PROFESSIONAL VISION OF BEL AIR, INC.
530 Baltimore Pike • Bel Air, MD 21014
(410) 879-1105

PATIENT FORM

Date:

GENERAL INFORMATION

First, MI, Last, Preferred Name:
Street Address:
City, State, Zip Code:
Primary Phone # (Type):
Secondary Phone # (Type):
E-mail address:
Date of Birth:
Gender:
Occupation/Employer:
Emergency Contact Person and Phone Number:

INSURANCE INFORMATION

Vision Insurance:
Vision Insurance Primary Member's Name:
Vision Insurance Member ID:
Vision Insurance Primary Member's Date of Birth (DOB):

Primary Medical Insurance:
Primary Medical Insurance Primary Member's Name:
Primary Medical Insurance ID#:
Primary Insurance Policy# / Group ID#:
Relationship to Primary Insured (circle one): self spouse parent child

Secondary Medical Insurance:
Secondary Medical Insurance Primary Member's Name:
Secondary Medical Insurance ID#:
Secondary Insurance Policy# / Group ID#:

EYE HISTORY

Date of Last Eye Exam:
Currently Wear Glasses?
Currently Wear Contacts?
Reason for Today's Visit:

Have you or a family member experienced or been treated for any of the following? Circle all that apply:

Cataracts	yes	no	family
Crossed Eye	yes	no	family
Glaucoma	yes	no	family
LASIK or RK	yes	no	family
Lazy Eye	yes	no	family
Macular Degeneration	yes	no	family
Retinal Detachment	yes	no	family

Are you currently experiencing, or have experienced any of the following? Circle all that apply:

Blurry vision	near or distance	Current	Previous
Eye Burning		Current	Previous
Eye Discharge		Current	Previous
Double Vision		Current	Previous
Eye Dryness		Current	Previous
Excess Tearing/Watering		Current	Previous
Eye Infection		Current	Previous

Eye Pain or Soreness	Current	Previous
Floaters or Spots	Current	Previous
Halos	Current	Previous
Headaches	Current	Previous
Eye Itching	Current	Previous
Light Flashes	Current	Previous
Light Sensitivity	Current	Previous
Eye Redness	Current	Previous
Sandy/Gritty Feeling Eyes	Current	Previous

MEDICAL HISTORY

Have you or a family member experienced or been treated for any of the following? Circle all that apply:

AIDS/HIV	yes	no	family
Allergies	yes	no	family
Arthritis	yes	no	family
Autoimmune Disease	yes	no	family
Blood/Lymph Disorder	yes	no	family
Cancer	yes	no	family
Crohn's Disease	yes	no	family
Diabetes	yes	no	family
Ears, Nose, Throat Conditions	yes	no	family
Fibramyalgia	yes	no	family
Gastrointestinal Conditions	yes	no	family
Heart Disease	yes	no	family
Hepatitis	yes	no	family
High Blood Pressure	yes	no	family
High Cholesterol	yes	no	family
Kidney Disease	yes	no	family
Lupus	yes	no	family
Neurological Conditions	yes	no	family
Psychiatric Disorder	yes	no	family
Seizures	yes	no	family
Skin Conditions	yes	no	family
Stroke	yes	no	family
Thyroid Dysfunction	yes	no	family

Current Medications (prescription/OTC and dosage):

Medication Allergies, if any:

Are you pregnant or nursing?	**yes**	**no**
Do you smoke?	**yes**	**no**
Have you ever smoked?	**yes**	**no**
Are you sensitive to eye drops?	**yes**	**no**

SIGNATURE:

Date:

Professional Vision — HIPPA Compliance & Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a **Patient Rights** section describing your rights under law. You have the right to review our **Notice** before signing this consent. The terms of our **Notice** may change. If we change our **Notice**, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction but if we do we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this **Consent**, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior **Consent**. The Practice provides this form to comply with the **Health Insurance Portability and Accountability Act of 1996 (HIPPA)**.

The patient understands that:

- Protected heath information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice and receive a paper copy of this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent.

Please complete the list of phone numbers where we can contact you. Reasons for our needing to contact you include but are not limited to the need to confirm or change appointments, to discuss insurance or payment situations, to respond to your inquiries, etc. In using these numbers, we may talk directly with you or leave a message on an answering machine.

Phone numbers where **Professional Vision** may contact me:

(Home phone)_____ (Work phone)_____

(Cell phone)_____ (Other phone) _____

PRINT PATIENT NAME _____

Patient Signature _____

Relationship to patient (if other than patient) _____

Office Representative initials _____Date_____

I give permission for you to release my information to the following (Name, Relationship & Phone Number):

_____

_____

_____

Privacy Notice

WELCOME! We would like to welcome you to our practice. The professionals at our practice provide each patient with quality vision solutions and exceptional customer service. Our staff is experienced in all areas of vision care. Maintaining healthy eyes requires regular vision and eye exams. We look forward to serving you.

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.

THIS NOTICE IS EFFECTIVE 04/21/2002 AND UNTIL FURTHER NOTICE.

Right to Notice: As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPAA), Professional Vision can use your protected health information for treatment, payment and health care operations.

a) **Treatment** - We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

b) **Payment** - We may use and disclose your health information to obtain payment for services we provide you.

c) **Health Care Operations** - We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: Most uses and disclosures that do not fall under treatment, payment, health care operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

Emergency Situations: In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your healthcare.

Marketing: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may also use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health or safety.

National Security: We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders via phone, e-mail or letter.

Your Rights as a Patient: You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or health care operations.

- You have the right to receive confidential communications regarding your protected health information.
- You have the right to inspect and copy your protected health information.
- You have the right to amend your protected health information.
- You have the right to receive an account of disclosures of your protected health information.
- You have the right to a paper copy of this notice of privacy practices.

Legal Requirements: Professional Vision is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are posted to this site, or are available within our office.

Complaints: If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint.

Contact Information: For further information about Professional Vision Center's privacy policies, please contact Dr. Jeffrey Kessler at the following address or phone number:

Dr. Jeffrey Kessler
Professional Vision Center
530 Baltimore Pike
Bel Air, MD 21014
410-879-1105