please list only the name of the benefit provider.

DISCLOSURES *Physicians and parents of minor children do not need to be listed.*

In addition to myself, I **authorize** the disclosure of any or all my patient record to the following people:

LEGAL NAME: RELATIONSHIP:

LEGAL NAME: RELATIONSHIP:

NOTE: If the parent of a minor is no longer permitted to access the records of the patient, legal documentation must be provided before access can legally be denied.

INITIAL & ACKNOWLEDGE ***Initial*** *next to each of the following statements and sign below.*

_____ I acknowledge that insurance is a contract between me and my insurance company. It is my responsibility to know my policy and benefits. Collegiate Peaks Eyecare will make every attempt to determine coverage and file claims accurately. However, in the event of disputes regarding coverage, deductibles, copays, etc., it must be handled between me and my insurance provider.

_____ I acknowledge that I have had the opportunity to review a copy of the Notice of Privacy Practices of Collegiate Peaks Eyecare.

_____ I certify that the information provided here is accurate to the best of my ability. I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of my medical benefits to the physician or supplier filing the claim. I understand that I am personally responsible for any charges incurred at Collegiate Peaks Eyecare including but not limited to my copays and deductibles.

_____ I understand that Collegiate Peaks Eyecare may be out-of-network for my selected insurance or benefit provider. If my insurance is out-of-network, I acknowledge that I have been made aware and that I would like to continue with my appointment and services understanding that I am responsible for all charges. I understand that I may ask additional questions and have had the opportunity to review the surprise/balance billing disclosure form.

By **initialing above** and **signing below**, I consent to and acknowledge my cooperation with the above statements.

SIGNATURE: DATE:

Patient or Parent/Legal Guardian

We understand that everyone hates paperwork; *we do too*. We ask these questions so that we can assess the health of your eyes and visual system to the best of our ability. We do much more than have you look at letters on the wall, and many seemingly unrelated health conditions can have a big impact on your vision. We want you to see the best that you can now and into the future. Thank you for taking the time to participate in these questions; simply answer to the best of your knowledge.

LEGAL NAME: DOB: / / DATE:

REASON FOR TODAY'S VISIT: DATE OF LAST **EYE** EXAM:

CURRENT MEDICATIONS:

If you brought your list today, we are happy to copy it. Please also include any OTC medications or eye drops.

ARE YOU ALLERGIC TO ANY MEDICATIONS? ❑YES ❑NO **IF YES**, PLEASE LIST THEM:

DO YOU HAVE A LATEX SENSITITY? ❑YES ❑NO OTHER ALLERGIES:

PRESCRIPTION EYEWEAR HISTORY

DO YOU CURRENTLY WEAR GLASSES? ❑YES ❑NO **IF YES**, DO YOU WEAR THEM: ❑ PART-TIME ❑ FULL-TIME

I TYPICALLY USE MY GLASSES FOR: ❑ WORK ❑DRIVING ❑READING ❑SAFETY ❑HOBBIES

IF HOBBIES, PLEASE LIST THEM: _____

DO YOU WEAR SUNGLASSES? ❑YES ❑NO **IF YES**, DO YOU WEAR PRESCRIPTION SUNGLASSES? ❑YES ❑NO

DO YOU CURRENTLY WEAR CONTACTS? ❑YES ❑NO **IF NO**, ARE YOU INTERESTED IN TRYING CONTACTS? ❑YES ❑NO

IF YES, WHAT BRAND DO YOU WEAR? HOW OFTEN: ❑ PART-TIME ❑ FULL-TIME

SURGICAL HISTORY

OCULAR (EYE) SURGERIES

PROCEDURE:	YEAR:	EYE:	SURGEON:
PROCEDURE:	YEAR:	EYE:	SURGEON:
PROCEDURE:	YEAR:	EYE:	SURGEON:

NON-OCULAR SURGERIES

PROCEDURE:	YEAR:	SURGEON:
PROCEDURE:	YEAR:	SURGEON:
PROCEDURE:	YEAR:	SURGEON:

SOCIAL HISTORY

ALCOHOL USE: ❑NONE ❑SOCIAL ONLY ❑1-2 DRINKS DAILY ❑3+ DRINKS DAILY ❑ALCOHOL DEPENDENCE

TOBACCO USE: ❑NEVER ❑FORMER ❑LIGHT ❑AVERAGE ❑HEAVY

OTHER SUBSTANCE USE: ❑NO ❑YES **IF YES**, TYPE & FREQUENCY:

PLEASE CONTINUE TO THE BACKSIDE OF THIS FORM

PERSONAL MEDICAL HISTORY *If you have every been diagnosed with the following, please check all that apply.*

CARDIOVASCULAR	INTEGUMENTARY	MUSCULOSKELETAL
☐ High Blood Pressure	☐ Rosacea / Eczema	☐ Arthritis (Osteo)
☐ Stroke / TIA	☐ Dry Mouth / Swallowing Problems	☐ Gout
☐ Heart Disease	☐ Psoriasis	☐ Osteoporosis
☐ Vascular Disease	☐ Herpes Zoster (Shingles)	NEUROLOGICAL
☐ Other	HEAD/ENT/DENTAL	☐ Bell's Palsy
☐	☐ Hearing Loss	☐ Brain Tumor
ENDOCRINE	☐ Sinusitis	☐ Multiple Sclerosis
☐ Diabetes Type 1	☐ Dry Mouth	☐ Parkinson's Disease
☐ Diabetes Type 2	☐ Laryngitis	☐ Seizures
☐ Hormonal Dysfunction	☐	☐ Migraines
☐ Thyroid Disorder (High or Low)	HEMATOLOGIC/LYMPHATIC	PSYCHIATRIC
GASTROINTESTINAL	☐ Bleeding Abnormalities	☐ Alzheimer's
☐ Crohn's	☐ Leukemia / Lymphoma	☐ Anxiety
☐ Colitis	☐ Anemia	☐ Bi-Polar Disorder
☐ Ulcer / Acid Reflux	☐ Temporal Arthritis	☐ Depression
☐ Inflammatory Bowel Disease	☐ Cancer:	☐ Learning Disability
☐ Celiac Disease	☐	☐ Schizophrenia
GENITOURINARY	IMMUNOLOGIC/ALLERGY	☐
☐ Prostate / BPH	☐ Autoimmune Disorders	RESPIRATORY
☐ Renal Disease (Kidney)	☐ HIV / AIDS	☐ Asthma
☐ Sexually Transmitted Disease	☐ Lupus	☐ COPD
☐ Syphilis	☐ Sarcoidosis	☐ Emphysema
☐	☐ Sjogren's Syndrome	☐ Lung Cancer
CURRENTLY PREGNANT or NURSING	☐ Rheumatoid Arthritis	☐ Sleep Apnea
❑ Pregnant ❑ Nursing	☐	☐

CURRENT EYE SYMPTOMS *If you are experiencing the following, please check all that apply.*

☐ Dry Eye	☐ Eyestrain	☐ Cataracts
☐ Eye Infection or Inflammation	☐ Eye Pain	☐ Glaucoma
☐ Floaters / Flashes of Light	☐ Severe Sensitivity to Lights	☐ Retinal Detachment
☐ Iritis or Uveitis	☐ Headaches	☐ Macular Degeneration
☐ Retina Defect or Degeneration	☐ Amblyopia/Lazy Eye	☐ Sandy/Gritty Feeling
☐ Redness	☐ Poor Night Vision	☐ Distorted Vision/Halos
☐ Burning	☐ Bothersome Night Glare	☐ Loss of Side Vision
☐ Itching	☐ Double Vision	☐ Fluctuating Vision
☐ Excess Tearing/Watering	☐ Total Loss of Vision	☐ Foreign Body Sensation
☐ Discharge	☐ Tired Eyes	☐ Other

IMMEDIATE FAMILY HISTORY *Please check all that apply, including only Parents, Siblings, and Children.*

	Relationship to Patient			*Relationship to Patient*
☐ Amblyopia/Lazy Eye		☐ Cancer		
☐ Blindness		☐ Diabetes Type 1 or 2		
☐ Cataracts		☐ Heart Disease		
☐ Glaucoma		☐ Stroke		
☐ Retinal Detachment		☐ High Blood Pressure		
☐ Macular Degeneration		☐ Thyroid Disease (H/L)		

DR. MATTHEW L. SCOTT, O.D.
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FAX: 719-631-2577

NOTICE OF PRIVACY PRACTICES

Privacy Officer – Matthew L. Scott, O.D.
Effective Date – October 23, 2017

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.

We care about our patients' privacy and strive to protect the confidentiality of your medical information at this practice. Federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

Who Will Follow This Notice?
Any health care professional authorized to enter information into your medical
record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

How We May Use and Disclose Medical Information About You:
The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

For Treatment: We may use and disclose medical information about you to provide you with medical treatment or services. Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

For Health Care Operations: We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

Persons Involved in Your Care: We may disclose medical information about you to a relative, close friend or any other person you identify if that person is involved in your care and the information is relevant to your care. Example: if the patient is a minor, we may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances.

Required by Law: We will use and disclose medical information about you whenever we are required by law to do so. There are many state and federal laws that require us to use and disclose medical information. Example: state law requires us to report gunshot wounds and other injuries to the police and to report known or suspected child abuse or neglect to the Department of Social Services. We will comply with those state laws and with all other applicable laws.

National Priority Uses and Disclosures Made Without Your Consent or Authorization
When permitted by law, we may use or disclose medical information about you without your permission for activities that are recognized as "national priorities." The government has determined that under certain circumstances, it is so important to disclose medical information that it is acceptable to disclose medical information without the individual's permission. Some examples include:
• Law enforcement or correctional institution, such as required during an investigation by a correctional institution of an inmate;
• Threat to health or safety, such as to avert or lessen a serious threat;
• Workers' compensation or similar programs, such as for the processing of claims;
• Abuse, neglect or domestic violence, such as if you are an adult and we reasonably believe you may be a victim of abuse;
• Health oversight activities, such as to a government agency to investigate possible insurance fraud;
• Court or legal proceedings, such as if a judge orders us to do so;
• Research organizations, such as if the organization has satisfied certain conditions about protecting the privacy of medical information;
• Coroner or medical examiner for identification of a body;
• Public health activities, such as required by the US Food and Drug Administration (FDA); and
• Certain government functions, such as using or disclosing for government functions like Military and veterans' activities and national security and intelligence activities.

Uses and Disclosures of Protected Health Information Requiring Your Written Authorization
The following uses and disclosures of medical information about you will only
Be made with your authorization (signed permission) from you or your personal representative:
• Uses and disclosures for marketing purposes.
• Uses and disclosures that constitute the sales of medical information about you.
• Most uses and disclosures of psychotherapy notes, if we maintain psychotherapy notes.
• Any other uses and disclosures not described in this Notice.

You have several rights with respect to medical information about you. This section of the Notice will briefly mention each of these rights. If you would like to know more about your rights, please contact our Privacy Officer.

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will thereafter no longer use or disclose medical information about you for the reason covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care we have provided you.

Your Individual Rights Regarding Your Medical Information Complaints: If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint. To file a written complaint with us, you may bring your complaint directly to our Privacy Officer, or you may mail it to the following address: Collegiate Peaks Eyecare, PO Box 3179, Buena Vista, CO 81211. To file a written complaint with the federal government, please use the following contact information: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201 OR Toll-Free Phone: 1-877-696-6775 OR https://www.hhs.gov/hipaa/filing-a-complaint/index.html OR Email: OCRComplaint@hhs.gov.

Right to Request Restrictions on Uses and Disclosures: You have the right to request that we limit the use and disclosure of medical information about you for treatment, payment and healthcare operations. Under federal law, we must agree to your request and comply with your requested restriction(s) if:
1. Except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment of healthcare operation (and is not for purposes of carrying out treatment); and, 2. The medical information pertains solely to a healthcare item or service for which the healthcare provided involved has been paid out-of-pocket in full. Once we agree to your request, we must follow your restrictions (except if the information is necessary for emergency treatment). You may cancel the restrictions at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before the cancellation. You also have the right to request that we restrict disclosures of your medical information and healthcare treatment(s) to a health plan (health insurer) or other party, when that information relates solely to a healthcare item or service for which you, or another person on your behalf (other than a health plan), has paid us for in full. Once you have requested such restriction(s), and your payment in full has been received, we must follow your restrictions(s).

Right to Request Confidential Communications: You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that medical information we have about you 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. To request an amendment, your request must be made inwriting and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to an Accounting of Disclosures We Have Made: You have the right to receive an accounting (which means a detailed listing) of disclosures that we have made for the previous six (6) years. If you would like to receive an accounting, you may send us a letter requesting an accounting, fill out an Accounting Request Form, or contact our Privacy Officer. Accounting Request Forms are available from our Privacy Center. The accounting will not include several types of disclosures, including disclosures for treatment, payment or healthcare operations. If we maintain your medical records in an Electronic Health Record (EHR) system, you may request inclusion of disclosures for treatment, payment or healthcare operations. The accounting will also not include disclosures made prior to April 14, 2003. If you request an accounting more than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting.

Right to Request an Alternative Method of Contact: You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address. We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, you must provide us with a request in writing. You may write us a letter or fill out an Alternative Contact Request Form. Alternative Contact Request Forms are available from our Privacy Officer.

Right to Notification if a Breach of Your Medical Information Occurs: You also have the right to be notified in the event of a breach of medical information about you. If a breach of your medical information occurs, and if that information is unsecured (not encrypted), we will notify you promptly with the following information: 1. A brief description of what happened; 2. A description of the health information that was involved; 3. Recommended steps you can take to protect yourself from harm; 4. What steps we are taking in response to the breach; and, 5. Contact procedures so you can obtain further information.

Right to Opt-Out of Fundraising Communications: If we conduct fundraising and we use communications like the U.S. Postal Service or electronic email for fundraising, you have the right to opt-out of receiving such communications from us. Please contact our Privacy Officer to opt-out of fundraising communications if you chose to do so.

Right to a Paper Copy of This Notice: You have the right to a paper 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. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Changes to This Notice: We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper right corner of the first page.