The Eye Clinic Inc.
Leaders In Comprehensive Eye Care

3545 Lincolnway East
Massillon OH, 44646

830 Amherst Rd SE, Suite 204
Massillon OH, 44646

6046 Whipple Ave., NW
North Canton OH,44720

Due to HIPPA laws we are not permitted to speak with anyone in regards to your care unless they are listed by our patient.

Please list the person(s) that you would allow us to speak to in regards to your personal medical information.

Name _____**Relationship** _____

Contact # ____-_____-_____

Name _____**Relationship** _____

Contact # ____-_____-_____

Name _____**Relationship** _____

Contact # ____-_____-_____

Name _____**Relationship** _____

Contact # ____-_____-_____

Patient Information I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization shall be in effect until revoked by the patient.

_____ Date_____
Signature or Personal Representative

_____
Description of Personal Representative's Authority (attach necessary documentation)

Notice Of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) 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 reviewed The Eye Clinic Inc.'s *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 Private 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 or 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.

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address:

I understand that a copy of the Notice of Privacy Practices policy will be provided to me upon request.

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

(!) An emergency existed & a signature was not possible at the time.

<> The individual refused to sign.

(!) A copy was mailed with a request for a signature by return mail.

(!) Unable to communicate with the patient for the following reason:

<> Other:_____

Prepared By: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Signature_____ Date_____

The Eye Clinic Inc. Notice of Privacy Practices and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a “friendly” version. A more complete text will be presented to you upon request and is posted in our offices.

This notice describes how we, The Eye Clinic, Inc., use or disclose your Protected Health Information ("PHI"). PHI is information that identifies you and relates to health care services, the payment of health care services or your physical health or condition, in the past, present or future. This notice also describes your rights to access and control your PHI.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of PHI information with other healthcare providers for treatment, with health insurance payers who provide payment and for healthcare operations.
2. We are required to notify affected individuals following a breach of unsecured PHI.
3. We will not use or disclose your PHI without authorization, except described in our privacy notice.
4. We may change, add, delete or modify any of these provisions to better serve the needs of the practice and the patient.
5. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
6. Your confidential information will not be used for the purpose of marketing or advertising of products, goods or services.
7. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
8. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
9. You agree to bring any concerns or complaints regarding privacy to the attention of The Eye Clinic, Inc. privacy officer.
10. We agree to provide patients with access to their records in accordance with state and federal laws.
11. You have the right to a Personal Representative. You may identify persons to us who may serve as your authorized personal representative.
12. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.
13. You have a right to inspect and copy your PHI upon request.

14. You have the right to request that we amend your records, if you believe that your PHI is incorrect or incomplete.
15. You may request an accounting of disclosures of your PHI made by us.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____

(PRINTED NAME)

_____

Date_____

(SIGNATURER)

This notice is effective April 1, 2013

The Eye Clinic Inc.
Notice of Privacy Practice

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 and Accountability Act of 1196 (HIPPA) 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. HIPPA provides penalties for covered entitles that misuse personal health information.

As required by HIPPA 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 a physical 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 you 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 of this 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 such authorization in writing and we are required to abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights to your protected health information, which you can exercise by presenting a written request to the Privacy 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 September 01, 2012 and 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 provisions 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 and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information or to file a complaint:

The Eye Clinic Inc.
Privacy Officer
3545 Lincoln Way E. Suite A
Massillon, Ohio 44646
330-837-5191
Toll Free: 1-877-696-6775

The US Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue SW
Washington, D.C. 20201
202-619-0257

Medical History Questionnaire

Name _____ Birth Date _____

Physician referring you _____ Physician Phone _____

Physician Address _____ Date of last exam _____

REVIEW OF SYSTEMS

Please mark all the apply.

Current Symptoms		Past Diagnosis and Medical History	
EYES			
Loss of vision	☐	Burning	☐
Blurred vision	☐	Foreign body sensation	☐
Distorted vision (halos)	☐	Excessive tearing/watering	☐
Loss of side vision	☐	Occasional tearing	☐
Double vision	☐	Glare/Light sensitivity	☐
Dryness	☐	Eye pain or soreness	☐
Mucous discharge	☐	Chronic infection of eye/lid	☐
Redness	☐	Sites, Chalazion	☐
Sandy or gritty feeling	☐	Fluctuating visual acuity	☐
Itching		Tired Eyes	

Ocular surgeries: (list type of surgery, which eye, and date of surgery)

_____

_____

_____

Past surgical history: (list type of surgery and date of surgery)

_____

_____

_____

List all medications currently taken (include dosage)

_____

_____

_____

List any medical or drug allergies

_____

_____

_____

GENERAL

- Fatigue ☐
- Malaise ☐
- Chills ☐
- Fever ☐
- Night Sweats ☐
- Appetite Changes ☐
- Weight Changes ☐
- Weakness ☐

HEENT

- Head injury ☐
- Decreased Hearing ☐
- Tinnitus ☐
- Earache ☐
- Hay Fever ☐
- Sinus Pain ☐
- Stuffiness ☐
- Discharge ☐
- Dry Mouth ☐
- Sore Throat ☐
- Dentures ☐
- Difficulty swallowing ☐

CARDIOVASCULAR

- Angina ☐
- Heart Attack ☐
- High Cholesterol ☐
- High Blood Pressure ☐
- Low Blood Pressure ☐
- Murmur ☐
- MVP ☐
- Thrombophlebitis ☐
- Various Veins ☐

PULMONARY

- COPD ☐
- Wheezing ☐
- Cough ☐
- Hemoptysis ☐
- Asthma ☐
- TB ☐
- SOB ☐

GENERAL

- Fatigue ☐
- Malaise ☐
- Chills ☐
- Fever ☐
- Night Sweats ☐
- Appetite Changes ☐
- Weight Changes ☐
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HEENT

- Head injury ☐
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- Earache ☐
- Hay Fever ☐
- Sinus Pain ☐
- Stuffiness ☐
- Discharge ☐
- Dry Mouth ☐
- Sore Throat ☐
- Dentures ☐
- Difficulty swallowing ☐

CARDIOVASCULAR

- Angina ☐
- Heart Attack ☐
- High Cholesterol ☐
- High Blood Pressure ☐
- Low Blood Pressure ☐
- Murmur ☐
- MVP ☐
- Thrombophlebitis ☐
- Various Veins ☐

PULMONARY

- COPD ☐
- Wheezing ☐
- Cough ☐
- Hemoptysis ☐
- Asthma ☐
- TB ☐
- SOB ☐

DERMATOLOGICAL		DERMATOLOGICAL	
Rash	☐	Rosacea	☐
Lumps	☐	Dermatitis	☐
Itching	☐	Psoriasis	☐
Dryness	☐		
GASTROINTESTINAL		**GASTROINTESTINAL**	
Diarrhea	☐	N/V	☐
Constipation	☐	Diarrhea	☐
Stool Changes	☐	Constipation	☐
Hemorrhoids	☐	Stool Changes	☐
Indigestion	☐	Hemorrhoids	☐
Difficulty with Swallowing	☐	Indigestion	☐
Acid Reflux	☐	GERD	☐
GENITOURINARY		**GENITOURINARY**	
Blood	☐	Blood	☐
BPH	☐	BPH	☐
Difficult Urination	☐	Difficult Urination	☐
Enlarged Prostate	☐	Enlarged Prostate	☐
Increased Frequency	☐	Increased Frequency	☐
Frequent UTI's	☐	Frequent UTI's	☐
Incontinence	☐	Incontinence	☐
Kidney Stones	☐	Kidney Stones	☐
ENDOCRINE		**ENDOCRINE**	
Polydipsia	☐	Polydipsia	☐
Nervousness	☐	Nervousness	☐
Diabetes	☐	Diabetes	☐
Hypoglycemia	☐	Hypoglycemia	☐
Goiter	☐	Goiter	☐
Hair Loss	☐	Hair Loss	☐
Heat/COD Intolerance	☐	Heat/COD	☐
Weight Changes	☐	Weight Changes	☐

NEUROLOGICAL		NEUROLOGICAL	
Alzheimer's	☐	Alzheimer's	☐
Dizziness	☐	Dizziness	☐
Epilepsy	☐	Epilepsy	☐
HAs	☐	HAs	☐
Migraines	☐	Migraines	☐
MS	☐	MS	☐
Neuropathy	☐	Neuropathy	☐
Paralysis	☐	Paralysis	☐
Parkinson's Disease	☐	Parkinson's Disease	☐
Seizures	☐	Seizures	☐
Stroke	☐	Stroke	☐
TIAs	☐	TIAs	☐
Tremor	☐	Tremor	☐

PSYCHIATRIC		PSYCHIATRIC	
Depression	☐	Depression	☐
Manic-Depression	☐	Manic-Depression	☐
Mania	☐	Mania	☐
Anxiety	☐	Anxiety	☐
Panic Attacks	☐	Panic Attacks	☐
Past Suicide Attempts	☐	Past Suicide Attempts	☐

HEMATOLOGIC		HEMATOLOGIC	
Easy Bruisibility	☐	Easy Bruisibility	☐
Excessive Bleeding	☐	Excessive Bleeding	☐
Enlarged Lymph Nodes	☐	Enlarged Lymph Nodes	☐
Anemia	☐	Anemia	☐

MUSCULOSKELETAL		MUSCULOSKELETAL	
Arthritis	☐	Arthritis	☐
Swelling	☐	Swelling	☐
Stiffness	☐	Stiffness	☐
Muscle Aches	☐	Muscle Aches	☐
Muscle Weakness	☐	Muscle Weakness	☐
Leg Cramps	☐	Leg Cramps	☐
Back Pain	☐	Back Pain	☐
Joint Pain	☐	Joint Pain	☐

PAST HISTORY

Past or current diseases or problems (include date of onset)

_____

_____

_____

Family History Disease		Relationship to Patient
Blindness	☐	_____
Cataract	☐	_____
Glaucoma	☐	_____
Macular degeneration	☐	_____
Retinal detachment	☐	_____
Arthritis	☐	_____
Cancer	☐	_____
Diabetes	☐	_____
Heart attacks	☐	_____
High blood pressure	☐	_____
Kidney disease	☐	_____
Lupus	☐	_____
Sjogrens Syndrome	☐	_____
Stroke	☐	_____
Thyroid disease	☐	_____
Tuberculosis	☐	_____
Other		_____

SOCIAL HISTORY

Current occupation_____

Do you drive?	YES	☐	NO ☐
Do you have visual difficulty when driving?	YES	☐	NO ☐
Do you have problems with night vision?	YES	☐	NO ☐
Have you ever tried to wear contacts?	YES	☐	NO ☐
Do you currently wear glasses?	YES	☐	NO ☐

If YES, how long have you had the current pair? _____

Do you drink alcohol?	YES	☐	NO ☐

If YES, how many glasses a day? _____

Do you smoke?	YES	☐	NO ☐

If YES, how many packs a day? _____

Have you ever had a blood transfusion?	YES	☐	NO ☐
Have you ever been in intimate contact with a person who had a sexually transmitted disease?	YES	☐	NO ☐

General Information

Thank you for allowing us to participate in your eye care. If you have insurance, we are committed to helping you receive your maximum allowable benefits. We understand that the insurance field can be quite confusing. Our financial policy is provided to assist you in understanding your responsibility to both The Eye Clinic Inc. and your insurance carrier. **Ultimately, all financial liability rests with the patient**. This includes but is not limited to routine vision exam, special testing or procedures such as OCT, HRT, Visual Field, Fundus Photography, Pachymetry, Topography, Ultrasound, Gonioscopy, Punctal Plug Insertion, or External Photos. Our technicians are able to explain any test or procedure that has been scheduled for you.

When you come to The Eye Clinic Inc. for your appointment, you will be asked to provide us with a photo ID and your insurance card. We will scan your insurance card for our records. You will also be asked to verify your address, telephone number, and insurance information. Please bring a full list of your current medications including dosages.

Patient Financial Policy

Refraction and Contact Lens exam & fee: A refraction is the process of determining your best-corrected vision. It is an essential part of an eye examination and is necessary to write a prescription for glasses or contact lenses. Our fee for the refraction is $28.00. The fee for a contact lens evaluation/ fitting may vary due to the complexity of the fitting and type of contact lenses. The refraction and contact lens evaluation/fittings are not a covered benefit by most insurance companies, including Medicare.

Insurance: Your insurance policy is a contract between you and your insurance company. As medical providers, our relationship is with you and not your insurance company. While the filing of insurance claim forms is a courtesy we extend to our patients, any unpaid charges are your responsibility. You are expected to know and follow all regulations as agreed to by you and your insurance company regarding referrals, second opinions or pre-certifications. **Any out of pocket expenses such as co-pays, coinsurance and deductible must be paid at the time of service.** Failure to provide copies of insurance cards may result in denial of your claim, and you will be held responsible for the balance. **If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order for your visit to be covered. If you do not have a valid referral, you will be asked to pay for the visit prior to your examination.**

Supplemental insurance: If you have supplemental insurance, we will send a claim to that company as a courtesy. Your signature on this form authorizes The Eye Clinic Inc. to bill and receive payment from your insurance company.

Worker's Compensation: In order for us to file a claim with Worker's Compensation, you must fill out all required paperwork which is available at our reception desk. We must have adequate information to bill either you MCO or Self-Insured plan. If you do not have this information available when you come in for your appointment, you will be responsible for all charges incurred until we receive this information from you.

Motor Vehicle Accidents: If you are involved in a motor vehicle accident, and you receive treatment from The Eye Clinic Inc., you will be responsible for payment of all charges incurred. We will provide you with a statement which you can turn into your medical or auto insurance carrier for reimbursement
No Insurance: Payment in full is due at the time of service
Methods of payment: We accept cash, check, Visa, MasterCard and Discover
NSF Checks: Any check that does not clear your bank account will result in a $25.00 fee
Refunds: If an overpayment has been made, a refund check will be issued to you. Overpayments for $5.00 or less will be credited to your account.
Statements: If there is a balance on your account after filing your insurance carrier, you will receive a statement. Payment is expected **by the due date** on your statement. If you have any questions regarding your statement, please contact the Billing department immediately. Your account will be considered delinquent after 30 days from your first statement. **Any debt old or new is expected to be satisfied to continue services with The Eye Clinic Inc. Failure to do so may result in dismissal.**

Services rendered to minor/dependent patients: For services rendered to minor patients, the parent(s) or guardian(s) of the minor are responsible for payment.

I have read and understand the financial policy of The Eye Clinic Inc. regarding payments and insurance. I agree to pay for services and tests not covered by my insurance plan. I also understand that I am responsible for following my insurance plan's regulation, policies and procedures. I addition, I understand that my signature authorizes the The Eye Clinic Inc. to discuss my medical or other relevant information with my attending physician or my insurance carrier as needed.

_____

Patient signature/Guarantors Signature

Please state relationship to patient if you are signing on their behalf

_____

Date_____