Eye Brain Connection

CONFIDENTIAL CASE HISTORY

(PLEASE PRINT LEGIBLY)

Name: _____ Sex: Female or Male Date: _____

Street: _____ City/State/Zip: _____

Phone: C: (___)_____ H: (___)_____ W: (___)_____

Email: _____

Would you like to receive our monthly email on health and vision? ___Yes ___No

DOB: _____ Age: _____ Ht:_____ Wt:_____ Blood Type: O A B AB

Marital Status: M D S W

Emergency Contact/ # _____

Partner's Name_____

Children's' Name/Ages: _____

Occupation: _____

Occupational Stressors (Chemical, Physical, Structural, Psych): _____

List all know Allergies:

_____

_____

Recent Exams (give dates): Physical _____ Eye _____

Dental _____ Ob/Gyn _____ Specialist _____

Referred to our office by? _____

Do you have health insurance? ___ Yes ___No If yes, who is the carrier? _____

Please list your visual concerns in your order of importance:

1._____ 4._____

2._____ 5._____

3._____ 6._____

Name: _____

Please list major health concerns in your order of importance:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

List ALL medications (prescriptions and over-the-counter) you take. (Use additional pages if necessary.)

Name of Prescription/OTC	Dosage	How long have you taken this and for what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____

List ALL nutritional supplements you now take. (Use additional pages if necessary.)

Name of Supplements	Dosage	How long have you taken this and for what condition?
_____	_____	_____
_____	_____	_____
_____	_____	_____

List ALL prior surgeries, hospitalizations, injuries, fractures, dislocations, and illnesses.

Doctor Name	Date	Treatments / Procedures	Results
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____
_____	____/____/____	_____	_____

Please check all of the following conditions you have experienced in your lifetime.

☐ Cancer	☐ Stroke	☐ Mumps	☐ Measles	☐ Kidney infection	☐ Goiter
☐ Hepatitis	☐ Diabetes	☐ Anemia	☐ Ulcers	☐ ADD/ADHD	☐ Heart disease
☐ Pneumonia	☐ Alcoholism	☐ Chicken Pox	☐ Gout	☐ Depression	☐ Chronic Fatigue
☐ Seizures	☐ Asthma	☐ Fibromyalgia	☐ Appendicitis	☐ Thyroid disease	☐ Parkinson's
☐ Epilepsy	☐ Allergies	☐ Alzheimer's	☐ MS	☐ Gall Bladder Inflammation	

Please check all of the following conditions your family has experienced.

Father:	☐ Cancer	☐ Stroke	☐ Heart Disease	☐ Diabetes	☐ Parkinson's	☐ Alzheimer's	☐ MS
Mother:	☐ Cancer	☐ Stroke	☐ Heart Disease	☐ Diabetes	☐ Parkinson's	☐ Alzheimer's	☐ MS
Sisters:	☐ Cancer	☐ Stroke	☐ Heart Disease	☐ Diabetes	☐ Parkinson's	☐ Alzheimer's	☐ MS
Brothers:	☐ Cancer	☐ Stroke	☐ Heart Disease	☐ Diabetes	☐ Parkinson's	☐ Alzheimer's	☐ MS
Grandmother (M):	☐ Cancer	☐ Stroke	☐ Heart Disease	☐ Diabetes	☐ Parkinson's	☐ Alzheimer's	☐ MS
Grandfather (M):	☐ Cancer	☐ Stroke	☐ Heart Disease	☐ Diabetes	☐ Parkinson's	☐ Alzheimer's	☐ MS
Grandmother (P):	☐ Cancer	☐ Stroke	☐ Heart Disease	☐ Diabetes	☐ Parkinson's	☐ Alzheimer's	☐ MS

Name: _____

Grandfather (P): ☐ Cancer ☐ Stroke ☐ Heart Disease ☐ Diabetes ☐ Parkinson's ☐ Alzheimer's ☐ MS

List any other health concerns not listed:

_____
_____
_____
_____
_____
_____

INFORMED CONSENT

Informed Consent to Examination and Treatment

I hereby request and consent to the performance of examination, and any other procedures, including, but not limited to, diagnostic tests, blood testing, salivary testing, and/or neurological therapy techniques, on me, my child, or the person named below for which I am legally responsible, which are recommended by Dr. Terence A. Trinka and/or other licensed doctors of optometry who now, or in the future, render treatment to me while employed by, working for, associated with, or serving as an on-call doctor for Eye- Brain Connection.

1. I hereby authorize Dr. Trinka to examine and treat my conditions as he deems appropriate with optometric and functional healthcare, and I give authority for performance of these procedures.
2. Dr. Trinka and the Eye Brain Connection will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

I affirm that I am not currently pregnant or trying to become pregnant. Should this condition change, I will notify Dr. Trinka and/or their staff as soon as possible.
Initials_____ Date of last Menstrual Period _____/_____/_____

☐☐**I have read** or ☐☐**I have had read to me** the above explanation of the functional health care and optometric treatments. By signing below, I state that I have weighed the risks involved in undergoing optometric treatments and functional healthcare and have decided that it is in my best interest to undergo the optometric and functional healthcare treatment recommended. Having been informed of the risks, I hereby give my consent for optometric treatment and functional healthcare treatment. I understand results are not guaranteed.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I understand the information above and guarantee all forms were completed correctly and to the best of my knowledge. I further understand it is my responsibility to inform this office of any changes in my medical status.

_____ _____/_____/_____
Signature of Patient Date

_____ _____
Signature of Patient's Representative (if minor or physically incapacitated) Relationship to Patient

Name: _____

FINANCIAL POLICY

I understand that the policy of Eye Brain Connection requires payment in full for all services rendered at the time of my office visit, unless other arrangements have been made. If my account has not been paid within 30 days from the date of service and no financial arrangements have been made, I will be responsible for any expenses incurred in the collection of my account. **Initial**_____

I understand and agree that health and accident insurance are an arrangement between my insurance carrier and me. I authorize Eye Brain Connection to release any information required to process insurance claims. However, I clearly understand and agree that all services rendered are charged directly to me, and that I am ultimately responsible for payment of my account. **Initial**_____

I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will become immediately due and payable. **Initial**_____

I understand that regardless of my payment method, any nutritional supplements, supplies, equipment, or educational materials I purchase must be paid for in full. These items will not be charged to my account and there is no refund on opened or used products. Unopened or unused products may be returned for a credit within 6 months.**Initial**_____

Any outstanding balances that are my responsibility will be billed to me, and will be due in full within 15 days from the date of the billing notice. Any accounts that become 45 days delinquent will be subject to a finance charge of 1.75% per month (21% APR). Any accounts that become more than 60 days delinquent will be referred for assignment to our collection agency. All additional charges equal to the cost of collection including agency and attorney fees and court costs incurred and permitted by laws governing these transactions will be added to the amount due. **Initial**_____

If your check is not paid on presentment, you agree to pay a charge of $20, or any higher amount allowed by law. We may electronically debit or draft your account for this charge. Also, if your check is returned for insufficient or uncollected funds, your check may be electronically re-presented for payment. Returned checks are subject to a $30 returned check fee in addition to any other bank fees accrued by this office in the collection of funds. **Initial**_____

There will be a missed appointment fee of $75 should you fail to provide this office with at least one (1) day advance notice of cancellation or to reschedule. **Initial**_____

I also understand that if this is a personal injury or auto accident case, my charges are not contingent based on my settlement. (See **'Personal Injury Financial Policy'** on next page) **Initial**_____

_____ _____/_____/_____
Signature of Patient Date

_____ _____
Signature of Patient's Representative (if minor or physically incapacitated) Relationship to Patient

Name: _____

Health Insurance Portability and Accountability Act (HIPAA)
PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT
AND HEALTHCARE OPERATIONS

I, (Print Name) _____, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected healthcare information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice would be available to me at any time in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice before signing this Consent, and has encouraged me to read the Privacy Notice carefully before my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning and leaving a message on my voice mail or with the individual answering the phone. I also understand my name may be viewed on a sign-in sheet, referral board, and/or clinic newsletter and may be called when the doctor is ready to see you.
4. The Practice may use and/or disclose my PHI (which includes information about my heath or condition and the treatment provided to me) in order for the practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations. This includes contacting my general physician, any specialists, and/or any other practitioners I have seen.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read, and understand, the foregoing notice and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____/_____/_____

Signature of Patient Date

_____ _____

Signature of Patient's Representative Relationship to Patient (if minor or physically incapacitated)