4895 State Route 52
Jeffersonville, NY 12748

T: 845-482-2425
F: 845-482-2430

Annual Patient History Form

*We ask that all our patients complete this form **annually** to keep our files up to date.*
Please return to front desk or any staff member prior to your visit with the doctor.

Today's Date: _____ Full Name: _____ Birthday: _____

Cell: _____ Home or Work: _____ Email: _____

Emergency Contact Name: _____ Number: _____

What is the reason for your visit today?

ANNUAL EYE EXAM ☐ CONTACT LENS EXAM ☐ FOLLOW UP ☐ EMERGENCY ☐

Today I would like to:

ORDER GLASSES ☐ ORDER CONTACTS ☐ GET A COPY OF MY RX ☐ NONE OF THESE ☐

Do you have any of the following eye conditions? (CHECK ALL THAT APPLY)

FLOATERS ☐ DOUBLE VISION ☐ BLURRED VISION ☐ DRY EYES ☐ MACULAR DEGENERATION ☐

GLAUCOMA ☐ LAZY EYE ☐ ALLERGY EYES ☐ LASIK ☐ RETINAL PROBLEM ☐

OTHER/EXPLAIN:

NONE ☐

Do you have a family history of eye conditions? (CHECK ALL THAT APPLY)

GLAUCOMA ☐ MACULAR DEGENERATION ☐ RETINAL DETACHMENT ☐ BLINDNESS ☐ LAZY EYES ☐

OTHER/EXPLAIN:

NONE ☐

PLEASE TURN THE PAGE TO COMPLETE THE FORM →

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DO YOU HAVE ANY ALLERGIES TO MEDICATIONS: YES ☐ or NO ☐

IF YES, PLEASE LIST:

DO YOU TAKE ANY PRESCRIPTION MEDICATIONS: YES ☐ or NO ☐

IF YES, PLEASE LIST:

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS:(CHECK ALL THAT APPLY)

HIGH BLOOD PRESSURE ☐	DIABETES ☐	HIGH CHOLESTEROL ☐	COPD ☐
HEART DISEASE ☐	STROKE ☐	THYROID DISEASE ☐	CANCER ☐
AUTO-IMMUNE DISEASE ☐	MIGRAINE ☐	MULTIPLE SCLEROSIS ☐	PSYCHIATRIC ☐
OTHER/EXPLAIN:			NONE ☐

MISCELLANEOUS

MEDICAL INSURANCE: _____ PREVIOUS EYE DR: _____

LAST EYE EXAM: _____ PRIMARY CARE DR: _____

PHARMACY: _____

OCCUPATION PAST OR PRESENT: _____

ANY SPECIFIC VISUAL NEEDS: _____

HIPAA AGREEMENT, PATIENT REPONSIBILITIES, INSURANCE SIGNATURE AND CONSENTS

HIPAA

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 is available in the office. Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services at www.hhs.gov

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 information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care.
2. 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.
3. 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.
4. 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.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. 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.

MEDICAL SERVICES

Medical insurance helps cover the treatment and management of eye diseases and screening for eye diseases if you have certain systemic conditions (such as diabetes or hypertension). If your insurance determines that a medical service is not covered, you will assume full responsibility for the service(s). We will bill your insurance plan for services and products if we are a participating provider. We make every attempt to obtain advanced authorization of your benefits before services are rendered. We do need information from you to obtain insurance authorization. You will be financially responsible if there are fees not paid for by your insurance plan such as deductibles, co-pays, and non-covered services. A "refraction" or determination of glasses prescription is not covered by medical insurance and will be charged separately. All services are non-refundable.

COPAYS

I understand that I am responsible to pay all co-payments in full at the time of service. Co-payments cannot be waived at any time by the provider of service or by Eyes on Main St. Optometry.

DEDUCTIBLES

If my insurance determines that I have not met my deductible, I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by my insurance and/or provider. Yearly deductibles cannot be waived at any time by Eyes on Main St. Optometry.

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I understand that I am responsible for 100% of all professional fees rendered on the date of service. I understand that I am also required to make payment for at least 50% of materials at the time materials are ordered. If I am supplying my own frame, I understand that many plastic and metal products may weaken over time and I will not hold Eyes on Main St. Optometry responsible for

accidental laboratory breakage. If I do not pick up my materials within 60 days from my initial order, my materials will be returned to the laboratory, and my initial deposit will not be refunded. If I am to receive contact lenses by mail, I understand that I am required to pay in full at time of service. If I am fit for contacts, I understand that contact lens prescriptions are kept on file and I hereby consent to email delivery of my contact lens prescription upon request.

WARRANTIES

Our Patient Satisfaction Guarantee applies to all single vision, bifocals and progressive lenses. We use only premium single vision optics and premium progressive addition lenses. We will remake non-adapt progressive, bifocal or single vision lenses **one time**, in the same frame. If a patient cannot adapt to a progressive lens, we will replace it with a lined bifocal or a single vision lens, in the same frame. While we make every attempt to solve these rare issues, no refunds will be given in a case where a patient does not adapt to a progressive, bifocal or single vision lens. Patients have 60 days from the date of the order to report any issues with the prescription. After 60 days, there cannot be any remake of lenses. All lenses purchased in polycarbonate with scratch coating and/or any premium anti-reflective coatings are warrantied for ONE year against scratches and/or damage from the date of purchase. There is a $50 fee to activate the lens warranty. All frames purchased in our office are warrantied for 1 year against breakage due to manufactures defects. There is a $50 fee to activate the frame warranty. Lenses and frames are only warrantied for ONE time replacement within one year from the date of purchase. If lenses and frames are being warrantied at the same time, the customer is responsible for activating both warranties for $100.

OPTOMAP RETINAL PHOTOGRAPHY & REFRACTION SERVICES

We are proud to offer the newest Optomap Wide Field Retinal Imaging as a service to our patients. We believe that prevention is key by offering cutting-edge eye care technology to ensure our patients maintain a lifetime of superior vision and eye health. The wide field digital retinal photo is taken as part of your pre-testing evaluation before you see the doctor, and takes less than 2 minutes to complete. To ensure our patients achieve their best vision possible, our office requires this screening and a refraction annually for all patients. These services cannot be opted-out of, as they are part of our comprehensive examination.

*As dictated by medical insurance company policies, the refraction and retinal screening photos are **not** covered by insurance. All insured patients will be required to pay the $60 fee for these services in addition to their copay or deductible.*

My signature below acknowledges that:

- *I consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes in office policy.*
- *I agree to the terms and conditions of the office policies listed above, and I authorized Eyes on Main St. to share my information with my insurance providers. I understand that this consent shall remain in force from this time forward.*
- *I understand I will be getting Optomap Retinal Imaging and a Refraction as part of my annual eye exam.*

PRINT NAME: _____ **DATE:**_____

SIGNATURE: _____