MEDICAL HISTORY

NAME ____________________ DATE __________

EYE / VISION REVIEW

PLEASE **CIRCLE** IF YOU HAVE ANY OF THE FOLLOWING:

GLAUCOMA	DIFFICULTY READING	EYE PAIN	FLASHES OR FLOATERS
MACULAR DEGENERATION	DISTORTED VISION	WATERING	CROSSED EYE
RETINAL DETACHMENT	LOSS OF SIDE VISION	SENSITIVITY TO LIGHT	DOUBLE VISION
VISION LOSS	DRYNESS	DIFFICULTY WITH GLARE	ITCHING
BLURRED VISION	REDNESS	DIFFICULTY DRIVING	EYE DISCHARGE

REVIEW OF SYSTEMS

DO YOU HAVE ANY OF THE FOLLOWING?

			DESCRIBE
DIABETES	Y	N	
HIGH BLOOD PRESSURE	Y	N	
AUTOIMMUNE / ARTHRITIS	Y	N	
HEART / CIRCULATORY	Y	N	
LUNGS / ASTHMA	Y	N	
STOMACH / ULCERS	Y	N	
MUSCLE / JOINT	Y	N	
HEADACHES	Y	N	
FEVER / NAUSEA	Y	N	
EAR/ NOSE / THROAT	Y	N	
NEUROLOGICAL	Y	N	
PSYCHIATRIC	Y	N	
KIDNEY / LIVER	Y	N	
THYROID	Y	N	
BLOOD DISORDERS	Y	N	
URINARY TRACT	Y	N	
ALLERGIES	Y	N	
HIV / AIDS	Y	N	
CANCER	Y	N	

OTHER:

FAMILY HISTORY

DO ANY BLOOD RELATIVES HAVE ANY OF THE FOLLOWING?

			WHO?
GLAUCOMA	Y	N	
MACULAR DEGENERATION	Y	N	
RETINAL DETACHMENT	Y	N	
VISION LOSS	Y	N	

SURGERIES / INJURIES

HAVE YOU HAD ANY EYE SURGERIES, EYE INJURIES, OR OTHER SURGERIES?

Y N (IF YES, PLEASE LIST)

MEDICATIONS

DO YOU TAKE ANY MEDICATIONS BY MOUTH, INJECTION, OR EYEDROPS?

Y N (IF YES, PLEASE LIST)

ALLERGIES

ARE YOU ALLERGIC TO ANY MEDICATIONS?

Y N (IF YES, PLEASE LIST)

SOCIAL HISTORY

ARE YOU PREGNANT / BREAST FEEDING?	Y	N
DO YOU WEAR GLASSES / CONTACTS?	Y	N
DO YOU SMOKE / USE TOBACCO?	Y	N
DO YOU USE ALCOHOL?	Y	N

DESCRIBE ANY SPECIFIC VISION NEEDS FOR HOBBIES OR WORK: __________

OFFICE USE ONLY: DATES REVIEWED

DATE	CHANGES		TECH / DR.		DATE	CHANGES		TECH / DR.		DATE	CHANGES		TECH / DR.	
	Y	N				Y	N				Y	N		
	Y	N				Y	N				Y	N		
	Y	N				Y	N				Y	N		
	Y	N				Y	N				Y	N		
	Y	N				Y	N				Y	N		

HENDERSON EYE CENTER

OUR FINANCIAL POLICY

Thank you for choosing us as your Eye Care providers. We are committed to your treatment being successful. Please understand payment of your bill is considered part of treatment. The following is a statement of our financial policy, which we would like you to read and sign prior to any treatment, so that misunderstandings or frustrations may not occur in regards to your bill. We ask all patients to complete our Information and Insurance Form before seeing the doctor.

PAYMENT IS DUE AT THE TIME OF SERVICE
WE ACCEPT CASH, CHECKS, DEBIT CARD, OR VISA/MASTER CARD

REGARDING INSURANCE

Please remember, insurance is considered a method of reimbursing the patient for fees paid to the doctors and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. We will gladly bill your insurance company as a courtesy, but you are responsible for the entire bill regardless of deductible or co-pays.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MINOR PATIENTS

The adult (parent or guardian) accompanying a patient younger than 18 years of age is responsible for payment. The insured adult must be present to sign the appropriate form. For unaccompanied minors, non- emergency treatment will be denied.

MISSED APPOINTMENTS

Unless cancelled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

INTEREST

We reserve the right to charge interest in the amount of 18% APR, as provided by state law, to all accounts that are 60 (sixty) days past due.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read this Financial Policy. I understand and agree to this policy.

X_______________________________ date__________________
Print name of patient

X__________________________________ date____________________
Signature of Patient/Responsibility party

Effective date of notice: April 14, 2003

NOTICE OF PRIVACY PRACTICES

Henderson Eye Center, PC
3330 Ginger Creek Dr, Suite C, Springfield, IL 62711
Privacy and Public Information Officer: Dr. Wade Henderson

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 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 treatment, 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. 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.

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 federal 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 or 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;
- [specify other uses and disclosures affected by state law].

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 or write 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. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

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 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 at 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 (or sixty days if the information is stored off-site). 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. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. 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 notice in our office, have copies available in our office, and post it on our Web site.

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.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of *Henderson Eye Center* Notice of Privacy Practices.

Patient name (Please Print)____

Signature ______________________________ Date ________________