

SHARPER VISION CENTERS, Inc, AMG

PLEASE TELL US HOW YOU FOUND US

DOCTOR _____ FRIEND _____ INSURANCE CO. _____
(DOCTOR'S NAME) (NAME OF FRIEND)

PHONE BOOK _____ RADIO _____ NEWSPAPER _____ OTHER _____
(WHICH ONE?) (WHAT STATION?) (WHICH ONE?)

PATIENT PERSONAL INFORMATION

NAME _____ DATE OF BIRTH ____/____/____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE () _____ WORK PHONE () _____ MOBILE PHONE () _____

GENDER: MALE _____ FEMALE _____ E-MAIL (OPTIONAL) _____

DRIVER'S LICENSE _____ SOCIAL SECURITY NUMBER _____

ETHNICITY: _____ RACE: _____ PREFERRED LANGUAGE: _____

EMERGENCY CONTACT: _____ TELEPHONE: () _____

FINANCIAL INFORMATION

METHOD OF PAYMENT: MEDICARE _____ PRIVATE INSURANCE _____ CASH/CREDIT CARD _____

MEDICARE NUMBER _____

INSURANCE _____ POLICY # _____ GROUP # _____

RELATIONSHIP TO INSURED: SELF _____ SPOUSE _____ PARENT _____ (NAME OF INSURED): _____

INSURANCE _____ POLICY # _____ GROUP # _____

RELATIONSHIP TO INSURED: SELF _____ SPOUSE _____ PARENT _____ (NAME OF INSURED): _____

AUTHORIZATION AND TREATMENT, AND FOR RELEASE OF MEDICAL RECORDS

I hereby authorize SVC, Inc. physicians and assistants to treat me. Also, by signing below I am authorizing for SVC, Inc., and its doctors to furnish the above insurance companies all the necessary information which they may request.

It is the policy of SVC, Inc., to require payment at the time services are provided. I am aware that I am responsible for the balance of my account beyond 90 days, regardless of my medical policy. **For procedures requiring out patient services or in office lasers, you will be responsible for payment if your insurance company has not paid at 6 weeks.** By signing below I am stating that I understand this policy. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediate carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment below.

I hereby irrevocably assign to the doctor all payments for medical services rendered and ALL MAJOR MEDICAL BENEFITS, from my insurance companies and Medicare.

X _____ /____/____
(Patient's or guardian's signature) (Date signed)

X _____ /____/____
(Signature of insured) (Date signed)

SHARPER VISION CENTERS
Patient History Form

Name _____ **Date** _____

Eye Health History:

What is the primary reason for today's visit?

1. Are you experiencing any of the following symptoms? (Please circle all that apply)

Eye pain Discharge Light Sensitivity Decreased Vision Dry Eyes
Double Vision Floaters Flashes of light Glare - day or night

2. Do you have any problems with you current glasses or contact lenses? Please describe _____

3. Date most recent glasses or contacts were prescribed mm/dd/yy _____

4. What type of glasses or contact lenses do you have?

5. Have you ever had an eye injury or eye condition? Please describe _____

6. Have you ever had **EYE surgery**? Please list date, circle eye and type of surgery

Date: _____ Eye: Right/Left _____

Date: _____ Eye: Right/Left _____

7. Are you currently taking **EYE medications**? Please list names and dose _____

8. Do you keloid (scar tissue overgrowth) after healing from cut or surgery? **Yes / No**

9. **Men** – Have you ever or currently taking "prostate medication" like FLOMAX/Rapaflo or Alpha- blockers?
Please list medication name and/or how long ago?

10. Are you **allergic to any** medications? Please list

Please circle any of the following that you would like to discuss with doctor you today

LASIK	IntraLasik	Modern Cataract surgery	Retina Diseases	Intraocular Lens Implants
Glaucoma	Dry Eyes	Diabetic Eye Disease	Macular Degeneration	Crystalens, Multifocal Rezoom or ReStor

Patient History Form (cont.)

Medical History:

Are you being treated for?		
<u>Condition</u>	<u>Yes</u>	<u>No</u>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		
Have you had any general surgeries? Describe _____		

Current Medications/Vitamins & Dose (Rx or Over Counter)	
1	_____
2	_____
3	_____
4	_____
5	_____
6	_____
7	_____
8	_____
9	_____
10	_____

Family Medical History:		
<u>Condition/Relationship</u>	<u>Yes</u>	<u>No</u>
Glaucoma/ _____	<input type="checkbox"/>	<input type="checkbox"/>
Retina Disease/ _____	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration/ _____	<input type="checkbox"/>	<input type="checkbox"/>
Blindness/ _____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes/ _____	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/ _____	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension/ _____	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		

Social History (please circle)			
Exercise	Minimal	Regular	Active
Stress Level	Low	Med	High
Alcohol	None	Socially	Occasionally
Smoking	Current every day Smoker		
	Some days smoker	Former smoker	
		Never	
Any Particular Diet? Describe			

Review of Systems: Do you presently have any problems in the following area?			
	<u>Yes</u>	<u>No</u>	<u>Explain</u>
General health	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nose	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mouth/Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neck	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genito-urinary	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hemato-Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	_____

Sharper Vision Centers, A Medical Group, Inc. 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. You have the right to obtain a copy of this Notice upon request.

Patient Health Information

Under Federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment and related medical information. Your health information also includes payment, billing and insurance information.

How We Use Your Patient Health Information

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose information without your permission.

Example of Treatment, Payment, and Health Care Options

Treatment:

We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care.

Payment:

We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of the payments from your health plan.

Health Care Operation:

We will use and disclose your health information to conduct standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses:

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may interest you.

Other Uses and Disclosures:

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Research: We may use or disclose information approved for medical research.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to the public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths of coroners, medical examiners, funeral directors, and organ donation agencies.

Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

Military and Special Government Functions:

If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensation: We may release information about you for workers' compensation or similar programs providing benefits for work-related injuries or illness.

In any other situations, we will ask for your written authorization to disclose information. You can later revoke that authorization to stop any future uses or disclosures.

Individual Rights

You have the following rights with regard to your health information. Please contact the person listed below to obtain appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidential Communications: You may ask us to communicate with you

confidentially by, for example, sending notices to a special address or not using a postcard to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. A fee may apply.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing or add the missing information.

Accounting Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding health information, and to abide by the terms of this Notice currently in effect.

Changes in Privacy Policies

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact:

Ann Quinonez
4201 Torrance Blvd., Suite 520
Torrance, CA 90503
(310) 792-1010
Effective Date: April 14, 2003

SIGN HERE ↓

I, _____,
hereby acknowledge receipt of the
Notice of Privacy Practice given to me.