PATIENT INFORMATION RECORD

PATIENT INFORMATION (Please Print)

Patient Name (First, MI, Last)	Sex M F	Marital Status NM M W D SEP	Date of Birth
Address (including City, State, Zip Code)			Social Security Number
Email	Home Phone	Cell Phone	Work Phone
Preferred Contact for Appointment Reminders (please check) Call Home ☐ Cell ☐ Work ☐ Email ☐			
Patient's Occupation	Employer		

Spouse's Name	Spouse's Date of Birth	Social Security Number
Spouse's Occupation	Spouse's Employer	Spouse's Contact Number
Emergency Contact	Emergency Contact Relationship	Emergency Contact Phone
Do you have the following?	Living Will	Power of Attorney

INSURANCE INFORMATION

Do You Have Insurance? Yes No IF YES, PLEASE PRESENT INSURANCE CARD AT RECEPTION		
Primary Policy Holder	Date of Birth	Relationship
Insurance Name	Policy Number	Group Number
Secondary Insurance Policy Holder	Date of Birth	Relationship
Insurance Name	Policy Number	Group Number

Referral Information: How did you hear about our office?

	Name of Referral/Website	Referral Information (Phone/Address)
One of Our Patients		
Internet		
Professional Referral		
Other		

Ho Vision Group

Neuro-Optometric Physician

1) Authorization for Optometric Services and Assignment of Insurance Benefits

I hereby authorize Dr. Jamie Ho to examine, diagnose, treat, and manage my eye health and visual conditions as necessary. I hereby assign all health insurance benefits Ho Vision Group for services rendered. This assignment includes benefit programs of which I am a beneficiary. I authorize the release of all information from all sources necessary to secure payment for service rendered. The benefits/funding outlined above have been explained to me. I am aware and understand that this does not guarantee services will be reimbursed as outlined.

Please also note that if a referral is required for your insurance to see a specialist, it is your responsibility to have that at your time of visit.

I understand that I am responsible for payment of charges not covered by my insurance including: copayments, coinsurance, and unmet deductibles which are due at time of service.
Refractions when performed are a non-covered service by medical insurance and are due at the time of service. The fee for refraction is $85.00.

Any returned checks will be charged a $30.00 fee, and a 30% return fee will be applied to any eyeglasses, contact lenses, and/or nonprescriptive low vision aids that are ordered then cancelled by the patient.
Any patient who fails to show for an appointment and has not contacted our *office* prior with at least 48 hours notice will be considered a *No Show* and charged a $30.00 *fee*.

_____

Patient or Responsible Party Signature Date

2) Disclosure of Health Information and Release of Medical Records

I hereby authorize the release and use of my or my child's health information, medical, and/or billing records to the physicians, hospital, clinics, third party payors, teachers, special educators, or others as I may direct. These records include but are not limited to examinations and progress notes, fundus photographs, retinal angiograms, ultrasonography, reports, visual field charts, and all other medical and financial information pertinent to my previous health care. It is customary for our practice to send a summary report of examination findings to the patient's referral source if applicable.

_____

Patient/Responsible Party Signature Date

Ho Vision Group

HIPAA SHORT FORM NOTICE OF PRIVACY PRACTICES

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this Notice of our legal duties and privacy practices with respect to health information about you; and/or your child
- Follow the terms of the Notice that is currently in effect.

How we may use and disclose health information about you:

- For treatment
- For payment
- For health care operations
- For appointment reminders
- To avert a serious threat to health and safety
- National Security and Intelligence activities
- Coroners, health examiners and funeral directors
- Protective Services for the President and others
- As required by the Military or Veterans and Workers Compensation
- Public Health risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- As required by Law
- Security Officials for Inmates

Your rights regarding Health Information about you:

- Right to an Accounting of Disclosures
- Right to Request Restrictions
- Right to Request Confidential Communications
- Right to a Paper copy of this Notice (**The long full HIPAA Policy is available upon request**)
- Right to Inspect and copy
- Right to Amend

- <u>There have no changes to individuals authorized to have access to appointments, scheduling, and my medical information since the last HIPAA form I have signed.</u>

Acknowledgement of Receipt of this Notice:

_____ _____

Patient Signature Date

_____ _____

Patient Name Printed Authorized Provider Representative

Communication Information:

How would you prefer that we get in touch with you? ☐ Telephone ☐ Email ☐ Mail

Due to the Privacy Act, I hereby give permission **(unless initialed "NO")** for Ho Vision Group to leave a voice mail or recorded message (NO___), send emails concerning appointments and billing (NO___), speak with spouse or family member concerning appointment (NO___), medical condition (NO___), or billing inquiries (NO__).

I authorize you to speak to the named below concerning appointments, medical conditions, etc. as well as any provider I am referred by or to.

Name	Relationship	Street Address, City, State, Zip Code	Phone No.
Name	Relationship	Street Address, City, State, Zip Code	Phone No.
Name	Relationship	Street Address, City, State, Zip Code	Phone No.

Demographic Information:

Preferred Language
- ☐ English
- ☐ Spanish
- ☐ French
- ☐ Japanese
- ☐ Vietnamese
- ☐ Decline to specify

Race:
- ☐ American Indian / Alaska Native
- ☐ Asian
- ☐ Black / African American
- ☐ Hispanic
- ☐ Native Hawaiian / Other Pacific Islander
- ☐ White
- ☐ Decline to specify

Ethnicity:
- ☐ African American
- ☐ Asian
- ☐ Caucasian
- ☐ Hispanic or Latino
- ☐ Not Hispanic of Latino
- ☐ Other Pacific Islander
- ☐ Decline to specify

Do you currently use or wear any of the following?

	Wear Glasses		Wear Contact Lenses		Hand Telescopes/Magnifiers

PATIENT HEALTH QUESTIONNAIRE

NAME_____ DATE of BIRTH_____DATE_____

CURRENT HEALTH:

Do you take any medications regularly? Yes No

If yes, please list:

_____

_____

_____

Do you have any allergies to food, or medicine? Yes No

If yes, please list

_____

_____

CURRENT and PAST HEALTH

Have you ever experienced any of the following conditions?

	Macular Degeneration		Glaucoma		Strabismus
	Retinal Detachment		Cataracts		Lazy Eye / Amblyopia
	Diabetic Retinopathy		Color Blindness		Other

	Heart Disease/TIA		Arthritis		Diabetes
	High Blood Pressure		Crohns / IBS		Thyroid Disease
	Vascular Disease		Rosacea		Bleeding Disorder
	Stroke/CVA		Multiple Sclerosis		Cancer
	Asthma/Emphysema		Seizures		Learning Disabilities
	Kidney Disease		Headaches / Migraines		Sexually Transmitted Disease
	Liver Disease		Neurological Diseases		Other:
	Prostate Disease		Psychiatric Conditions		

Social History

		Date Started	Quantity / Type / Frequency
	Tobacco Use		
	Narcotic Use		
	Alcohol Use		
	Blood Transfusion		

NAME_____DATE of BIRTH_____DATE_____

Please list all previous surgeries including eye surgeries.

Date	Type of Surgery	Doctor and/or Hospital

Please check any of the conditions you are currently being affected by.

	Blurry Vision		Dry Eyes		Headaches
	Fluctuating Vision		Itchy Eyes		Reading Difficulties
	Vision Loss		Burning Eyes		Ocular Fatigue
	Distorted Vision		Gritty/Sandy Sensation		Balance Difficulty
	Double Vision		Flashing Lights		Frequent Falls
	Squinting		Floaters		Bumping into Objects
	Light Sensitivity		Eye Pain		Other:
	Lazy Eye / Amblyopia		Eye Redness		

FAMILY HEALTH

Do any of your blood relatives have any of the following conditions?

		Relationship			Relationship
	Glaucoma			Diabetes	
	Macular Degeneration			Hypertension	
	Retinal Detachment			Heart Disease	
	Poor Vision / Low Vision			Stroke	
	Amblyopia / Strabismus			Cancer	
	Other Eye Conditions			Neurologic Disease	
				Other Systemic Conditions	