**Medical/Vision History Questionnaire Hudson Valley Eye Doctor**

Last First Today’s Date

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Last Eye Exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Eye Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What Brings you in today??\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear glasses [ ] NO [ ] YES If yes, how old is your present pair of glasses?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear contact lenses [ ] NO [ ] YES How old is the pair of lenses you are wearing today?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of contact lenses: [ ]Ridgid [ ] Soft [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are they comfortable [ ] NO [ ] YES

What type/brand of contact lens disinfection system do you use?

**VISION EXAM** Without Glasses or Contact lenses With Glasses With Contact Lenses

How is your vision? Clear / Not Clear Clear / Not Clear Clear / Not Clear

Distance Vision Clear / Not Clear Clear / Not Clear Clear / Not Clear\_\_\_\_\_

Near Vision Clear / Not Clear Clear / Not Clear Clear / Not Clear

Computer,phone,tablet Clear / Not Clear Clear / Not Clear Clear / Not Clear\_\_\_\_\_

**Refraction is the determination of your eyeglass prescription. This may be covered under your vision benefit for a Routine Eye Care. If you are here for an eye health issue and you will be using your medical insurance, and want glasses or a fitting for contact lenses, there will be a charge.**

***If you have any of symptoms below, they require a medical visit and will be billed to your medical coverage. Evaluation and treatment are not routine and are not covered under your routine vision benefit. Treatment and care,* *follow-up visits may be necessary. You will be responsible for any co-pays or deductibles.\_***

**Do you have problems with the following areas? If yes, please provide information.**

Loss of Vision NO YES Excessive Tearing NO YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blurred Vision NO YES Glare/light sensitivity NO YES \_\_\_

Distorted vision NO YES Eye pain or soreness NO YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Double Vision NO YES Infection of eye or lid NO YES \_\_\_\_\_\_\_\_\_\_\_\_\_

Mucous discharge NO YES Tired Eyes NO YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Redness NO YES Crossed eyes, lazy eye NO YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sandy or gritty NO YES Drooping Eyelid NO YES\_\_\_\_\_\_\_\_\_\_\_\_\_

Itching NO YES Flashes/Floaters NO YES \_\_\_\_\_\_\_\_\_\_\_\_\_

Burning NO YES Other NO YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Foreign body

Sensation NO YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medial History:**

**Last Medical Exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Care Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have any Allergies or Allergies to Medication [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Diabetes [ ] NO [ ] YES TYPE 1 (Insulin dependent) TYPE 2 (Non-Insulin dependent) Years Diabetic\_\_\_\_\_\_\_\_\_\_\_**

**Last Blood Sugar:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_A1C\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Diabetes is a medical diagnosis and requires a medical visit including testing and imaging. Diabetic evaluation is not part of a routine vision care visit. It will require a scheduled appointment separate from your vision benefit exam.\_\_\_***

**Females: Are you pregnant and or nursing [ ] NO [ ] YES**

***LIST ALL MEDICATIONS* Surgeries**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred Pharmacy and location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SOCIAL HISTORY: This information is kept strictly confidential.**

**Tobacco products [ ] NO [ ] YES Alcohol [ ] NO [ ] YES**

**Non-prescribed drugs [ ] NO [ ] YES STD’S [ ] NO [ ] YES**

**Hepatitis [ ] NO [ ] YES HIV [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Review of Systems FAMILY HISTORY Parent(P) Grandparent (GP)**

**EAR, NOSE, MOUTH, THROAT [ ] NO [ ] YES Sibling (S) (living or deceased) \_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Allergies/ Hayfever [ ] NO [ ] YES Blindness [ ] NO [ ] YES \_\_\_\_\_\_\_\_\_\_**

 **Sinus [ ] NO [ ] YES Cataract [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_**

 **Chronic Cough [ ] NO [ ] YES Crossed Eye [ ] NO [ ] YES \_\_\_\_\_\_\_\_\_\_**

 **Dry Throat/Mouth [ ] NO [ ] YES Macular Degeneration [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_**

**RESPIRATORY Retinal Detachment [ ] NO [ ] YES \_\_\_\_\_\_\_\_\_\_\_**

 **Asthma [ ] NO [ ] YES Glaucoma [ ] NO [ ] YES \_\_\_\_\_\_\_\_\_\_\_**

 **Chronic Bronchitis [ ] NO [ ] YES Arthritis [ ] NO [ ] YES \_\_\_\_\_\_\_\_\_\_\_**

 **Emphysema [ ] NO [ ] YES Cancer [ ] NO [ ] YES \_\_\_\_\_\_\_\_\_\_\_**

**VASCULAR/CARDIOVASCULAR Diabetes [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_\_**

 **Diabetes [ ] NO [ ] YES Heart Disease [ ] NO [ ] YES \_\_\_\_\_\_\_\_\_\_**

 **Heart Pain [ ] NO [ ] YES High Blood Pressure [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_\_**

**GASTROINTESTINAL Kidney Disease [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_\_**

 **Diarrhea [ ] NO [ ] YES Auto-immune Disease [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_\_**

 **Constipation [ ] NO [ ] YES** **Thyroid Disease [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_\_**

**GENITO-URNIARY Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Genitals/ Kidney [ ] NO [ ] YES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Bladder [ ] NO [ ] YES**

Current Occupation/ or School Grade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ] Single [ ]Married [ ]Widowed [ ] Divorced Living Arrangements (asked only to determine if assistance is needed for the visually disabled).

**BONES/JOINT/MUSCLES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Rheumatoid Arthritis [ ] NO [ ] YES**

 **Muscle/Joint Pain [ ] NO [ ] YES**

**LYMPHATIC/HEMATOLOGIC\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Anemia [ ] NO [ ] YES**

 **Bleeding [ ] NO [ ] YES**

**PSYCHIATRIC [ ] NO [ ] YES**

**PATIENT INFORMATION HUDSON VALLEY EYE DOCTOR DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Mr. Miss. Ms. Mrs. Dr Marital Status: Single Divorced Married Widow

Last Name First Name MI Nickname

Address: City State Zip

Phone: Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

e-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ e-mail [ ] NO [ ] YES TEXT [ ] NO [ ] YES

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Student: full/part-time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **GUARANTOR, RELATIONSHIP** [ ] SELF If you are filling this form out for your child, please list **YOUR i**nformation here

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guarantor’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_e-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

**Health / Major Medical Insurance**: Name of Insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appointment cancellation or no show without 24 hour notice incurs a charge of $50.00. All Co-Pays and unpaid deductibles are due at the visit. Payments accepted: Cash Debit Card Credit Card CareCredit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I authorize release of information to all my insurance companies.

2. I authorize my insurance company to send payment directly to my doctor.

3. I understand that I am responsible for my bill, and there may be charges that my insurance company does not cover, and I will pay for those non-covered services.

4. I give my consent to electronic filing of my insurance claims and prescriptions.

5. I understand that it is my responsibility to obtain a referral for service if it is required by my insurance company.

If I do NOT have the necessary referrals required by my Insurance company, I will be responsible for payment of the services rendered.

**Print Patient’s Name Patient’s Signature (Guarantor/Guardian) Date**

**Lifestyle Questionnaire** : Answers assist us in assessing your visual needs.

**1. What do you like about your current pair of glasses and or contact lenses?**

**2. What don’t you like about your current pair of glasses and or contact lenses?**

**3. Your activities (circle all that applies:** Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cooking sewing needlepoint/knitting board games soldering/welding painting golf

Woodworking art skiing/skating/snowboard motocycle/motorcross autorepair cards

Crafts fishing boating nature/birding snorkeling/scuba/swim electrical sports

Musical instruments gaming hunting target shooting/archery gardening/landscaping

**4. Does your work entail unusual visual demands?**

Driving Distance viewing Outdoor work Natural or artificial lighting caustic environment

Near work Indoor work clean room abrupt changes in light level clean room

Position microscope/telescope Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Are you bothered by glare from any of the following? (circle all that apply)**

Night driving/headlights haze fluorescent lights LED lights smart phone

Sunshine/UV exposure tablets computer screen other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. What electronic devices do you use and how much time do you spend on each device?**

Smart Phone\_\_\_\_\_\_\_\_ Tablet\_\_\_\_\_\_\_\_\_ Video Games\_\_\_\_\_\_\_\_\_\_\_\_\_ IPod\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other electronic devices:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you wear Blue-blocking eyewear? [ ] NO [ ] YES

Do your eyes tire or do you have fluctuating vision while using these devices? [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. Do you use a computer/ laptop?** [ ] NO [ ] YES How many screens/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Distance from your eyes to the computer screen?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Laptop screen?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Screen Position?** Right Left Center **Screen Top** [ ] straight ahead [ ] below line of sight

How many hours a day are you using the computer/laptop work and home?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8. Do you currently use more than one pair of glasses?** [ ] NO [ ] YES

Bifocals Distance Golf Scuba specs Tennis Shooting Ski goggles Swim goggles

Trifocals Reading Sunglasses Driving Hobby Sports/safety Hobby

Progressive computer Intermediate Music Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9. Contact Lenses** [ ] NO [ ] YES Type and Brand:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Disinfection system:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How many hours of wear?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all family members living at home:

Name Last Eye Exam Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

HUDSON VALLEY EYE DOCTOR OF OPTOMETRY, P.C.

ELAINA M. GROO, O.D. & JOHN KAKNIS, O.D.

304 FULLERTON AVENUE

NEWBURGH, NY 12550

845-565-2020

ELAINA M. GROO,O.D., COMPLIANCE OFFICER

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; participating 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 will ask you for special written permission.

 **We will ask for special written permission in the following situations: When information is asked for by another professional or entity filling a prescription, requests for copy of prescriptions or any information regarding your health information.**

**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* court 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 of disclosure is our idea. Sometimes, you may initiate the process if it’s your idea for us to send our 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 the 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 EMail 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 Email to your personal Email 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 Email 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 your 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 Email 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 permitted disclosures 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 email 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 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 Email 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 Email 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 Email 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.

**Hudson Valley Eye Doctor**

Dr. Elaina M. Groo and Dr. John Kaknis

Optometrist

304 Fullerton Avenue

Newburgh, New York 12550

845-565-2020

 Health Insurance Privacy Practice (HIPPA)

Acknowledgement of Notification and Receipt *(Please sign ONE Notice of Privacy)*

**[ ] I acknowledge that I have been given or downloaded a copy from DrElainaMGroo.com. to read and review a copy of this Office’s Notice of Privacy Practices.**

**[ ] I have elected NOT to take a copy of the Notice of Privacy Practices**

Print your Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**[ ] I acknowledge that I have been given to read and review a copy of this**

 **Office’s Notice of Privacy Practices and I received a copy on this date or downloaded a copy from DrElainaMGroo.com.**

Print your Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**[ ] I hereby give permission to this office the use of my cell phone number for**

**communication either by a phone call or text.**

**[ ] I hereby give this office permission to communicate by my e-mail below:**

**Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_E-Mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

In addition to my insurance carrier, you are hereby given permission to discuss my medical and or financial records with the following person [s]s

Name Relationship Phone #

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_