PATIENT REGISTRATION/HEALTH HISTORY

Today's Date:

Last Name	First	Middle	Best Phone ( )
Address	City	State Zip	Work Phone ( ) -
Birthdate / Age / Sex M F	Occupation (If Student, Grade in School)		Soc. Sec. No. - -
Name of Vision Insurance Carrier	If Group Coverage, Name Of Employer & Group Policy No.		Vision Ins. Policy No.
Name Of Medical Insurance Carrier	If Group Coverage, Name Of Employer & Group Policy No.		Medical Ins. Policy No.
Name Of Responsible Party	Birthdate	Patient Relationship To Responsible Party: Self___Spouse___Child Other ___	Soc. Sec. No. Of Responsible Party - -
Address Of Responsible Party (If different than above)	City	State Zip	Home Phone Of Responsible Party ( ) -
How Did You Find Out About Our Office?			

Vision History

When was your last complete eye exam? Month_____Year _____

Where?_____ May we contact them if previous eye history is needed? Yes / No

Do you wear glasses? Yes / No	If yes, how long?	Do you wear contacts? Yes / No	If yes, how long?

How do you use your current glasses? (Please Check)

____rarely ____driving only ____sports only
____all the time ____over contacts ____sunwear only
____distance only ____computer only ____work/safety only
____reading only ____recreation only

How would you classify your current contacts? (Please Check)

Wearing schedule	Remove from eye	Type of contact lens
____daily wear	____daily	____hard
____extended wear	____every____week(s)	____hard (gas permeable)
____recreation only	____every____month(s)	____soft (yrly replacement)
	____other	____soft (freq replacement)
		____soft (disposable)

Do you currently have or have you recently experienced any of the following? (Please Check)

____blur at far ____ double vision ____ eye infection(s) ____lazy eye
____blur at near ____ halos around lights ____ eyes feel dry ____hearing disorder
____blur at computer ____ night blindness ____ eyes itch ____learning disorder
____change in vision ____ see flashing lights ____ eyes red ____reading disorder
____sudden loss central vision ____ see spots ____ eyes water ____dyslexia
____sudden loss peripheral vision ____ eye injury ____ eye pain ____eye strain
____light sensitivity: ____ eye surgery ____ crossed eye ____work on computer
____daytime (sunlight)
____nighttime (headlights)

Family history of eye disease: (Please Check)

____Glaucoma ____Disease of Cornea ____Disease of Retina ____Macular Degeneration
____Other Please List: _____

Sports, activities and hobbies:

Are you involved in any sports, activities, or hobbies? Please List: _____

Medical History

Name of family doctor_____Date of last physical? Month_____Year _____

May we contact them if previous medical history is needed? Yes / No Phone No. _____

Please List all medications you are currently taking: _____

Do you have any history of allergies (including medication)? Please List: _____

Do you currently have or have you ever been diagnosed with any of the following? (Please Check)

____arthritis/joint disease: ____anemia ____pregnancy (currently) ____eczema
____rheumatoid ____blood disorder ____asthma ____skin disorder (other)
____osteoarthritis ____pituitary disorder ____tuberculosis ____cancer
____lupus erythematosus ____thyroid disorder ____lung disease ____HIV
____musculoskeletal disorder ____liver disease ____seasonal allergies
____nerve disorder ____kidney disease ____sinus problems
____multiple sclerosis ____heart disease ____frequent headaches
____carotid artery disease ____high cholesterol ____migraine _____Staff Initial
____transient ischemic attack ____high blood pressure ____head injury
____stroke ____diabetes ____seizure disorder _____Date

PROFESSIONAL & MATERIAL FEE PAYMENT POLICY

We ask that payment be made in full at the time professional services are rendered. This includes any insurance co-payments. Payment for all prescription materials, both spectacles and contact lenses, must be collected prior to their being ordered. All processional fees related to contact lens fitting and follow-up are due at the time the contact lenses are ordered. Any delinquent accounts part 90-days will be turned over to collections, in which case, there may also be court costs and attorney fees added to the delinquent balance. A $20 fee will be billed for any returned checks.

The following is a list of insurance companies we currently have provider contracts with and will bill for you. Please make sure we have a current copy of your insurance card and a referral number, prior to services being rendered. We will do our best to verify your coverage, however, if coverage is denied or benefits are misquoted, we will bill you for any unpaid balance. If you do not have your current insurance card, or we are not a provider for your insurance carrier, payment will be expected at the time services are rendered.

Aetna	GreatWest	Rocky Mountain HMO	United Health Care
Benesight	InterCare	Rocky Mountain UCFW	Vision Care Direct (VCD)
BlueCross/BlueShield	Medicare	Secure Horizons	Vision Care Provider Network (VCPN)
Cigna	PHCS	Spectera	Vision Service Plan (VSP)

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996 (HIPPA), is a federal program promulgated by the Department of Health and Human Services, creating national standards to protect all medical records and other individually identifiable information used or disclosed in any way by our office. The Act give you, the patient, significant new rights regarding your medical records and individually identifiable information, which combined are referred to as your protected health information (PHI).

As required by "HIPPA", we have prepared this explanation of our privacy practices regarding your protected health information. This notice describes how protected health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We may use or disclose with or without your authorization your protected health information for purposed of treatment, payment, and during our normal health care operations. Examples are as follows:

- **Treatment** – your protected health information may be given to another health care provider for the purpose of co-managing any diagnosed condition found during either a routine or acute care office visit.
- **Payment** – your protected health information may be given to a third party entity by means of mail, phone, or electronically, for the purpose of collecting reimbursement for services rendered, confirming insurance coverage, and utilization review.
- **Health Care Operations** – your protected health information may be reviewed by employees of our office in order to perform their routine daily activities. In the event of a merger or acquisition of our practice your protected health information may be transferred to another covered entity.

We may contact you by mail or phone for appointment reminders or to provide you with information on products or services we provide which may be of benefit or interest to you. We may not provide your protected health information to any third party for marketing purposes without your prior written authorization.

We may disclose information to the Food and Drug Administration (FDA) for public health purposes related to the safety, quality, or effectiveness of FDA-regulated products, including adverse events, product defects or dangerous products.

Any other uses or disclosures of your personal information will be made only with your written authorization. You may revoke any authorization in writing and we are obligated to abide by that written request, except in the event that information was already released based upon a prior authorization.

You have certain rights with regards to your protected health information. You may exercise these rights at any time by presenting them in writing to our Privacy Officer.

- **You have the right** to restrict disclosures of your protected health information from any person or entity identified by you in writing; including by not limited to, family members, insurance carriers, or other health care practitioners. We will abide by this request unless you remove it in writing.
- **You have the right** to request to receive confidential communication of protected health information by alternative means or to any alternative location.
- **You have the right** to inspect, copy, or amend your protected health information at any time. Under certain circumstances we have the right to deny this request.
- **You have the right** to request a copy of any disclosures made by our office of your protected health information for any five year period beginning after April 2003.

If you feel we have not properly respected the privacy of your protected health information, you may file a complaint with our Privacy Officer or the Department of Health and Human Services, Office for Civil Rights. By signing below, you are acknowledging that you have read our Notice of Privacy Practices. This also serves as authorization for columbine Vision Clinic to communicate any protected health information necessary for treatment, payment, or health care operations as outlined above.

Patient Signature: _____ Date: _____

Would you like to view a copy of our Privacy Practices Policy? ❑ Yes ❑ No