EATON
EYECARE OF GRANBY

David Eaton Jr., O.D.
16 East Granby Road – Granby, CT 06035
Office: 860-653-3008 Fax: 860-653-0359

MEDICAL HISTORY QUESTIONAIRE

Name:_____ Date of Birth: _____ Date: _____
Address: _____ Primary Phone: _____
_____ Secondary Phone: _____
Email Address: _____ Last Eye Exam Date: _____
Medical Doctor: _____ Dr.'s Phone: _____ Last Medical Exam Date: _____

MEDICAL HISTORY

Do you have allergies to medications? Yes No If yes, please explain: _____
_____

List any medication you take (including oral contraceptives, aspirin, over the counter medications & home remedies):

_____
_____
_____

List all major injuries, surgeries and/or hospitalizations you have had:

_____
_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infection or eye injury: _____
_____

Are you pregnant or nursing? Yes No
Do you wear glasses? Yes No How old is your pair of lenses? _____
Do you wear contacts Yes No How old if your pair of lenses? _____
Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? _____

FAMILY HISTORY

Please check if you have any family history for the following conditions

Disease / Condition	**No**	**Yes**	**Not Sure**	**Relationship to You** (parents, grandparents, siblings, children; living or deceased)
Blindness	☐	☐	☐	
Cataract	☐	☐	☐	
Crossed Eyes	☐	☐	☐	
Glaucoma	☐	☐	☐	
Macular Degeneration	☐	☐	☐	
Retinal Detachment / Disease	☐	☐	☐	
Arthritis	☐	☐	☐	
Cancer	☐	☐	☐	
Diabetes	☐	☐	☐	
Heart Disease	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Lupus	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Other:	☐	☐	☐	

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SOCIAL HISTORY

Do you drive?	Yes	No	
Do you use tobacco?	Yes	No	If yes, type/amount/how long: _____
Do you drink alcohol?	Yes	No	If yes, type/amount/how long: _____
Do you use illegal drugs?	Yes	No	If yes, type/amount/how long: _____

OCULAR HISTORY

- ☐ Allergic Conjunctivitis
- ☐ Blepharitis
- ☐ Cataract
- ☐ Contact Lenses
- ☐ Corneal Dystrophy
- ☐ Diabetic Retinopathy, Background or Proliferative
- ☐ Dry Eyes
- ☐ Glasses
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Macular ERM
- ☐ Narrow Angle
- ☐ Ocular Hypertension
- ☐ Ophthalmic Migraine
- ☐ Pseudoexfoliation
- ☐ Retinal Tear
- ☐ Strabismus
- ☐ PVD
- ☐ Vitreous Floaters

OCULAR SURGERY

- ☐ Blepharoplasty
- ☐ Cataract Surgery
- ☐ Corneal Transplant
- ☐ DSAEK
- ☐ Eye Muscle Surgery
- ☐ Intravitreal Injections
- ☐ LASIK
- ☐ LPI
- ☐ LTP
- ☐ PRK
- ☐ Ptosis Repair
- ☐ Punctal Plugs
- ☐ Strabismus Surgery
- ☐ Retinal Laser
- ☐ Trabeculectomy
- ☐ Tube Shunt
- ☐ Yag Capsulotomy

If there is any other information you would like to share with the doctor, please provide it below.

_____
_____
_____
_____
_____

All information is kept strictly confidential. You, of course may discuss any portion of this form directly with the doctor

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Dr David Eaton Jr., OD and Eaton EyeCare of Granby participates in most Insurance plans. What this participation means is that the office will submit all claims to Insurance(s) you provide us, and they will pay us directly for COVERED SERVICES.

This DOES NOT mean that you will have no financial responsibility to Eaton EyeCare of Granby.

YOU ARE RESPONSIBLE FOR:

DEDUCTIBLES- if your insurance company has any (Medicare is $166/year). If you have met your deductible, you may be responsible for the entire bill.

CO-PAYS- if your insurance company asks for this, it MUST BE PAID AT THE TIME OF THE VISIT, or the visit may need to be rescheduled.

REFRACTION FEE- some insurances cover a REFRACTION, while others do not. You will be responsible for the $42 fee if your insurance doesn't.

REFERRAL FORMS - some insurances require you to get a REFERRAL from your primary care provider.

PROVIDING THE CORRECT/UPDATED INSURANCE INFORMATION-You are responsible to provide us with your updated insurance. If we do not have your correct insurance information, you will be responsible for the entire bill. You will be billed if the claim is unpaid; after four billing cycles the bill will be sent to Collection.

KNOWING IF INSURANCE HAS A SEPARATE VISION RIDER- Some plans do not pay for Routine eye exams. Some need Prior Authorization, and some plans we do not participate in.

MISSED OR CANCELLED APPTS - 24 hours in advance is necessary for cancelling an appointment. A $30.00 charge can be incurred for not complying.

MEDICAL EYE EXAMS VS ROUTINE EYE EXAMS

Your exam will be coded MEDICALLY if you report any symptoms and/or eye problems or are being evaluated/treated for a medical condition, or if the doctor discovers a condition during the exam. An eye exam is considered ROUTINE if you do not report any symptoms and/or medical eye conditions prior to and during your visit and pending the doctor does not discover any conditions.

In order for us to submit all of your claims, we need you to sign the following statement and provide us with **ALL of Your ACCURATE INSURANCE information**. This includes your PRIMARY insurance and your SECONDARY insurance(s).

BENEFICIARY SIGNATURE REQUIREMENTS

I request that payment of any authorized benefits be made on my behalf to Dr. David Eaton, Jr. OD, Eaton EyeCare of Granby for any services furnished to me by Dr Eaton. There are additional fees for contact lenses, such as fittings and checkups. I authorize any holder of my medical information about me to determine these benefits or benefits payable for related services.

PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____

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HIPPA PATIENT CALLING INFORMATION

NAME: _____ DATE OF BIRTH: _____

How may we contact you?

Home Phone: _____	Cell Phone: _____	Work Phone: _____
___ DO NOT leave message	___ DO NOT leave message	___ DO NOT leave message
___ Leave a brief message	___ Leave a brief message	___ Leave a brief message
___ Leave a detailed message	___ Leave a detailed message	___ Leave a detailed message

With whom do you allow us to share your personal medical information?

Primary Care Physician: _____ Phone: _____

Name: _____ Relationship: _____

Phone Number(s): _____

Name: _____ Relationship: _____

Phone Number(s): _____

Regarding Appointment Confirmation Only

As a service to our patients, Eaton EyeCare confirms appointments one day in advance.

In the event the call is not answered, a message is left with the date, time and provider name.

____ May call to confirm my appointment ___ DO NOT call to confirm my appointment

I understand it is MY responsibility to notify the offices of any changes in my call information.

Signature_____ Date: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION. AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY. _Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice). We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations mean those administrative and managerial functions that we must carry out in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA;
- [specify other uses and disclosures affected by state law] .

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Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for healthcare prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

- Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization.
- You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.
- We will obtain your written authorization for uses and disclosures of your health information that are not identified in this notice or are not otherwise permitted by applicable law.
- We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health. care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health mformat1on as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. For any of the requests listed please send a written request to us at the address below. You have the right:

- To request restrictions on the health information we may use and disclose for treatment, payment and healthcare operations. <u>We are not required to agree to these requests</u>.
- To receive confidential communications of health information about you in any manner other than described in our authorization request form.. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.
- To inspect or copy your health information. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.
- To amend health information. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You must give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request We may also deny your request if the health information: was not created by us, unless the person that created the information is no longer available to make the amendment, or is not part of the health information kept by or for us,
- To receive an accounting of disclosures of your health information. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive. no longer than 6 years prior to the date. 'of your request. Your request must state how you would like to receive the report (paper, electronically)
- To designate another party to receive your health information. If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must clearly identify the designated recipient and where to send the copy of the health information.

<u>Contact Person:</u>

For all questions, requests or for further information related to the privacy of your health information is:

David Eaton, Jr., DO
16 East Granby Road, Granby, CT 06035
Office: 860-653-3008 Fax: 860-653-0359
davideatonjrod@yahoo.com

<u>Complaints:</u>

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or e-mail shown above. If you prefer, you can discuss your complaint in person or by phone.

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Changes to this notice:

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

Notice Revised and Effective: August 1, 2017

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Eaton EyeCare of Granby, David Eaton, Jr., O.D., Notice of Privacy Practices.

Date: _____ Patient Name: _____ Signature: _____