

Welcome To Bluebonnet Vision Associates

Last Name	First Name	Date	Last 4 of SSN
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Home phone	Cell phone	Email
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Address	City	State	Zip
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Employer	Occupation	Birth Date / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
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Vision Insurance Company	Vision Insurance Member ID	Primary Insured
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Medical Insurance Company	Medical Insurance Member ID	Primary Insured
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How Did You Hear About Us? <input type="checkbox"/> Insurance Network <input type="checkbox"/> Facebook <input type="checkbox"/> Google <input type="checkbox"/> Referral <input type="checkbox"/> Other:	Date of Last Eye Examination / /
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Primary Care Physician Name, Practice name/address & Phone number

Reason For Visit

<input type="checkbox"/> Yearly Exam	<input type="checkbox"/> Eyes Itch	<input type="checkbox"/> Headaches
<input type="checkbox"/> New Glasses	<input type="checkbox"/> Eyes Water	<input type="checkbox"/> Droopy Eyelid
<input type="checkbox"/> New Contacts	<input type="checkbox"/> Eyes Feel Dry	<input type="checkbox"/> Flashes/Floaters
<input type="checkbox"/> Soft	<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Double Vision
<input type="checkbox"/> Daily <input type="checkbox"/> 2 wk <input type="checkbox"/> Monthly	<input type="checkbox"/> Eye Strain	<input type="checkbox"/> Sensitivity to Light
<input type="checkbox"/> RGP	<input type="checkbox"/> Eyes Burn	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Scleral	<input type="checkbox"/> Eyes Feel Tired	

Personal Medical History

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cancer	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Lasik/PRK Surgery
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Eye Injuries
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Thyroid	<input type="checkbox"/> "Lazy Eye"	<input type="checkbox"/> Retinal Problems
<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Refractive surgery	<input type="checkbox"/> Other: _____
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Blindness	<input type="checkbox"/> Cataract Surgery	

Family Medical History – (circle M for mother, F for Father, S for Sibling)

<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Retinal Detachment	<input type="checkbox"/> Blindness	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer
<input type="checkbox"/> Cataracts	<input type="checkbox"/> High Blood Press.	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Other: _____

Social History

Do you drink? No Yes 1/ day 2-3/wk More

Do you Smoke? No Yes 1-5/day 1 pack/day More

Are You Pregnant? No Yes, months _____

Hobbies: _____

Sports: _____

Computer: How many hours a day? _____

Current Medications, include over-the-counter vitamins

Allergies to Medications Yes No

Allergies to Contact Solution:
 No Yes, please list

Digital Retinal Photography/Screening

As part of your eye exam, the doctor recommends retinal photography for all patients. Using a highly sophisticated camera, we are able to obtain a digital photograph of the back of your eye (retina) which provides the doctor with a more detailed view of the retina as compared to traditional methods.

Retinal imaging assists the doctor to more readily detect diseases such as diabetes, hypertension, glaucoma, retinal detachments, and tumors which can result in vision loss. This is an important test and is strongly recommended for patients with a personal/family history of eye diseases such as glaucoma or macular degeneration as well as diabetes and hypertension.

Additionally, this photo provides additional documentation that becomes part of your record and can be compared yearly to monitor any subtle changes that may occur in the retina. Like yearly x-rays at the dentist or blood work at your yearly physical, a retinal photo provides the doctor with important information regarding your ocular health today.

It is important to note that retinal imaging is not a substitute for dilation.

The procedure is fast, painless, requires no direct contact, and there are no unwanted side effects like blurry vision. The doctor will review your photo with you and answer any questions you may have.

The cost of this procedure is \$39 and is not usually covered by most insurance plans.

Yes, I consent to retinal photos today.

No, I decline retinal photos today and understand the importance of this test.

Patient Signature _____

Date: _____

Informed Consent for the Dilation of the Eyes

Pupil dilation is an important component of every comprehensive eye examination. It provides the most adequate view of the inside of your eye and allows your doctor to rule out internal eye problems and diseases including glaucoma, macular degeneration, and cataracts. Additionally, systemic conditions such as high blood pressure and diabetes can be detected during thorough evaluation of the eye.

Dilation involves administering a series of drops into your eyes, followed by a waiting period of at least 20 minutes. Your doctor will examine your eyes using different instruments. The side effects of the drops include short term blurring of your near vision and increased sensitivity to lights, causing some difficulty as it relates to vision while working and/or driving. These effects may last 4-6 hours

Please initial one of the lines below:

_____ I consent to dilation.

_____ I would like to **reschedule** the dilation. There is no additional fee if you return for dilation completion within 30 days.

_____ I would like to **refuse** dilation. I understand that my refusal of dilation limits the doctor’s ability to detect certain eye and medical conditions. I understand that I am releasing Dr. Tomeff and Associates from any liability from not having a complete dilated exam and I agree to hold the practice harmless as a result of my actions.

FINANCIAL RESPONSIBILITY

I agree to be responsible for payment of all services rendered on my behalf or my dependents. Payment is due in full at the time services are rendered. Professional fees are nonrefundable.

Signature:

(If minor, guardian signature)

The exam fee includes prescription rechecks for a period of 90 days from today’s date. There will be an office visit fee assessed (minimum of \$45) after this time.

SIGNATURE ON FILE AUTHORIZATION

Statement to permit payment of any health insurance or vision plan benefits to supplier, physician or patient.

I understand and agree that I am responsible for the payment of any and all charges incurred as a result of this or any subsequent office visit(s).

I understand and agree to accept responsibility for payment of all claims should my insurance carrier deny all or part of a claim.

I understand and agree that all insurance deductibles and any incurred expenses not covered by the insured’s health carrier must be paid for at the time of service.

I hereby authorize payment directly to Dr. Tamatha Tomeff and/or Bluebonnet Vision Associates for any services rendered to me at their location.

I authorize the release of all medical information to the insured’s health insurance carrier that is:

- 1) Acquired during my examination and
- 2) Which may have a bearing on the benefits payable under this or any other plan that provides benefits or services.

I authorize Dr. Tamatha Tomeff, or any of her authorized agents, to assist me in obtaining payment from my health insurance companies.

I authorize a copy of this “signature on file” form to be used in place of the original and that this copy may be used on all my insurance submissions.

Signature:

(If minor, guardian signature)

Date:

AUTHORIZATION TO SEND TEXT MESSAGES

By signing this form, I authorize Bluebonnet Vision Associates to send text messages to my cell phone informing me of important information related to my appointments, eyewear purchases and trial lenses.

I understand that standard text messaging rates may apply to any messages received from Bluebonnet Vision Associates. I also understand that I, or Bluebonnet Vision Associates may revoke this permission in writing at any time. I agree not to hold Bluebonnet Vision Associates liable for any electronic messaging charges or fees generated by this service. I further agree that in the event my cell phone number and/or cell provider changes I will inform the applicable department at Bluebonnet Vision Associates.

You are not required to authorize the use of text messaging and a decision not to sign this authorization will not affect your health care in any way. If you prefer not to authorize the use of text messaging, we will continue to use U.S. Mail, telephone and email to communicate with you.

I accept and **DO** want to receive text messages.

I decline and **DO NOT** want to receive text messages currently.

This authorization will remain in effect until revoked in writing by me.

Name: _____

Cell Phone Number: _____

CONTACT LENS FITTING POLICY

If you are requesting a contact lens prescription, our office provides a contact lens evaluation, fitting, and follow-up in order to determine your contact lens prescription. Our office **does not** release the contact lens prescription until you have been successfully evaluated and fitted. The evaluation fee includes contact lens follow-up care for a period of 90 days from today's date. A full exam fee will apply after 90 days. If you require treatment for any medical condition during the fitting period, additional charges apply. Professional services are nonrefundable. It is the patient's responsibility to return to the office for contact lens follow-up care as indicated by the doctor. In the State of Texas contact lens prescriptions are valid for one year per the doctor's professional judgement.

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. If you have any questions please contact our office.

Bluebonnet Vision Associates is required by law to:

- Maintain the privacy of your protected health information;
- Give you this notice of our duties and privacy practices regarding health information about you;
- Follow the terms of our notice that is currently in effect.

HOW Bluebonnet Vision Associates MAY USE AND DISCLOSE YOUR HEALTH INFORMATION:

Described as follows are the ways Bluebonnet Vision Associates may use and disclose health information that identifies you (Health Information, or PHI). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to us and stating that you wish to revoke permission you previously gave us.

Treatment. Bluebonnet Vision Associates may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care,

Payment. Bluebonnet Vision Associates may use and disclose Health Information so that we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment. However, if you pay for your services yourself (e.g. out-of-pocket and without any third party contribution or billing), we will not disclose Health Information to a health plan if you instruct us to not do so.

Health Care Operations. Bluebonnet Vision Associates may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the care you receive is of the highest quality. Subject to the exception above if you pay for your care yourself, we also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operations.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services, Bluebonnet Vision Associates may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you. We will not, however, send you communications about health-related or non health-related products or services that are subsidized by a third party without your authorization.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, Bluebonnet Vision Associates may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, Bluebonnet Vision Associates may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through an approval process. Even without approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising and Marketing. Health Information may be used for fundraising communications, but you have the right to opt-out of receiving such communications. Except for the exceptions detailed above, uses and disclosures of Health Information for marketing purposes, as well as disclosures that constitute a sale of Health Information, require your authorization if we receive any financial remuneration from a third party in exchange for making the communication, and we must advise you that we are receiving remuneration.

Other Uses. Other uses and disclosures of Health Information not contained in this Notice may be made only with your authorization.

SPECIAL SITUATIONS:

As Required by Law. Bluebonnet Vision Associates will disclose Health Information when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner, This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

YOUR RIGHTS:

You have the following rights regarding Health Information Bluebonnet Vision Associates have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to our office.

Right to Amend. If you feel that the Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our office.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than Treatment, payment and health care operations for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our office.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our office. We are not required to agree to all such requests. If we agree, we will comply with your request unless the information is needed to provide you with emergency

treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing, to our office. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, <https://bluebonnetvision.com/> To obtain a paper copy of this notice please request it in writing.

Right to Electronic Records. You have the right to receive a copy of your electronic health records in electronic form.

Right to Breach Notification. You have the right to be notified if there is a Breach of privacy such that your Health Information is disclosed or used improperly or in an unsecured way.

CHANGES TO THIS NOTICE:

Bluebonnet Vision Associates reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing. You will not be penalized for filing a complaint.

I acknowledge having been provided this Notice. Signed: _____