ABUNDO EYE CARE

Patient information

Last name:___________________________ **First name**:____________________________ **M.I.**_____

Address:_______________________________________ **City**________________ **ST**____ **Zip**_______

Cell Phone:_______________________________ **Work Phone**:______________________________

Email___________________________________

Date of Birth______________________________

Gender: ☐Male ☐Female ☐Other_________

Last 4 of SS **(to look up vision ins)**:______________

Employee Status: ☐F/T ☐P/T ☐Student ☐Self-Employed ☐Retired ☐Other_________________

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Race:

☐American Indian or Alaska Native ☐Asian ☐Black or African American
☐Native Hawaiian or Pacific Islander ☐White ☐Declined to specify

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined to specify

Occupation:________________________________ **Referred by**:_____________________________

Vision Insurance Name:______________________ **ID**:___________________________________

- **Subscriber name & DOB**____
- ☐**Check if self**

Medical Insurance Name:_____________________ ID:____________________________________

- **Subscriber name & DOB**____
- ☐**Check if self**

Medical provider name:____

Medical provider address:____________________________City__________________ST____ Zip______

Medical provider phone:______________________________

☐ **Check if you need a diabetic eye report sent to your doctor**

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Medical History Questionnaire

1. When was your last eye exam
   ☐1 yr ago ☐2 years ago ☐3 years ago ☐More than 4 years ago ☐Never had an eye exam before
2. Check any symptoms you have
   ☐Blurred Distance Vision ☐Blurred Near Vision ☐Eye pain ☐Floaters in Vision
   ☐Tired Eyes ☐Eyestrain ☐Vision Fatigue ☐Dry eyes
   ☐Computer vision problems ☐Distorted Vision ☐Double Vision ☐Loss of vision
   ☐Flashes of light ☐Double Vision ☐Night Vision Problems ☐Glare sensitivity
   ☐Color Vision problem ☐Mucous discharge ☐Chronic infection of eye/lids
   ☐Redness ☐Sandy/gritty feeling ☐Itching ☐Burning
   ☐Other____
3. Check any eye disorders or diseases you have:
   ☐Allergic conjunctivitis ☐Blepharitis ☐Cataracts ☐Diabetic eye disease
   ☐Dry Eyes ☐Macular degeneration ☐Ocular hypertension
   ☐Ocular migraine ☐Retinal detachment ☐Amblyopia
   ☐Floaters ☐Glaucoma ☐ No eye diseases
   ☐Other____
4. Check any eye surgeries
   ☐Blepharoplasty ☐Cataract surgery: _Right _Left ☐Corneal transplant
   ☐Eye muscle surgery ☐LASIK ☐PRK ☐Ptosis repair ☐Retinal laser surgery
   ☐YAG Capulotomy ☐Macular degeneration injections
   ☐Other____
5. Check any medical problems you have:
   ☐Anxiety ☐Arthritis ☐Asthma ☐Cancer ☐Type 2 Diabetes
   ☐Type 1 diabetes ☐Depression ☐Hypertension (High Blood Pressure)
   ☐Hypercholesterolemia ☐Hypothyroid ☐Stroke ☐Heart disease
   ☐Other____
6. Check Any Medical Surgeries:
   ☐Appendectomy ☐Cystectomy (bladder) ☐Breast: lumpectomy
   ☐Breast: mastectomy ☐Diverticulitis ☐Colostomy
   ☐Heart bypass ☐Heart Valve replacement ☐Hip joint replacement
   ☐Knee joint replacement ☐Prostatectomy ☐Splenectomy
   ☐Hysterectomy ☐No medical surgeries ☐No medical surgeries
   ☐Other____
7. List any medications you take (including pills, creams, drops, oral contraceptives, aspirin, over-the-counter medications, and home remedies):
   ____
   ____
   ☐Not taking any medications
8. Medications you are allergic to:____
   ☐No known allergies to medications
9. Do you wear glasses: ☐No ☐Yes: what type & how old are they_________________________
10. If you wear contacts, check your type of contact lenses:
    ☐RGP ☐Hybrid contacts ☐Disposable soft: Dailies ☐Disposable soft: Monthly
    ☐Disposable soft: 2 week ☐Full time wear ☐Part-time wear

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11. Are you pregnant and/or nursing? ☐No ☐Yes: How far along?____________________
12. Check Family History of Eye Diseases
    - ☐Glaucoma: ☐Mother ☐Father ☐Grandmother ☐Grandfather ☐Other____________________
    - ☐Cataracts: ☐Mother ☐Father ☐Grandmother ☐Grandfather ☐Other____________________
    - ☐Macular degeneration: ☐Mother ☐Father ☐Grandmother ☐Grandfather ☐Other__________
    - ☐Keratoconus: ☐Mother ☐Father ☐Grandmother ☐Grandfather ☐Other__________________
    - ☐Blindness: ☐Mother ☐Father ☐Grandmother ☐Grandfather ☐Other ____________________
    - ☐Retinal detachment: ☐Mother ☐Father ☐Grandmother ☐Grandfather ☐Other____________
    - ☐Other:____
13. Check Family Medical History
    - ☐Hypertension: ☐Mother ☐Father ☐Grandmother ☐Grandfather ☐Other_________________
    - ☐Heart disease: ☐Mother ☐Father ☐Grandmother ☐Grandfather ☐Other_________________
    - ☐Diabetes: ☐Mother ☐Father ☐Grandmother ☐Grandfather ☐Other_________________
    - ☐Cancer: ☐Mother ☐Father ☐Grandmother ☐Grandfather ☐Other_________________
    - ☐Hyperthryoid: ☐Mother ☐Father ☐Grandmother ☐Grandfather ☐Other_________________
    - ☐Hypothryoid: ☐Mother ☐Father ☐Grandmother ☐Grandfather ☐Other_________________
    - ☐Arthritis: ☐Mother ☐Father ☐Grandmother ☐Grandfather ☐Other_________________
    - ☐Other____
    - ☐No family history of medical problems
14. Do you use tobacco products? ☐No ☐Yes: type/amount/how long?___________________
15. Do you drink alcohol? ☐No ☐Yes: type/amount/how long?___________________

Optomap Consent

At Abundo Eye Care, we provide our patients with the best possible standard of care by offering the Optomap retinal exam (non-invasive imaging) that help will help see early signs of many retinal diseases and systemic conditions such as retinal holes or detachments, glaucoma, optic nerve disease, age related macular degeneration, high blood pressure, diabetes. The image becomes a permanent part of your medical file, allowing the doctor to make important comparisons year over year. If Dr. Abundo decides that there is a need for dilation, this will be discussed during your exam. These images The discounted $35 co-pay for this procedure is generally a non-covered service unless being used to actively follow ocular disease.

☐YES: I understand the importance of having the OPTOMAP Retinal Exam and would like to have it performed ($35 copay)
☐NO OPTOMAP: I decline to have the Optomap performed on me.
☐Dilated Eye Exam: I prefer to have a dilated eye exam instead.
☐NO DILATION: I, under my own will and judgment, refuse to have my eyes dilated and accept all risk of declining such treatment. Furthermore, I understand that the Doctor may not be able to detect cases in which the retina is diseased or harboring tumorous growths. Thus, the process of early detection and diagnosis of certain eye conditions may be hindered and timely referral to a specialist and effective treatment may not be possible resulting in permanent blindness or even death.

____

Patient/Guardian signature Date

ABUNDO EYE CARE

Consent to Treat Form

I give permission for **Abundo Eye Care** to give me medical treatment. I allow **Abundo Eye Care** to file for insurance benefits to pay for the care I receive.

I understand that:

- **Abundo Eye Care** will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.
- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician

____ ________________________

Patient/Guardian Signature Date

Financial Agreement

If applicable, insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances that are not paid may be billed to you. Please keep statements and follow-up with your insurance carrier to ensure prompt payment. Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility. Patients are asked to confirm their appointments at least 24 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to keep your appointment may result in a charge for the time reserved, as this time could be given to another patient in need. It is required to confirm an appointment with a specialist at least 24 hours in advance. If a 24-hour notice is not given, a cancellation fee of a minimum $25 will apply. There will be a minimum fee of $30 for any checks returned as Non-Sufficient Funds (NSF).Patient balances that go unpaid for 180 or more days may be referred to a collection company or attorney. In the event this occurs, you will be liable for the collection cost. Further, in the event any unpaid account balance is referred to an attorney for collection, you may also be responsible for all costs and reasonable attorney's fees incurred in connection therewith. I understand that and agree to be responsible for payment of all services rendered on my behalf or my dependents' behalf. I understand that I will be liable for the collection cost. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

- *REFRACTION FEE*: The part of your evaluation that determines your prescription is called a "refraction". A refraction is also done under certain circumstances for diagnostic purposes. If you have routine vision benefits such as VSP, EyeMed or other vision insurance, your refraction is typically included with your exam benefits. Medical insurances that do not include routine vision benefits, such as Medicare, do not cover a refraction. The fee for a refraction is $40.00
- *EYEWEAR AND CONTACT LENS ORDERS*: Abundo Eye Care uses the most advanced supply chain system for the ordering of eyewear and glasses available. This system enables us to begin processing your order before you even leave the office. While this expedites the order and decreases the number of days until you receive your order, it limits our ability to change or cancel your order once it is placed. Prescription lenses are "custom made" and we begin incurring charges as soon as the order enters the system. Changes or cancellations to an order can be made depending on the status of the job. Any charges incurred at the time of the change or cancellation will be billed at 50% of retail. There is a $4.00 restocking fee per item on all contact lenses.All frames purchased at our office carry a one-year warranty against normal wear and tear, but not abuse. Lenses that have been treated with a scratch coating or a level "B" antireflective coating carry a one-year warranty with a one-time replacement. "TD2" scratch coating and Level "C" antireflective coatings carry a two-year warranty with a one-time replacement. If you choose to use your own frame in your eyewear order, we will give you a professional opinion of its condition. However, we accept no responsibility for loss, breakage or warranty for materials supplied by you.My signature below verifies I understand and agree to the above Eyewear policy.
- *CONTACT LENS FEES* Contact lens evaluation services are not an included part of an eye health evaluation and vision assessment, and additional fees apply. Fees are customized according to the complexity of the case and the predicted time necessary to care for the individual patient. Evaluation fees cover fitting, training, sample cleaning solutions, two months of follow up and a pair of initial disposable trials. Specialty lenses and office visits outside the initial two month period are not included and additional fees may apply. Fees for contact lens evaluation services range between $60 and $300 and can only be firmly quoted after a baseline vision status is determined. As with glasses, contact lens materials are an additional fee. If allowed, insurance benefits may be applied to contact lens overages.

FINANCIAL DISCLAIMERS We will attempt to verify your plan eligibility for services and/or materials before your appointment. Verification of eligibility is done as a courtesy only and is not a guarantee of payment. Please check with your plan if you have any questions regarding your eligibility. Liability: If I have medical insurance or routine vision benefits, I authorize my plan carrier to directly pay Abundo Eye Care. I also authorize Abundo Eye Care to release any information required for payment to be made. If my plan carrier does not pay, or partially pays, I understand I am responsible for the payment in full or the remaining balance. This includes any collection fees, court costs and attorney fees incurred in collecting the balance. There is a $25 fee for returned checks.

____ ____________________

Patient/Guardian Signature Date

ABUNDO EYE CARE

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

- 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.

Your Rights

- **When it comes to your health information, you have certain rights.**

This section explains your rights and some of our responsibilities to help you. We respect our legal obligation to keep health information that identifies tou private. We are obligated by to give your notice to give you notice of our privacy practice. This notice describes how we protect your health information and what rights you have regarding it.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information listed below.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 2021, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choices to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health and safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We routinely use your health information inside our office for this purpose without any special permission. If we need to disclosure any information outside our office, for this reasons, we usually wikll ot ask you for any special written permission. Uses and Disclosures for Other Reasons without Permission - In some limited situationsm the law allows aor reuquires us to use or disclosure your health information without your permission. Not all the situations will apply to us; spme may never come up at our office at all. Such uses or disclosures are:

- When a state or federal mandates that certain health information be rported for a specific purpose.
- For public health purposes, such as contagious diease reporting, investigate or surveillance; and notices to and from the federal Food and Drug Adminstration regarding drug or medical devices.
- Disclosure 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 investigate of possible violation of healthcare laws.
- Disclosure for judical administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies.

- Disclosures 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 to our office; or to report a crime that happened somewhere else.
- Disclosure to a medical examiner to identify a dead person or determine the cause of death; or funeral directors to aid in burial; or 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 rankings government officials; for lawful national intelligence activities; for military purposes; or the evaluation and health of members of the foreign service.
- Disclsoure de-identified information.
- Disclosure relating to workers compensation programs
- Disclosure of a "limited data set" for research, public health or healthcar operations.
- Incidiential disclosures that are unavoidable by-product of permitted use or disclosures.
- Disclosures to "business associates" who perform healthcare operations for us who commit to respect the privacy of your health information.
- Uses or disclosures required by Utah Law.

Other Uses and Disclosures

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form". Federal law determines the content of an "authorization form". Sometimes, we may initiate the authorization process if the user disclosure is our idea. Sometimes, you may initiate the process if it is your idea for us to send your information to someone else. Typically, in this situation you will give use 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 auhtorization, we cannot make the use or disclosure. If you do sign one, you might revoke it at any time, unless we have already acted in reliance upon it. Revocations must be in writing. Send them to *Abundo Eye Care.*

Treatment, Payment, and Healthcare Operations

The most common reason why we use or disclosure your health information is for treatment, payment, or healthcare operations. Example of how we use or disclosure information for treatment purposes are: setting up an appointment for you, showing your visual aids, referring you to another doctor or clinic for care; or getting copies of your health information for other professionals. Example of how we use or disclosure your health information for payment purposes are: asking you about your health or vision care plans, or the sources of payment, preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health operations" mean those administrative and managerial functions that we have to do inorder to run our office. Example of how we use or disclosure your health information for healthcare 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.

How else can we use or share your health information?

We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Appointment Reminders and Newsletters

We might 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 treatment of services available at our office that might help you. We might use a newsletter for this purpose. Unless you tell us otherwise, we will mail you a appointment reminder on a postcard, and/or leave you a reminder message on our home answering machine or with someone who answers your phone if you are not home.

Our Notice of Privacy Practice

By law, we must abide the terms of this noitce of privacy practice 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 and havce copies available.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Privacy Officer

Roland E. Abundo, O.D.

Phone: 801-255-8500

Email: dr_abundo@comcast.net