Marin Eyes

MARIN OPHTHALMIC CONSULTANTS
CONFIDENTIAL MEDICAL QUESTIONNAIRE

Name:_____ Date of Birth:_____ Date:_____

Do you currently have any problems in the following areas? Please mark **YES** or **NO.**

EYES:	YES	NO
Blurry Vision	☐	☐
Glare/light sensitivity	☐	☐
Poor night vision	☐	☐
Pain or soreness	☐	☐
Irritation	☐	☐
Discharge	☐	☐
Redness	☐	☐
Cataract	☐	☐
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Retinal Problems	☐	☐
Other Problems	☐	☐

EARS, NOSE, MOUTH, THROAT:		
Dizziness	☐	☐
Sinus congestion	☐	☐
Dry mouth / throat	☐	☐
Hoarseness	☐	☐

RESPIRATORY:		
Asthma	☐	☐
Emphysema	☐	☐
Shortness of breath	☐	☐
Tuberculosis	☐	☐
Wheezing	☐	☐
Chronic cough	☐	☐

CARDIOVASCULAR:		
Heart attach	☐	☐
Irregular heart beat	☐	☐
Hypertension	☐	☐
Pacemaker	☐	☐
Congestive heart disease	☐	☐
Angina	☐	☐

INTEGUMENTARY:		
Skin: eczema / psoriasis	☐	☐
rash	☐	☐

PSYCHIATRIC:		
Depression / Mood Swings	☐	☐
Other	☐	☐

NEUROLOGICAL:	YES	NO
Blackout	☐	☐
Migraine	☐	☐
Stroke	☐	☐
Palsy	☐	☐
	☐	☐

GENERAL:		
Cancer, type_____	☐	☐
HIV	☐	☐
Fever	☐	☐
Weight Loss	☐	☐
Lupus	☐	☐

MUSCULOSKELETAL:		
Arthritis, type_____	☐	☐

HEMATOLOGICAL / LYMPHATIC:		
Blood disorder	☐	☐
Anemia	☐	☐
Slow clotting time	☐	☐

GASTROINTESTINAL:		
Hepatitis	☐	☐
Intestinal problems	☐	☐

GENITOURINARY:		
Kidney disorder	☐	☐
Kidney stones	☐	☐

ENDOCRINE:		
Diabetes	☐	☐
Insulin dependent	☐	☐
Non-insulin dependent	☐	☐
Thyroid disorder	☐	☐

ALLERGIC AND IMMUNOLOGIC:		
Seasonal allergies	☐	☐
Anaphylactic reaction	☐	☐

DRUG ALLERGIES:_____

_____

_____

_____

MEDICATIONS:

NAME	DISEASE OR CONDITION	DOSAGE & FREQUENCY

SURGERIES

PART OF BODY	DISEASE OR CONDITION	DATE

COMMENTS:

Name: _____ Date: _____

MarinEyes

Visual Lifestyle Questionnaire

MarinEyes' mission is to provide you with the highest quality, personalized eye care available. In order to do so we need to learn about your individual needs and preferences. The more we can learn about how, where and when yo use your eyes, the easier it will be for us to provide you with the best possible eyewear recommendations.
The following questions are intended to help us help you. *Physicians and Staff at MarinEyes*

Were you referred to us by an Optician or Optometrist? No Yes Referred by: _____

Are you currently: (please check all that apply)

☐ Retired ☐ Homemaker ☐ Student ☐ Employed/Occupation:_____

Please tell us how you use your eyes in the pursuit of your lifestyle

During an average day, how many hours do you spend reading or doing close work? ..... ☐

How far is the reading or close work material for you? (Check all that apply)

☐ 12 - 14 inches (holding a book) ☐ 24 inches (arms length) ☐ further than 24 inches but less than 20 feet

How wide is the reading material or close work? (Check all that apply)

☐ standard page (8 1/2 x 11) ☐ newspaper width ☐ blueprint width ☐ computer width

Do you ever perform any work or read things above eye level or over your head? (examples: garage mechanics, plumbers, carpenters, grocery clerks, meter readers, etc.)	YES	NO
How many hours during an average day do you use a computer at work and/or at home?.....		
Are you required to wear safety glasses at work?		
Are you bothered by the glare of the sun during the day or at sunrise/sunset?	YES	NO
Are you aware of halos around or glare from oncoming headlights or streetlights at night?	YES	NO
Does your work or activities cause you to go from indoors to outdoors frequently?	YES	NO

Circle your Hobbies or Work:

Reading	Card/board games	Yard work	Golfing	Water sports	Non Contac
Needlecraft	Painting	Power tools	Walking/Running	Going to the beach	sports
Model making	Playing musical instrument	Home workshop	Hunting/Shooting Horseback/Bike	Boating/Fishing	Contact sports

Other: _____

Have you ever felt your eyeglass lenses were:

☐ Too thick? ☐ Too heavy? ☐ Made your eyes look larger? ☐ Made your eyes look smaller?

What do you like most about your present glasses? Least?

_____

What one aspect of your visual lifestyle do you wish your new eyeglasses could improve?

_____

Have you ever considered any of the following: (Please circle all that apply)

☐ Contact Lenses ☐ Lasik ☐ Clear Lens Extraction

Thank you for completing this survey and allowing us to serve you better

MarinEyes
Marin Ophthalmic Consultants

****TO ALL PATIENTS**
It is important that complete and accurate insurance billing information is provided to our office, such as your and/or your subscriber's health insurance carrier, vision plan, social security number, date of birth and valid driver's license or ID. It is the patients' responsibility to know their own plans limitations & covered services and referral/authorization policies.

Benefit Assignment and Acknowledgement of Financial Responsibility
I authorize my listed insurance companies to make payment directly to MarinEyes for medical services. I understand that I am financially responsible for payment of all non-covered services, co-pays, deductibles, refractions and any other charges my insurance company deems my responsibility. Should my account become delinquent for a period of thirty (30) days or more, I hereby acknowledge that I will be responsible for the entire balance, interest, court costs and/or attorney fees.

****PRIVATE PAY PATIENTS (NO INSURANCE)**
Private pay patients are responsible for all charges incurred. Payment is required at the time of your service. Private pay patients include those who do not provide their social security number, date of birth, necessary referrals and authorizations or accurate and complete insurance information.

****HMO/PPO/POS PATIENTS**
HMO/PPO/POS patients are responsible for following the guidelines and understanding the limitations of their own insurance coverage. Many plans have a strict referral and preauthorization processes, which must be closely followed. If you have one of these plans and you do not provide us with the necessary referrals and/or authorizations, you may be held financially responsible for any charges incurred. Note: It is your responsibility to bill secondary insurance if you have an HMO, PPO or POS as your first insurance.

****MEDICARE PATIENTS**
We are participating providers in the Medicare program. Provided we have the correct billing information, we will bill your secondary insurance as a courtesy. We bill secondary insurance only **ONCE** unless Medicare forwards it automatically. Medicare patients are responsible for paying deductibles and any balance due.

****MEDI-CAL AND MEDI-CAL PENDING PATIENTS**
Medi-cal patients must present proof of eligibility prior to or at the time of service. Payment is required at time of service for Medi-cal pending patients and Medi-cal patients with a share of cost.

****WORKMAN'S COMPENSATION CLAIMS**
Patients are required to provide case number, name and phone number of case worker and complete Worker's Compensation Insurance Carrier information as well as name, address and phone number of employer. Patients who do not have complete information will be considered private pay at the time of visit.

****NOTICE OF NON-COVERED SERVICES**
Complete Eye Exams with our Physicians include a ***Refraction*** with an Optometrist. This test is **not** covered by Medicare and most other insurance carriers, in which case the charge is the responsibility of the patient. The charge for this ***Refraction*** is $45.00. A ***Refraction*** is a test to determine your glasses prescription. Your Doctor advises that you have this test to determine your visual acuity and the general health of your eye as part of your complete examination.

☐ Please check box only if you decline refraction.

SIGNATURE _____ DATE: _____

04/01/08

MarinEyes

NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include an comprehensive eye examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to our HIPAA Compliance Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 1, 2003 as we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provision effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provision of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

MarinEyes

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1966 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____

Initials: _____

Reason: _____

_____