PATIENT INFORMATION

The mission of Denver Vision is to offer our professional services to fulfill your visual needs with quality products and the knowledge of the importance of painting your vision and healthy of your eyes.

Name (Last, First, M.) __________________________, _________________ ____ Birthdate ___/___/______ Age ______

Last four digits of the patient social security number - ____________

Address ____ City __________________ State __________ Zip ____________

Employer (or school) / Occupation (or grade) _______________________________ / ______________________________

Home phone (____) ______-_________ Cell phone (____) ______-_________ Work phone (____) ______-_________

I would like to receive my appointment reminders via text? Yes / No

Email Address _________________________________ I would like to receive the Denver Vision newsletter? Yes / No

I would also like to receive other health information from Dr. Holtzman? Yes / No

Facebook page? Visit denvervision.org and our Facebook page.

What is the reason for your visit today? __________________________________ Do you want new eye glasses? Yes / No

How were you referred? P.C. Physician Insurance Advertisement Online

Referral Yes / No Who can we thank for referring you. __________________________

Denver Vision provides referral discounts, please talk to an associate for details!

Have there been any changes to the health of you or your family since your last eye exam? (explain)

____

Optional Questions

Gender: Male / Female

Lifestyle Questions

Do you… (circle all that are true)

Work at a computer Think you might benefit from thinner, lighter lenses? Spend time outside

Have an interest in testing the latest contact designs Have prescription sunwear? Have Children

Prefer not to wear your glasses at times? Want information on Lasik Have more than one pair of RX eyewear

Have family members in need of eye care?

Have you ever experienced, been diagnosed or treated for… (circle all that are true)

Blurry vision Cataracts Cross eye/eye turn Eye infections Flash of light Uncomfortable glasses

Itchiness Macular Degeneration Retinal detachment Tearing Glaucoma Headaches

Burning Corneal Abrasions Double vision Eye injury Floaters/spots Grittiness Lazy eye

Iritis/Uveitis Occasional dryness Sunlight sensitivity Trouble seeing at night

Medical History Questions

Primary Physician ______________________________________ City/State _________ Date of last physical __________

Medication allergies? Yes / No If yes, please list ____

List any current medications (RX or over the counter - including eye drops, vitamins, and birth control) _______________

____

Have you had any surgeries? Yes / No If yes, what surgery? ____

Have you ever been diagnosed or treated for any of the following health problems?

Allergies Cholesterol Diabetes Ear/Nose/Throat Cancer Eczema/Rashes

High Blood Pressure Sinus Throat Infections Neurological Thyroid Arthritis

Eye History Questions

Date of last eye exam ____________________ By whom _________________________ City/State _________________

Have you tried contact lenses? Yes / No. Do you currently wear contacts? Yes / No

If yes, what kind? _________________ What contact solution do you use ___________________________________

Are you satisfied with the vision and comfort of your current lenses? Yes / No

Would you prefer clear contact lenses or colored contact lenses? Clear / colored

If you wear bifocals, do the lines or head tilting bother you? Yes / No / Don't wear bifocals

Family Medical/Eye History (Circle all that apply)

Blindness Cataracts Corneal Problems Diabetes Glaucoma Heart Disease Lazy Eye

Macular Degeneration Retinal Problems

Other ____

To my knowledge, all of the information provided is accurate.

Sign ____ Date ______________________________

Insurance Information

PLEASE NOTE INSURANCE DOES NOT COVER THE CONTACT LENS FOLLOW-UP EVALUATION

Name of Insurance Company_________________________ Name of Insured __________________________________

Patient's relationship to the Insured __________________________ Insured Telephone Number (____) _____-_______

Insured's Social Security Number ___________-_________-___________ Group/ Policy Number ________________

Insured's Date of Birth _______________________________ Do you participate in a flex spending account? Yes / No

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

(Must be age 18 or older)

How would you like to pay today? Cash / Check / Credit Card

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company **not Denver Vision**. If your insurance company has not reimbursed our offices in full within 60 days, your credit card will be utilized and your insurance company will then pay you directly (if by mistake your insurance company sends the payment to us, we will of course sign over and forward the check to you).

If information is different then above, please fill out the following

Name (Last, First, M) _____________________, _______________, ___ Social Security Number ______-____-______

Address ____

I authorize medical benefits to the named provider. I understand that I am financially responsible for charges not covered by this authorization. I agree to pay all non-covered fees incurred within 60 days or my account may incur interest at the rate of 18% ANNUAL PERCENTAGE RATE. I further agree to pay all costs including actual attorney fees incurred for collection of my account.

Signed____ Date ___________________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU MAY GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

We respect our legal obligation to keep healthy information that identifies you private. We are obligated by law to give you notice of our privacy practice. This notice describes how we protect your health information and what rights you have regarding it. Unless you object, we will also share relevant information about your care with your family or friends that are helping you with your eye care.

The most common reason why we use your health care information is for treatment, payment, or health care operations. Examples for treatment are appointments, testing or examining your eyes, referring you to another doctor. Examples for payment are piling insurance, collecting unpaid amounts (either ourselves or through a collection agency or attorney). Examples of health care operation are financial or billing audits, personal decisions, defense of legal matters.

We routinely use your healthy information inside our office for these purposes without any special permissions. If we need to disclose your health information outside our offices for these reasons, we usually will not ask you for written permission.

In some limited situations, the law allows or requires us to use or disclose your health information without permission:

1. When a state or federal law mandates that certain health information be reported for a specific purpose.
2. For public purposes, such as contagious disease reporting, investigation or surveillance.
3. Disclosure to government authorities about victims of suspected abuse, neglect, or domestic violence.
4. Use or disclosure for health-related research, de-identified information, information relating to workers compensation programs, limited data set for research, publish health, health care operations, business associates who perform health care operations for us and who commit to respect the privacy of your health.

We may call or write to remind you of scheduled appointments, or when it is time for your routine appointment. Unless you tell us otherwise, we will mail you an appointment card or leave a reminder on your answering machine, or with someone who answers your phone if you are not at home.

We will not make any other uses or disclosures of your health information unless you sign a written authorization form.

The law gives you many rights regarding you health information; you can ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment and health care operations. Please ask us to mailing health information to a different address. We will accommodate these requests if reasonable, and if you pay us for any additional costs. You can get photocopies of your records; we have 30 days to send this information to you unless otherwise noted. As us to amend your healthcare information if you think it is incorrect or incomplete. You may receive additional copies of this Notice of Privacy Practices upon request.

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by the law.

If you think we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office of 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, or you can discuss your complaint in person or by phone.

I acknowledge that I have read and understand the term and conditions of this agreement

Print Name __________________________________ Sign Name ____ Date ___________________