HARVARD EYE ASSOCIATES

Patient Information Form

Last Name: _____ **First Name**: _____ **M.I.**: _____

Address – Street: _____

City: _____ **State**: _____ **Zip**: _____

Phone Numbers*: Home ☐: _____ Work ☐: _____ Cell ☐: _____

** Check box next to phone number(s) where we may leave a message*

Date of Birth: _____ **Social Security #:** _____ **E-mail address**: _____

Gender: ☐ Female ☐ Male **Ethnicity**: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to Specify

Race: ☐ Amer. Indian ☐ Asian ☐ White ☐ African-American ☐ Hawaiian ☐ Other Pac. Islander ☐ Decline

Employer Name: _____ **Occupation**: _____

How did you hear about Harvard Eye Associates? ☐ Internet ☐ TV Commercial ☐ Newspaper/Magazine
☐ Radio ☐ E-mail ☐ Drive-by ☐ Mail ☐ Health Event ☐ Family/Friend ☐ Employee
☐ Insurance ☐ Doctor Referral – First & Last Name: _____

Primary Physician's Full Name: _____ **Phone**: _____ **City**: _____

Optometrist's Full Name: _____ **Phone:** _____ **City:** _____

Pharmacy Name: _____ **Phone**: _____ **City**: _____

Primary Insurance: Insurance Co. Name: _____ ID#: _____ Group#: _____

Subscriber Name (if not self): _____ Subscriber's Date of Birth (if not self): _____

Secondary Insurance: Insurance Co. Name: _____ ID#: _____ Group#: _____

Subscriber Name (if not self): _____ Subscriber's Date of Birth (if not self): _____

Vision Insurance: Insurance Co. Name: _____ ID#: _____ Group#: _____

Subscriber Name (if not self): _____ Subscriber's Date of Birth (if not self): _____

Emergency Contact Information/Designated Individuals Release: Harvard Eye Associates (HEA) may release to, or discuss my personal health information (PHI) (except regarding treatment ☐, payment ☐, and/or administrative operations ☐), with the individuals listed below, verbally or in writing. I understand that HEA will make best efforts to verify the identity of the designated parties before disclosing PHI. I also understand that I may change any of the Emergency Contact Information/Designated Individuals Release information at any time in writing.

Name: _____ Relationship: _____ Ph#: _____

Name: _____ Relationship: _____ Ph#: _____

Your signature below indicates that the information provided above is accurate and complete to the best of your ability, and that you acknowledge you were advised of the Notice of Privacy Practices (NPP) for HEA. Our NPP provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our NPP is subject to change. The NPP is available on our website at wwww.harvardeye.com and in our office. You may request a copy of the NPP. By providing your email address above, you are opting in to receive email communications from Harvard Eye Associates.

_____ _____

Signature of patient (if over 18) or patient's parent or legal guardian *Date*

_____

If signed by parent/legal guardian, name of legal guardian

HARVARD EYE ASSOCIATES

Medical History

Last Name: _____ **First Name:** _____ **Date:** _____

Date of Birth: _____ **Gender:** Male ☐ Female ☐

Reason for visit today: _____

Current Eye Conditions: (*Please check, circle, and write where appropriate*)

☐ Cataracts ☐ Retinal Detachment ☐ Glare / Light Sensitivity ☐ Glaucoma
☐ Retinal Tear / Hole ☐ Irritation or Redness ☐ Macular Degeneration ☐ Keratoconus
☐ Blurred or Double Vision ☐ Diabetic Retinopathy ☐ Loss of Vision ☐ Dry Eyes
☐ Flashes or Floaters ☐ Pterygium ☐ History of Eye Trauma ☐ Astigmatism
☐ Artery / Vein Occlusion ☐ History of Iritis ☐ Other: _____

Previous Eye Surgeries: *(Please check, circle, and write where appropriate)*

☐ Cataract Surgery ☐ Radiation to Eye ☐ Glaucoma Surgery (ALT/SLT, stent, shunt, trabeculectomy)
☐ LASIK ☐ YAG Capsulotomy ☐ Laser Iridotomy (YLPI) ☐ PRK ☐ Diabetes Laser (PRP)
☐ Vitrectomy ☐ Pterygium Excision ☐ Retinal Detachment Repair ☐ Corneal Transplant
☐ Radial Keratotomy ☐ Retinal Tear Repair ☐ Macular Pucker / Hole Repair ☐ Other: _____

Previous Surgeries (other than eye): _____

List current medications: _____

_____

Allergies to medications: ☐ No ☐ Yes **If yes, which ones:** _____

Current / Previous Medical Conditions: (*Please check, circle, and write where appropriate*)

Cancer

☐ Breast ☐ Skin ☐ Prostate ☐ Leukemia ☐ Lymphoma ☐ Multiple Myeloma ☐ Brain
☐ Colon ☐ Uterine ☐ Lung ☐ Cervical ☐ Thyroid ☐ Other: _____

Cardiovascular

☐ Hypertension ☐ High Cholesterol ☐ Heart Attack (MI) ☐ Coronary Artery Disease
☐ Arrhythmia ☐ Atrial Fibrillation ☐ Pacemaker / AICD ☐ Deep Vein Thrombosis
☐ Peripheral Artery Disease ☐ Pulmonary Embolism ☐ Aneurysm ☐ Heart Failure (CHF) ☐ Stroke / TIA
☐ Valvular Disease (Aortic / Mitral Stenosis, etc.) ☐ Other: _____

Endocrine / Metabolic

☐ Diabetes (Type 1 or 2) ☐ Thyroid (Hypo or Hyper) ☐ Pituitary Mass ☐ Other: _____

Respiratory

☐ Asthma ☐ COPD ☐ Emphysema ☐ Bronchitis ☐ Other: _____

Neurological

☐ Seizure Disorder ☐ Parkinson's Disease ☐ Myasthenia Gravis ☐ Multiple Sclerosis ☐ Migraines
☐ Bell's Palsy ☐ Diabetic Neuropathy ☐ Horner's Syndrome ☐ Other: _____

HARVARD EYE ASSOCIATES

Rheumatologic

☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Fibromyalgia ☐ Polymyositis ☐ Temporal Arteritis
☐ Sjogren's Syndrome ☐ Ankylosing Sponylitis ☐ Sarcoidosis ☐ Scleroderma ☐ Gout
☐ Lupus ☐ Other: _____

Gastrointestinal

☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Celiac Disease ☐ Ulcers ☐ Hernia
☐ Diverticulitis ☐ Reflux (GERD) ☐ Other: _____

Genitourinary

☐ BPH ☐ Kidney Disease ☐ On Dialysis ☐ Other: _____

Hematologic

☐ Anemia ☐ Bleeding Disorder ☐ Sickle Cell Anemia ☐ Receiving Blood Transfusions
☐ Other: _____

Psychiatric

☐ Anxiety ☐ Depression ☐ Bipolar Disorder ☐ Dementia ☐ Schizophrenia
☐ Other: _____

Infectious Diseases

☐ Hepatitis B / C ☐ HIV / AIDS ☐ Tuberculosis ☐ Toxoplasmosis ☐ Lyme Disease
☐ Syphilis ☐ Pneumonia ☐ Meningitis ☐ Herpes Simplex
☐ Herpes Zoster (Shingles) ☐ Other: _____

Family Medical History (*Please check appropriate boxes below*)

☐ High Blood Pressure ☐ Diabetes ☐ Cancer ☐ Other: _____

Family History of Eye Disease (*Please check appropriate boxes below*)

☐ Glaucoma ☐ Retinal Detachment ☐ Color Blindness ☐ Macular Degeneration
☐ Other: _____

Social History

Do you smoke? ☐ No ☐ Yes (If yes, how much?_____) ☐ Formerly
Do you drink? ☐ No ☐ Yes (If yes, how much?_____) ☐ Formerly

Contact Lenses/Glasses (*Please check appropriate boxes below*)

Do you currently wear glasses? ☐ No ☐ Yes If yes, how old are your glasses? _____
Do you currently wear contact lenses? ☐ No ☐ Yes If yes, for how long? _____

My signature below indicates that the information provided above is accurate and complete to the best of my ability.

_____ _____
Signature of patient (if over 18) or patient's parent or legal guardian *Date*

_____
If signed by parent/legal guardian, name of legal guardian

HARVARD EYE ASSOCIATES

Lifestyle Questionnaire

Name: _____ **Date of Birth:** _____ **Date:** _____

Are you interested in learning more about procedures like LASIK that can reduce your need for glasses/contacts? Yes ☐ No ☐

How old are your current glasses?

Primary Pair: _____ Sunglasses: _____ Reading glasses: _____

Computer glasses: _____ Sport glasses: _____ Occupational glasses: _____

How much of a problem do you have with (please circle):	**None**					**Severe**
Glare from sunlight while driving	0	1	2	3	4	5
Glare around headlights in a car after dark	0	1	2	3	4	5
Difficulty reading street signs far away	0	1	2	3	4	5
Difficulty reading for long periods of time	0	1	2	3	4	5
Difficulty reading with your glasses in dim light	0	1	2	3	4	5
Difficulty with vision for sports (following golf ball, tennis ball)	0	1	2	3	4	5
Difficulty with hobbies requiring fine vision (sewing, carpentry)	0	1	2	3	4	5
Difficulty playing games like cards, bingo, etc.	0	1	2	3	4	5
Difficulty seeing small captions on the TV	0	1	2	3	4	5
Reading fine print (medicine bottles, telephone book, food labels)	0	1	2	3	4	5

Please answer the following questions by checking the appropriate boxes below:

Do you drive after dark? ☐ Often ☐ Sometimes ☐ Rarely/Never

Do you use a computer? ☐ Often ☐ Sometimes ☐ Rarely/Never

Do you do a lot of close detail work like sewing or building models? ☐ Often ☐ Sometimes ☐ Rarely/Never

Have you ever tried mono vision contact lenses (one eye near and one eye for distance?) ☐ Yes ☐ No

If you had to wear glasses after surgery for one activity, for which activity would you be most willing to wear glasses?

☐ Reading fine print ☐ Computer ☐ Driving

Please place an "X" on the following scale to **describe your personality** as best as you can:

<……/……>

Easy going Perfectionist

HARVARD EYE ASSOCIATES

Patient Questionnaire

Patient Name: _____ Date: _____ DOB: _____

Please fill out each section below:

Aesthetic Services:

Are you interested in more information on our aesthetic services and/or a consultation? ☐ Yes ☐ No

(*If yes, fill out this section and contact information section below)*

☐ Skin Care Advice	☐ Skin Care Products	☐ Injectable Treatments	☐ Juvederm/Restylane/Volbella
☐ Thin Lips	☐ Blotchy Skin	☐ Facial Veins	☐ Facial Fine Lines / Wrinkles
☐ Drooping Brow	☐ Drooping Eyelids	☐ Facial Fullness / Drooping	☐ Brown Spots / Age Spots / Freckles
☐ Scar Revision	☐ Neck Fullness	☐ Facial Contouring	☐ Unwanted Hair

☐ Length / Fullness of Eyelashes

LASIK Services:

Are you interested in more information on our LASIK services and/or a complimentary evaluation? ☐ Yes ☐ No

(*If yes, fill out this section and contact information section below)*

1. What are some of your hobbies / sports? _____
2. What is your motivation for looking into LASIK? _____
3. When would you be interested in having LASIK? _____
4. Would you like to learn more about payment plans that can make having LASIK more affordable? ☐ Yes ☐ No

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Contact Information:

I am interested in some/all of the additional services offered at this time. ☐ Yes ☐ No

If yes, what phone number may we reach you at to provide you with additional information? _____

Would you like us to send you additional information via email? ☐ Yes ☐ No

If yes, what is your email address? _____

_____ _____

Patient's Signature Date

HARVARD EYE ASSOCIATES

Financial Agreement and Lifetime Signature Authorization

Harvard Eye Associates (HEA) are privately-owned medical facilities that provide medical services on a fee-for-service basis. HEA relies solely on insurance reimbursement and patient payment(s) for services rendered in good faith. HEA receives no federal, state or other third-party funding; as such, HEA does not have provision for providing on-going indigent care. The following Financial Agreement is developed in accordance with Office of Inspector General (OIG) guidelines as well as all applicable State and Federal reimbursement guidelines.

Upon obtaining a copy of your insurance card(s), HEA will verify your eligibility and benefits including deductibles, copayments, coinsurance responsibility, etc. under your health insurance company, and HEA will submit claims for all medically necessary services to your health insurance company. Please note that payment is ultimately due from you in the event that your insurance company denies payment for any service(s); i.e. termination of coverage, coordination of benefits, non-payment of premium, etc.

Deductibles, coinsurances, and any non-covered services are the responsibility of the patient. To the extent possible and feasible, all patient financial responsibilities are payable at the time of service and / or prior to surgical procedures. Not all health insurance companies publish their (allowable) fee schedule; therefore coinsurance percentages cannot always be accurately calculated for pre-payment. A HEA statement will be sent to you after your health insurance has processed your claim(s); the balance due will compare to the Explanation of Benefits you will receive from your health insurance company. Should you dispute any amount on your Explanation of Benefits / statement, please contact your health insurance company member services for clarification of your benefits.

Copayment(s), as stipulated by your health insurance company, are due on the date of service.

Please note that OIG guidelines (FR Vol. 65, No. 194, Oct.5, 2000) relative to anti-kickback statutes, as well as contractual obligations to the health insurance companies from whom HEA will seek reimbursement for medical services, prohibit the routine discounting of published fees, “insurance-only billing” or waiver of any insurance-assigned charges otherwise due from the patient.

Self-Pay: In the event that (1) you are uninsured, (2) HEA and / or its affiliated facilities does not have a participating relationship with your health insurance plan(s), or (3) you elect to have non-covered medical services (i.e. cosmetic or other services determined by your health insurance plan to be “not medically necessary”, etc.), HEA accepts self-pay patients with this signed agreement that payment is due on the day services are rendered or in the case of surgical procedures, payment is due prior to the surgical procedure(s).

HEA does not accept litigated cases and services are not provided on a contingency basis under any circumstances.

HEA is not a banking institution and does not assess finance charges to cover the operational cost of managing payments by installment; therefore, no internal financing options (i.e. budget or other installment plans) can be extended.

Eye Refractions: Typically, medical insurance plans do not pay for the refraction part of your comprehensive eye examination. Eye refractions are necessary not only for prescribing glasses and contact lenses but do also for determining whether you have eye disease. Even if you do not wish to receive new glasses, the refraction is an essential part of you complete eye examination.

For your convenience, HEA accepts cash, check, money order and credit cards. In addition, HEA offers financing options through third party vendors.

Consent to Contact: By providing us with your landline or cell phone number(s), you give your consent for us, our agents, and to our collection agents, to contact you at these numbers, or, at any number that is later acquired for you, and, to leave live, or pre-recorded messages regarding any accounts or services. For greater efficiency, calls may be delivered by an auto dialer.

I understand all of the terms defined above; I consent to receiving treatment under the stated terms and I agree to honor all of my financial obligations to Harvard Eye Associates. I hereby authorize this provider and its employees, agents and assignees to contact me via email, text messaging and to my cellular devices. My signature below constitutes my Financial Agreement and Lifetime Signature Authorization.

Patient Name Printed	**Date**	**Patient / POA Signature**
HEA Employee Name	**Date**	**HEA Employee Signature**

Failure to honor your financial obligations to HEA in accordance with this signed Agreement will result in your account being referred to Collections and termination of the treatment relationship in accordance with the regulations that govern ethical medical care.

Effective 10/11/2016

HARVARD EYE ASSOCIATES
(949) 951-2020

Laguna Hills Office
24401 Calle de la Louisa, #300
Laguna Hills, CA 92653

San Clemente Office
665 Camino de los Mares, #102
San Clemente, CA 92673

Orange Office
1010 West La Veta, #175
Orange, CA 92868

Notice of Privacy Practices – Effective May 1, 2015

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.**

Your Rights

1. **Get an electronic or paper copy of your medical record**
   - You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
   - We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

2. **Ask us to correct your medical record**
   - You can ask us to correct health information about you that you think is incorrect or incomplete.
   - We may say "no" to your request, but we'll tell you why in writing within 60 days.

3. **Request confidential communications**
   - You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

4. **Ask us to limit what we use or share**
   - You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
   - If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

5. **Get a list of those with whom we've shared information**
   - You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
   - We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year at no charge, but may charge a cost-based fee if you ask for another within 12 months.

6. **Get a copy of this privacy notice**
   - You may ask for a paper copy of this notice at any time. We will provide you with a paper copy promptly.

7. **Choose someone to act for you**
   - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
   - We will make sure the person has this authority and can act for you before we take any action.

8. **File a complaint if you feel your rights are violated**
   - You can complain if you feel we have violated your rights by contacting our HIPAA Compliance Officer, 24401 Calle de la Louisa, Suite 300, Laguna Hills, CA 92653.
   - You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
   - We will not retaliate against you for filing a complaint.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

1. **Treat you**
   - We can use your health information and share it with other professionals who are treating you.
2. **Run our organization**
   - We can use and share your health information to run our practice, improve your care, and contact you.
3. **Bill for your services**
   - We can use and share your health information to bill and get payment from health plans or other entities.
4. **How else can we use or share your health information?**
   - We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**
5. **Help with public health and safety issues**
   We can share health information about you for certain situations such as:
   - Preventing disease
   - Helping with product recalls
   - Reporting adverse reactions to medications
   - Reporting suspected abuse, neglect, or domestic violence
   - Preventing or reducing a serious threat to anyone's health or safety
6. **Do research**
   - We can use or share your information for health research.
7. **Comply with the law**
   - We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
8. **Respond to organ and tissue donation requests**
   - We can share health information about you with organ procurement organizations.
9. **Work with a medical examiner or funeral director**
   - We can share health information with a coroner, medical examiner, or funeral director when a person dies.
10. **Address workers' compensation, law enforcement, and other government requests**
    We can use or share health information about you:
    - For workers' compensation claims
    - For law enforcement purposes or with a law enforcement official
    - With health oversight agencies for activities authorized by law
    - For special government functions such as military, national security, and presidential protective services
11. **Respond to lawsuits and legal actions**
    - We can share health information about you in response to a court or administrative order, or a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time, by letting us know in writing.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you.
The new notice will be available upon request, in our office, and on our web site.

HARVARD EYE ASSOCIATES
(949) 951-2020

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Orange, CA 92868

Patient's Rights and Responsibilities

Harvard Eye Associates has adopted the following Patient's Rights and Responsibilities. These will help you to understand what you can expect from your health care experience.

Patient Rights

You have the right to:

- Exercise these rights without regard to gender or culture, economic, educational, or religious background or the source of payment for your care.
- Be treated with respect, consideration and dignity.
- Know the name and credentials of the doctor and other staff who are providing your care.
- Receive, to the degree known, information concerning your diagnosis, evaluation, treatment, and prognosis. When it is medically inadvisable to give such information to you, the information is provided to a person designated by you or to a legally authorized person.
- Participate actively in decisions regarding your medical care. To the extent permitted by law, this includes the right to refuse treatment.
- Full consideration of privacy concerning your medical care program. Case discussion, consultation, examination and treatment are confidential and will be conducted discretely.
- Confidential treatment of all communications and records pertaining to your care and, except as required by law, the right to approve or refuse the release of your medical records.
- Responses to any reasonable requests you may make for service.
- Leave the facility even against the advice of your doctor.
- Continuity of care and to know in advance the time and location of your appointment as well as the doctor providing the care.
- Be advised if your doctor proposes to engage in or perform research affecting your care or treatment. You have the right to refuse to participate in such research projects.
- Examine and receive an explanation of your bill regardless of source of payment.
- Receive information about the Practice, its services, and its providers, and about patient rights and responsibilities, as well as about the Practice's compliance programs with respect to state law and federal regulations.
- Voice recommendations, complaints or appeals about Harvard Eye Associates, the care it provides, or its Patient Rights and Responsibility policy to Harvard Eye Associate's management and/or your health plan.
- Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding your medical care.
- Be provided with information for accessing care during office hours, after hours, and emergency care.

- Have an advance directive, such as a living will or durable power of attorney for healthcare, and be informed as to the Practice's policy regarding advance directives/living will.
- Appropriate assessment and management of pain, information about pain, pain relief measures and participation in pain management decisions.
- Give or withhold informed consent to produce or use recordings, film, or other images for purposes other than care, and to request cessation of production of the recordings, films or other images at any time.
- Access to and/or copies of your medical records within a reasonable time frame and the ability to request amendments to your medical records.
- Obtain information on disclosures of health information within a reasonable time frame.
- Receive information about unanticipated outcomes of care.

Patient Responsibilities

You have the responsibility to:

- Provide complete and accurate information, to the best of your ability, including your demographic, insurance and medical information.
- Make it known whether you clearly comprehend the course of your medical treatment and what is expected of you.
- Supply information that the Practice and its providers need in order to provide you with optimum care.
- Follow the treatment plan established by your doctor, including the instructions others involved in your care, or, be accountable for your actions should you refuse treatment or not follow the recommended treatment plan.
- Keep appointments and notify the Practice at least 24 hours in advance (when possible) when you are unable to do so.
- Accept personal financial responsibility for any charges not covered by his/her insurance.
- Follow Practice policies and procedures.
- Be respectful of all the health care professionals and staff, as well as other patients.
- Inform your providers about any living will, medical power of attorney, or other advance directive that could affect your care.