COLLEGIATE PEAKS EYECARE

Patient Information

Legal First Name_____ **Last** _____ **Middle** Initial _____ **Preferred Name**_____

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** Preferred #) ❑(Home)_____ ❑ (Cell) _____Spouse Name_____

Email Address_____ Primary Care Physician_____

Employer (or Grade if Student)_____ Occupation_____

For Minors (17 & Under) - Parent or Guardian Info

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 Insurance Cards and Driver's License 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 Name_____ Policy Holder's DOB _____

Medical Insurance - Secondary

Company _____ Policy Holder Name _____ Policy Holder's DOB _____

Vision Benefit Last 4 of SSN of Policy Holder _____

Company _____ Policy Holder Name_____ 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_____ _____

Signature (Patient / Parent or Legal Guardian if Minor) Date

You may disclose any or all of my patient record upon request to (include name and relationship): _____

_____

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

*If person listed above is a parent of a minor patient, additional documentation may be necessary to deny access.

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_____ _____

Signature (Patient / Parent or Legal Guardian if Minor) 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**
☐ 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 or 2	☐ Dry Mouth	☐ Parkinson's Disease
☐ Thyroid Disorder (High or Low)	☐ Laryngitis	☐ Seizures
☐ Hormonal Dysfunction	☐	☐ Migraines
☐	**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
Pregnant or Nursing (Currently)	☐ Rheumatoid Arthritis	☐ Sleep Apnea
❑ Pregnant ❑ Nursing	☐	☐

Date of Last Eye Exam_____

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

*We can copy your list*_____

_____

Latex Sensitivity: ❑ Yes ❑ No

Allergic to Medications: ❑ Yes ❑ No _____

_____

PLEASE FILL OUT BOTH SIDES OF THIS FORM

Please List All Ocular (Eye) Surgeries:

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

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

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

Current Eye Symptoms/Conditions:

Do you or have you ever experienced the following? ❑ Yes ❑ No (If yes, please check (X) applicable conditions.)					
	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		Severe Sensitivity to Lights		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

Social History

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

Use of Tobacco: ❑ Never ❑ Former Smoker ❑ Current Every Day Smoker ❑ Light Smoker ❑ Heavy Smoker

Use of Other Substances: ❑ None ❑ Type & frequency_____

Immediate Family History: (Parents, Siblings, 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 Disorder (High/Low)	

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

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

Procedure:_____ Year:_____ Dr._____

Procedure:_____ Year:_____ Dr._____

Procedure:_____ Year:_____ Dr._____

Collegiate Peaks Eyecare
PO Box 3179
Buena Vista, CO 81211

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

Toll-Free Phone: 1-877-696-6775
https://www.hhs.gov/hipaa/filing-a-complaint/index.html
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 in writing 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.