

Advanced Vision



Family Eye Care

Spencer Young, O.D.

3080 Northwest Ave, Bellingham WA 98225
(360) 526-0075 (360)733-9150 fax

WELCOME TO OUR OFFICE

Name _____

Street _____

City _____ State _____ Zip _____

HmPhone _____ WkPhone _____

Email _____

Preferred Contact: Mail Email Phone

Employer (or School) _____

Occupation (or Grade) _____

MEDICAL HISTORY

Allergies Type _____	No	Yes	Arthritis	No	Yes
Asthma	No	Yes	Cancer	No	Yes
Eye Diseases	No	Yes	Diabetes	No	Yes
Eye Injury	No	Yes	Heart Disease	No	Yes
Eye Surgery	No	Yes	High Blood Pressure	No	Yes
Lazy Eye	No	Yes	Kidney	No	Yes
Cataracts	No	Yes	Nerves	No	Yes
Glaucoma	No	Yes	Other _____	No	Yes

CURRENT MEDICATIONS (Rx or Over the Counter)

	No	Yes	Name of Medication
Allergies to Meds	No	Yes	_____
Antihistamines	No	Yes	_____
Diuretic (Water Pill)	No	Yes	_____
Blood Pressure Pill	No	Yes	_____
Oral Contraceptive	No	Yes	_____
Sleeping Tablets	No	Yes	_____
Eye Drops	No	Yes	_____
Other _____	No	Yes	_____

Are you currently under the care of a physician? No Yes

Name of Physician _____

FAMILY MEDICAL HISTORY Relationship

Blindness	No	Yes	_____
Cataracts	No	Yes	_____
Glaucoma	No	Yes	_____
Diabetes	No	Yes	_____
Heart Disease	No	Yes	_____
Macular Degeneration	No	Yes	_____

Today's Date _____ Date of Last Exam _____

Date of Birth _____ Age _____ Sex: M F

Social Security Number _____

What is the major purpose of this visit? _____

Any Problems with your present contact lenses or glasses? _____

Spouse (or Parent's) Name _____

Spouse (or Parent's) Work Phone _____

Vision Insurance _____

Do you participate in a flexible spending account? Yes No

Do You...

...Use Tobacco? Yes No

Type: _____ Frequency _____ How Long? _____

Drink Alcohol? Yes No

Type _____ Frequency _____ How Long? _____

...Work at a computer for long periods? Yes No

...Have more than one pair of glasses? Yes No

...Hobbies _____

...Spend time outdoors? How much? _____ hrs/wk

...Have prescription sunglasses? Yes No

...Have problems with glare or reflection, particularly when driving at night? Yes No

Have you ever worn/ are you currently wearing contacts?

Yes No

What kind? _____ Solutions used? _____

Are you interested in contacts? Yes No

Do you experience...

- Burning
- Spots
- Uncomfortable glasses
- Itching
- Soreness
- Sudden loss of vision
- Nausea
- Flashes of light
- Sensitivity to light
- Headaches
- Watery eyes
- Fainting or dizziness
- Tearing
- Redness
- Blurry distance vision
- Dryness
- Double vision
- Blurry near vision
- Eye strain
- Gritty feeling in eyes
- Reading problems
- Objects floating in vision
- Glare or reflection
- Trouble seeing at night
- Uncomfortable contact lenses
- Trouble reading or learning at work/ school
- Trouble working up close
- Other _____

How did you hear about our office?

- Friend or relative Who? _____
- Another Health Care Practitioner Who? _____
- Yellow page – which directory? _____
- Newspaper advertisement Radio Advertisement
- Internet site Which site? _____
- Previous patient Who? _____
- Other _____

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Notice of Privacy Policies

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; personal 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) (we usually will not) ask you for special permission.

(We will ask for special written permission in the following situations: _____.)

USES AND DISCLOSURES FOR OTHER REASON 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 purposes;
- 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;
- use 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 services;
- 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 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 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 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 photo copies 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 photo copies if we send you a written notice of the extension. If you want to review or get photo copies 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 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 amendments, 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 a shorter period if you want). By law, the list will include; disclosures for purposes of treatment, payment of 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 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.

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INSURANCE BILLING & PAYMENT POLICY

As a courtesy to our patients, we will bill all major medical insurance companies that allow us to do so. We request you furnish us with complete billing information at the time of your visit. If information is not given or is incorrect, you will be responsible for the balance in full.

In the event a secondary insurance policy is present, we will attempt to bill them if we are able. If not we will assist you in seeking reimbursement.

At the time of your visit we request you pay your co-pay, deductible or any other balance not covered by your insurance.

At the time of your visit we call the insurance company for a review of your benefits. However, **THIS IS NOT A GUARANTEE OF BENEFITS, ELIGIBILITY, OR PAYMENT. FINAL DETERMINATION IS MADE WHEN CLAIMS ARE RECEIVED AND EVALUATED BY THE INSURANCE COMPANY.** You are ultimately responsible for the bill and payment in full is required within thirty (30) days from the original date of service. We gladly accept payment by cash, check, Debit, Visa, MasterCard or Discover.

RELEASE OF BENEFITS & INFORMATION

I authorize my insurance benefits to be paid directly to the doctor's office. I am financially responsible for any balance due above and beyond those benefits. I authorize the doctor or insurance company to release any information required for this claim.

Signed: _____

Insurance Company: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICE

I acknowledge that I have read and understand *Spencer Young O.D.*'s Notice of Privacy Practice (HIPPA).

Patient Name: _____

Signature _____ Date _____