COLLEGIATE PEAKS EYECARE

Patient Information

Legal First Name_____ **Last** _____ **Middle** Initial _____ **Nickname**_____

Mailing Address_____ City _____ State_____ Zip_____

Date of Birth _____ Last 4 of SSN(adults) _____ Sex M / F Driver's Lic # & State _____

Primary Language_____ Race_____ Ethnicity (**Circle One**): Hispanic / Not Hispanic

Phone (x Mark Preferred #) ❑(Home)_____ ❑ (Work)_____ ❑ (Cell,optional) _____

Email Address_____ Employer (or Grade if Student)_____

Spouse (or Parent's Name)_____ Spouse (or Parent's Employer)_____

Responsible for Payment – Required *(Copays and Items not covered by Insurance)*

❑ **Self (OR)** Name_____ Address_____

Date of Birth_____ Last 4 of SSN _____ Driver's Lic # & State_____ Phone # _____

New Patients Only:

Who may we thank for referring you to our office? ❑ Friend or Family ❑ Another Doctor ❑ Saw Sign / Building ❑ Insurance List

❑ Newspaper ❑ Radio ❑ Yellow Pages ❑ Internet/Web Site?_____ ❑ Other _____

Insurance Information (Please Provide Cards for Copy)

** Insurance is a contract between you and your insurance company. It is your responsibility to know your policy and benefits. We 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 you and your insurance provider. **

Medical Insurance - Primary

Company _____ Policy Holder _____ Policy Holder's DOB _____

Medical Insurance - Secondary

Company _____ Policy Holder _____ Policy Holder's DOB _____

Vision Benefit Last 4 of SSN of Policy Holder _____

Company _____ Policy Holder _____ Policy Holder's DOB _____

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

X_____ _____

Patient Signature (or parent) Date

Please release any or all of my patient record upon request to: _____

Do NOT ever release any of my patient record to:_____

I certify that the information provided is accurate to the best of my ability. I understand that I am personally responsible for any charges incurred at Collegiate Peaks Eyecare. 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 medical benefits to the physician or supplier filing the claim.

X_____ _____

Patient Signature (or parent) Date

Collegiate Peaks Eyecare

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. Many health conditions have an impact on your vision. We want you to see the best that you can now and into the future. Thank you for your time!

Name_____ **Date of Birth**_____ **Date**_____

Reason for today's visit: _____

Personal Medical History:

Have you ever been diagnosed with any of the following? ❑ Yes ❑ No (If yes, please check (X) applicable conditions.)					
Cardiovascular		**Integumentary**		**Musculoskeletal**	
	Congestive Heart Failure		Acne Rosacea		Arthritis
	Elevated Cholesterol		Dry Mouth / Swallowing Problems		Gout
	Heart Disease		Psoriasis		Rheumatoid Arthritis
	High Blood Pressure			**Neurological**	
	Stroke / TIA	**Head/ENT/Dental**			Bell's Palsy
			Allergies		Brain Tumor
Endocrine			Dizziness		Multiple Sclerosis
	Adrenal Disorder		Headaches/Migraines		Parkinson's Disease
	Diabetes		Sinusitis		Seizures
	Thyroid (High or Low)				
		Hematologic/Lymphatic		**Psychiatric**	
Gastrointestinal			Bleeding Abnormalities		Alzheimer's
	Cancer: Colon, Liver		Leukemia / Lymphoma		Anxiety
	Colitis		Sickle Cell Disease		Bi-Polar Disorder
	Hepatitis		Temporal Arthritis		Depression
	Inflammatory Bowel Disease		Cancer:		Learning Disability
					Schizophrenia
Genitourinary		**Immunologic**			
	Prostate / BPH		Autoimmune Disorders	**Respiratory**	
	Renal Disease (Kidney)		HIV / AIDS		Asthma
	Sexually Transmitted Disease		Lupus		COPD
	Syphilis		Sarcoidosis		Emphysema
			Sjogren's Syndrome		Lung Cancer
Pregnant or Nursing (Currently)					Tuberculosis
❑ Pregnant ❑ Nursing					

Date of Last Eye Exam_____

Name of Family Physician_____ City/State_____ Date of Last Physical_____

Current Medications: (include eye drops, over the counter medications, oral contraceptives, vitamins, herbs, and prescriptions)

We can copy your list

Allergic to Medications: ❑ Yes ❑ No _____

PLEASE FILL OUT BOTH SIDES OF THIS FORM

Please List All Ocular Surgeries:

Procedure:_____ Year:_____ Which Eye?: _____ Dr._____

Procedure:_____ Year:_____ Which Eye?: _____ Dr._____

Procedure:_____ Year:_____ Which Eye?: _____ Dr._____

Social History

Use of Alcohol: ❑ None ❑ Social use only ❑ 1-2 drinks daily ❑ Above average use ❑ Alcohol Dependence

Use of Tobacco: ❑ Never ❑ Former Smoker ❑ Light Smoker ❑ Average Smoker ❑ Heavy Smoker

Use of Other Substances: ❑ None ❑ Type & frequency_____

Family History:

	Relationship to Patient			Relationship to Patient	
	Amblyopia/Lazy Eye			Cancer	
	Blindness			Diabetes	
	Cataracts			Heart Disease	
	Glaucoma			Stroke	
	Retinal Detachment			Thyroid Disease	
	Macular Degeneration			Other	

Contact Lens History

Do you currently wear contact lenses? ❑ Y ❑ N Hours per day: _____ Days per week:_____

Brand or prescription you are currently wearing? _____

Do you have a current pair of glasses in addition to your contacts? ❑ Y ❑ N

Glasses History

Do you currently wear glasses? ❑ Y ❑ N (Please Circle) Part-time Full-time Distance Near

Glasses being worn now: (Please Circle) Single Vision Bifocals (1 line) Trifocals (2 lines) Progressive (No-line)

Do you wear sunglasses: ❑ Y ❑ N Are your sunglasses your most recent prescription? ❑ Y ❑ N

Current Eye Symptoms/Conditions:

Do you or have you ever experienced the following? ❑ Yes ❑ No (If yes, please check (X) applicable conditions.)					
	Headaches		Excess Tearing/Watering		Blurred Near Vision
	Glare/Light Sensitivity		Eye Pain/Soreness		Fluctuating Vision
	Tired Eyes		Sandy/Gritty Feeling		Floaters/Spots
	Amblyopia/Lazy Eye		Foreign Body Sensation		Flashes of Light
	Burning		Mucous Discharge		Retinal Detachment
	Dryness		Distorted Vision/Halos		Glaucoma
	Itching		Loss of Side Vision		Cataracts
	Redness		Blurred Distance Vision		Macular Degeneration

Please List Other Surgeries (if they could have an impact on your vision):

Procedure:_____ Year:_____ Dr._____

Procedure:_____ Year:_____ Dr._____

Procedure:_____ Year:_____ Dr._____

PLEASE FILL OUT BOTH SIDES OF THIS FORM

Effective date of notice: October 1, 2014

NOTICE OF PRIVACY PRACTICES

Collegiate Peaks Eyecare

Matthew L. Scott, O.D.
421 Hwy 24 S, Buena Vista, CO 81211
Ph 719-581-4060 Fax 719-631-2577
healthyeyes@cpeakseye.com
Office Contact: Matthew L. Scott, O.D., Compliance Officer

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESSTO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatments, payment or health care operations. Examples of how we use or disclose 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 have to do 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.

We routinely use your health information inside our office for these purposes without any special permission. You are allowed to restrict disclosure for prescription medications by requesting that the prescription be supplied in paper format in order for you to present to the pharmacy of your choice. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

We will ask for special written permission in the following situations: If we receive remuneration for marketing of certain products or services, pictures and/or testimonials for social media or web use, pharmaceutical or medical research and industry journal publications.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. 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 U.S. 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 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” who perform health care operations for us and who commit to respect the privacy of your health information.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS

We may call, write or use other forms of correspondence to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We must agree to this if you have paid out-of-pocket in full for the item or service otherwise we do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax, or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new one in our office and have copies available in our office.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or 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 at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.