

# HEIGHTS EYE CENTER

WELCOME TO OUR OFFICE

Chart No.

Thank you for choosing our practice for your eye care needs. Please complete this form and return it to the receptionist who will use this information to prepare your chart. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

## Patient Information (Please Print)

Name \_\_\_\_\_ Date \_\_\_\_\_  
First Preferred Middle Last

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Male/Female \_\_\_\_\_ Social Security # \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ Telephone (Work) \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_

Please Check:  Minor  Single  Married  Divorced  Widowed  Separated

Name of Spouse \_\_\_\_\_ D.O.B. \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

### Complete if under 18 or a student

Father's Name \_\_\_\_\_ Employer \_\_\_\_\_

Address/Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Employer \_\_\_\_\_

Address/Phone \_\_\_\_\_

### Person or party responsible for this account (other than patient)

Relationship to patient \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address/Phone \_\_\_\_\_

### Patient's Primary Care Physician

Address/Phone \_\_\_\_\_

### Whom may we thank for referring you to us?

Address/Phone \_\_\_\_\_

### Whom to notify in emergency (nearest relative)

Address/Phone \_\_\_\_\_

### Primary Insurance

Mailing address \_\_\_\_\_

Insured \_\_\_\_\_ Relationship to insured \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

### Secondary Insurance

Mailing address \_\_\_\_\_

Insured \_\_\_\_\_ Relationship to insured \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Drivers License # \_\_\_\_\_

State \_\_\_\_\_

NOTE TO PATIENT: It is the policy of this office that patients pay when services are rendered, unless prior arrangements have been made.

### FOR OFFICE USE ONLY

Date:	FS updated: Yes No	New insurance cards: Yes No	Insurance verified: Yes No	Initials:
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# HEIGHTS EYE CENTER

## Life style Vision Questionnaire

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

Date: \_\_\_\_\_

**We recognize that your eyes are very important to you. We would like to know how you use your eyes on a daily basis. Along with your eye exam, this info will assist us in recommending the best options for your eyes and your personal lifestyle vision.**

- Do you wear glasses now? \_\_\_\_\_ No \_\_\_\_\_ Yes  
If Yes \_\_\_\_\_ All the time \_\_\_\_\_ Sometimes  
\_\_\_\_\_ Only for distance \_\_\_\_\_ Only for reading \_\_\_\_\_ Only for computer
- How important is it for you to see to read or use computer without glasses?  
Very important \_\_\_\_\_ Important \_\_\_\_\_ Somewhat important \_\_\_\_\_ Not important \_\_\_\_\_
- How many hours per day do you: read? \_\_\_\_\_ use computer? \_\_\_\_\_
- Do you drive at night? Socially \_\_\_\_\_ Occasionally \_\_\_\_\_ As profession \_\_\_\_\_

### Check the following activities you do on a regular basis:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Read newspaper, books | <input type="checkbox"/> Read medicine bottles | <input type="checkbox"/> Needlepoint                   | <input type="checkbox"/> Wall Street Journal |
| <input type="checkbox"/> Drive daytime         | <input type="checkbox"/> Drive nighttime       | <input type="checkbox"/> Shop                          | <input type="checkbox"/> Golf                |
| <input type="checkbox"/> Tennis                | <input type="checkbox"/> Hunt or Fish          | <input type="checkbox"/> Paint / Artist                | <input type="checkbox"/> Cook                |
| <input type="checkbox"/> Musician              | <input type="checkbox"/> Play Cards / Dominos  | <input type="checkbox"/> Movie theatre                 | <input type="checkbox"/> Dine in Restaurant  |
| <input type="checkbox"/> Photography           | <input type="checkbox"/> Spectator Sports      | <input type="checkbox"/> Bicycling, Roller blades, etc |  |

**Underline the above activities that you would like to see without glasses if possible**

- What occupational, recreational, or other activities do you currently engage in that are not listed above?

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# PATIENT MEDICAL HISTORY RECORD

DATE (MM/DD/YY)	REFERRED BY	BIRTH DATE
PATIENT'S NAME		SEX                      AGE
ADDRESS		PHONE (H)
EMPLOYER	OCCUPATION	PHONE (W)
SOC SEC NO.		PRIMARY CARE PHYSICIAN

**Please answer the following questions about your medical status and history:**

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc)?  
 Yes  No  If YES, please explain: \_\_\_\_\_
2. Have YOU ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?  
 Yes  No  If YES, please explain: \_\_\_\_\_
3. Have you ever had any surgery?  
 Yes  No  If YES, please provide date and reason \_\_\_\_\_

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4. Have you ever been hospitalized?  
 Yes  No  If YES, please provide date and reason \_\_\_\_\_

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5. Do you take any medications?  
 Yes  No  If YES, please list: \_\_\_\_\_  
 Do you take any eye medications: \_\_\_\_\_  
 Yes  No  If YES, please list: \_\_\_\_\_

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6. Do you have any drug or food allergies?  
 Yes  No  If YES, please list: \_\_\_\_\_

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**Review of Systems**

	Yes	No	If YES, please explain:
Do you currently have any of the follow problems?			
Chronic fever, unexpected weight loss/gain, fatigue .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems (e.g. chest pain, irregular heart beat).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory problems (e.g., shortness of breath, wheezing, coughing).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinal problems (e.g. pain or discomfort, blood in urine) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin problems (e.g. rashes, excessive dryness).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic problems (e.g., numbness, weakness, headaches, paralysis) .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric problems (e.g., depression, anxiety).....	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Family and Social History**

Do any medical or eye diseases run in your family (e.g., diabetes, high blood Pressure, cancer, glaucoma, muscular degeneration)?  
 Yes  No  If YES, please explain: \_\_\_\_\_

Do you smoke? If Yes, how much?  Drink alcohol? If Yes, how much

If employed, does your job include heavy computer usage?

Comments \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_



# HEIGHTS EYE CENTER

## Payment Policies

The best medical care can be provided only on the basis of mutual understanding. We encourage you to discuss any questions you may have regarding our policies with our billing staff.

### Eye Examinations & Refractions

Payment for routine eye examinations and refractions are expected at time of service. In some cases when a medical problem is found, we may be able to bill your medical insurance or Medicare.

### Refraction Policy

Refraction is the process of determining the eye's refractive error, or need for corrective spectacle and/or contact lenses. It is an essential part of an eye examination, but it is **NOT** a covered service by Medicare or most insurance regardless of the reason for the test being performed. **Our office fee for a refraction is \$30.00 and this fee is collected in addition to the patient's co-pay.**

### ACKNOWLEDGMENT

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The co-pay is separate from and not included in the refraction fee.

\_\_\_\_\_

**Patient Signature**

### Insurance Policy

We participate in Medicare and a variety of insurance plans and will direct bill your insurance for medical services under these plans for which we have an agreement. In this circumstance you are responsible for applicable deductibles, co-payments and refractions. We cannot be responsible for negotiating claims with insurance companies. Services not covered by your insurance company are your responsibility regardless of the status of the claim.

### Prior Authorization

Most HMO plans require you to obtain authorization for your visit from your primary care physician. It is **your responsibility to obtain this authorization. This authorization is required by your insurance company before you visit our office, even when the visit is for an urgent problem.**

### Optical Goods

Payment in full is expected at the time of delivery for all contact lenses, contact lens supplies and for glasses and optical accessories.

### Forms of Payment

For your convenience, we accept cash, check, Visa, MasterCard, Discover and American Express, Debit.

I have read or have had read to me, and understand and accept the Heights Eye Center payment policies.

\_\_\_\_\_

**Patient**

\_\_\_\_\_

**Date**

**Heights Eye Center  
Heights Surgery Center  
Heights Vision Correction Center**

**NOTICE OF PRIVACY PRACTICES**

**This notice describes how medical information about you may be used and disclosed by Heights Eye Center and how you can get access to this information. Please review it carefully.**

**Effective Date: April 14, 2003**

- Purpose of this Notice.** We consider any information that concerns your health, health care or payment for that care to be confidential and protected information. This notice describes our privacy practices, specifically how we use and disclose your medical information and what rights you have with respect to this information. This information includes your name, address, and other identifying data, and information on your health or the health services that have been or may be furnished to you. We require all of our employees, staff, volunteers and independent contractors to comply with these privacy practices.

We are required by federal law to obtain an acknowledgment from you that you received this Notice. Please sign the attached Acknowledgment Form and return it to our office.

- The Use and Disclosure of Medical Information for Treatment, Payment and Health Care Operations.** By law we are allowed to use and disclose your medical information for most purposes related to your medical treatment (“Treatment”), the payment for your medical treatment (“Payment”), and our health care operations or the operation of other covered entities to whom we disclose your medical information (“Operations”).

**Treatment** means the provision, coordination or management of health care and related services by or involving one or more health care providers, such as the coordination of consultations and referrals. For example, we can share most medical information regarding your health condition with another provider as part of a consultation. We may also contact you to remind you to make or that you already made an appointment; to notify you regarding treatment alternatives or other health-related benefits and services that may be of interest to you, or to raise funds for our own purposes.

Please note that by law, certain medical information, such as psychotherapy notes, generally may not be used or shared even when it is related to your treatment, unless we obtain an Authorization from you to use or release that information.

**Payment** means activities related to obtaining reimbursement from HMOs, insurers or other payers for services provided to you. Payment can also cover activities to determine your eligibility for services with your insurer, coordination of benefits with other insurers, billing, claim management, collection, medical necessity review activities, utilization review activities, and disclosure to consumer reporting agencies. For example, we can disclose to your health plan medical information that is required by the plan to determine whether the services we have provided to you are medically necessary. We can also disclose to your health plan a list of the services that you obtained from us so

that we can be paid by the health plan for providing the services to you.

**Operations** cover a range of activities that are necessary for the business of health care providers, payors or clearinghouses (i.e., entities performing certain billing or payment functions). They may be performed by our employees or, in some cases, by third-party contractors. These operations include: quality assessment and improvement activities; peer review; credentialing and licensing; training programs; legal and financial services; business planning and development; management activities related to privacy practices; customer services; internal grievances; creating de-identified information for data aggregation or other purposes; fundraising; certain marketing activities; and due diligence activities. For example, we may evaluate practitioner performance to ensure that they meet our quality standards. Engaging counsel to defend us in a legal action is another activity that is considered health care operations. Another example involves fundraising activities, in which we, a related foundation or an independent contractor may contact you in order to raise funds for us.

3. **Authorization for Other Uses and Disclosures of Your Medical Information.** Unless a use or disclosure is permitted for treatment, payment or operations purposes under Section 2 of this Notice, or is permitted or required under Section 4 or 5 of this Notice, we must obtain a signed Authorization from you to use or disclose your medical information. We may also require Authorization when using or disclosing certain highly protected information, such as substance abuse information. An Authorization is a written permission that specifically identifies the information that we will use or disclose, and when and how we will use or disclose it. You may revoke an Authorization at any time except that we have already used or disclosed your information in reliance on your Authorization.
  
4. **Use and Disclosure of Medical Information Without Your Consent or Authorization If You Don't Object Verbally.** Under certain circumstances, we may use or disclose your medical information without an Authorization or other written permission from you if we give you the opportunity to agree or object verbally. These circumstances are as follows:
  - To a relative, friend or individual involved in your care.** We may provide medical information about you to a relative or friend, or other individual involved in your care. We will attempt to seek, or in some circumstances, using our professional judgment, will infer your permission to make this disclosure. If we are not able, for instance, because of your condition or because you are not immediately present, we will use our best judgment to determine whether you would want this information shared.
  - For disaster relief.** We may use or disclose your medical information to an entity that assists in disaster relief efforts.
  
5. **Use and Disclosure of Medical Information Without Your Consent or Opportunity to Agree or Object Verbally.** In the following situations, we are permitted under law to use or disclose your medical information without obtaining your consent or authorization or allowing you to agree or object.

**As required by law.** Numerous state, federal and local laws permit or require certain uses and disclosures of medical information. However, we may only use or disclose your medical information to the extent authorized by the law.

**To business associates.** We may disclose your medical information to our business associates who perform functions on our behalf if we first receive satisfactory assurance

that the business associate will safeguard your information.

**For public health activities.** We may be asked or required by law to divulge medical information to a public health authority under the following circumstances:

- to report a birth, death, disease or injury, as required by law; as part of a public health investigations;
- to report child or adult abuse or neglect, or domestic violence, as authorized by law;
- to report adverse events (such as product defects), to track products or assist in product recalls or repairs or replacements, or to conduct post-marketing surveillance, as required by the Food and Drug Administration;
- to notify a person about exposure to a possible communicable disease, as required by law; and
- to your employer if, we are conducting an evaluation relating to the medical surveillance of the employer's workplace or to evaluate whether you have a work related injury and only to the extent that the disclosure concerns such surveillance or injury.

**For health oversight activities.** Health oversight activities include audits, government investigations, inspections, disciplinary proceedings, and other administrative and judicial actions undertaken by the government (or their contractors) by law to oversee the health care system. We may be asked or required to share medical information with a health oversight agency for these activities.

**To report victims of abuse, neglect or domestic violence.** If we believe that you are a victim of abuse, neglect or domestic violence, we may report this information to a governmental authority, social service or protective services agency if we believe the disclosure is necessary to prevent serious harm to you or another individual, if you cannot agree, or if the disclosure is required by law. If we make such a disclosure, you will be notified promptly unless notification to you would place you at serious risk of harm or is otherwise not in your best interest.

**For judicial and administrative proceedings.** We may disclose medical information as required by a court or administrative order, or in some instances pursuant to a subpoena, discovery request or other legal process.

**To law enforcement.** Police and other law enforcement may seek medical information from us. We may release this information to law enforcement under limited circumstances, for example, when the request is accompanied by a warrant, subpoena, court order, or similar legal process, or when law enforcement needs specific information to locate a suspect or stop a crime.

**To coroners, medical examiners and funeral directors.** We may release information regarding a person who has died as required by law or in order to facilitate funeral activities.

**For organ, eye, and tissue donation.** We may provide medical information to organ procurement organizations and similar entities in order to facilitate organ, eye and tissue donation and transplantation.

**For research purposes.** We may be approached by researchers to provide medical information for research purposes, such as tracking a particular disease. We may provide medical information to a researcher who has obtained a special waiver that allows the researcher to collect medical information with first obtaining the patient's permission. These waivers must be obtained from a committee established under federal law to oversee medical research. The researcher must demonstrate to the committee that the

information is necessary to the research and poses a minimal risk of an inappropriate use or disclosure.

**To avert a serious threat to health and safety.** We may use or disclose your medical information to avert a serious and imminent threat to the health and safety of an individual or the public.

**For military and other specialized government functions.**

- Armed Forces. We may disclose your medical information if you are a member of the Armed Forces, as deemed necessary by military command authorities, and if you are foreign military personnel, to your appropriate authority.
- National Security and Intelligence. We may disclose your medical information to authorize federal officials for lawful intelligence, counterintelligence, and other national security activities, and for protective services to the President and other heads of state or authorized persons.
- Correctional Institutions. If you are an inmate, we may disclose your medical information to correctional institutions or law enforcement personnel having lawful custody of you for administration and maintenance of the safety, security and good order of the correctional institution; of identification necessary to provide health care to you, or to protect you, other inmates, employees and officers of the institution, individuals participating in your transportation, or law enforcement at the institution.
- Other Government Agencies. We may disclose your medical information to other government entities that administer public benefits to populations similar to the population that we serve, if necessary to coordinate the function of the programs.

**For workers' compensation.** We may share information regarding work-related illnesses and injuries in order to comply with workers' compensation laws.

**Other permitted disclosures.** We may disclose your medical information as required or permitted by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act, as amended and interpreted from time to time.

**6. Individual Rights.** You have the following rights with respect to your medical information:

**Restrictions.** You have the right to request in writing to us to restrict how we use and disclose your medical information. We do not have to agree to the restrictions that you request. If we do agree to the restrictions that you request, we must comply with the restrictions, except in emergency circumstances. We also have the right to ask you to revoke a restriction.

**Confidential Communications.** You have the right to request in writing that we restrict the way in which we communicate information regarding your health, health care services, or payment. For example, you may ask that we communicate with you only at your home, not at your workplace. We will use reasonable efforts to accommodate your request.

**Access.** You have the right to inspect and copy most of your medical information maintained by us. Normally, we will provide you with access within 30 days of your request. We may charge a reasonable copying fee. In certain limited instances, we may deny you access, for example, when the request is for psychotherapy notes. You have the rights to a review of a denial of access to your medical information.

**Amendment.** You have the right to request that we amend your written medical information. For instance, you can request that we correct an incorrect surgery date in

your records. We will generally amend your information within 60 days of your request, and will notify you when we have amended your information. We can deny your request in circumstances, such as when we believe that your information is accurate and complete. You can file a statement of disagreement to a denial of your request for amendment, to which we may file a rebuttal.

**Accounting.** You have the right to request an accounting from us of certain disclosures made by us during the 6 years prior to your request, but no earlier than April 14, 2003. We will generally provide you with your accounting within 60 days of your request. Your request will be filled at no cost to you once every 12 months. For additional accountings, we will notify you in advance of the cost and give you an opportunity to continue or withdraw your request. These disclosures do not include those made for purposes of Treatment, Payment or Operations, those made pursuant to a signed Authorization or for other disclosures described in Section 2 of this Notice.

**Paper Notice.** If you have obtained this Notice electronically, you may obtain a paper copy by contacting our Privacy Officer or any staff member.

**Complaints.** If you believe that any of your rights with respect to your medical information have been violated by us, our employees or agents, you may file a complaint in writing to:

Bob Linzer, Privacy Officer  
Heights Eye Center Privacy Office  
427 West 20<sup>th</sup> Street, Suite 100  
Houston, Texas 77008 or call (713) 862-6631

Or you may contact:  
U.S. Department of Health and Human Services (DHSS)  
200 Independence Ave, S.W.  
Washington, D.C. 20201 or call (877) 696-6775

Under no circumstances will we take any retaliation against you for filing a complaint.

- 7. Our Duties.** We are required by law to maintain the privacy of your medical information and to provide you with this Notice of our legal duties and privacy practices with respect to your medical information. We must comply with the Notice currently in effect.

**We reserve the right to revise this Notice and will revise the Notice if we materially change any use, disclosure, individual right or legal duty or other privacy practice stated in this Notice. If we revise a Notice, copies will be available by asking Debbie Dierks, or any staff member. We reserve the right to change our privacy practices retroactively with respect to information that we created or received prior to issuing a revised Notice.**

