299 Carew Street, Suite 201
Springfield, MA 01104
(413)736-1833

382 North Main Street, Suite 101
East Longmeadow, MA 01028
(413)525-8601

PERSONAL / MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Sex: □ Male □ Female Date of Birth: ____/____/_____

SS#: _____-_____-_____ Age: _____ Marital Status: □ Single □ Married □ Widowed □ Divorced

Address: _____ City _____ State_____ Zip_____

Home Phone: (_____) _____-_____ Cell: (_____) _____-_____ Email: _____

Employer: _____ Occupation: _____ Driving □ Yes □ No

Emergency Contact Name: _____ Phone: (____) _____-_____ Relation: _____

Primary Care Physician: _____Referring /Specialty Dr._____

Pharmacy:_____ Location(street & city) _____

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White □ Other _____

Ethnicity: □ Hispanic □ Not Hispanic

Preferred Language: □ English □ French □ Italian □ Japanese □ Portuguese
□ Russian □ Spanish □ Vietnamese □ Polish □ Other _____

My Medical Information may be shared with: _____ Relation: _____ DOB: ____/____/_____

Insurance Information:

Who carries insurance: _____ Relation: _____ S.S. # _____-_____-_____

DOB: ____/____/_____ Name of Insurance Company: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Insurance/Office Polices

Insurance: I request that payments of authorized insurance benefits be made on my behalf directly to Eyesight and Surgery Associates for any service furnished to me by a physician or allied health professional employed by that corporation. I authorize release of any medical information necessary to determine those benefits. I am aware that I will be responsible for money not paid by my insurance, including but not limited to deductibles, co-pays, and uncovered services.

Cancellations: We require that you call our office at least 24 hours prior to your scheduled appointment if you need to cancel or reschedule. If you are more than 15 minutes late for your appointment, we may ask you to reschedule your appointment.

No Show: Our office will confirm your appointment two days prior to your office visit. If you cannot keep your appointment, please notify our office promptly. We reserve the right to charge or dismiss a patient for missed appointments.

Changes and Referrals: Patients are responsible to notify our office of any changes with your address, phone number, or insurance information. You are responsible for obtaining your insurance referrals. If your insurance denies your visit, you will be responsible for unpaid balances.

Prescription Refills: We will only refill prescriptions requests during normal business hours. Prescription refill request after hours will be filled the next business day. Please do not call the on-call physician for prescription refills.

After Hours: Calls received after normal business hours will be referred to the on-call physician. Please limit these calls to emergent situations only. The on-call physician may not be a physician of this practice and will not have access to your patient records.

Returned Checks: We reserve the right to charge any patient for a returned check for any services. There is a $25.00 fee for all returned checks, for each occurrence. Checks that are returned for closed accounts will be reported to the authorities.

Please turn paper over and continue on the other side

I have reviewed the insurance and office policies, and fully understand and agree to the policies as listed.

Signature: _____Relation to Patient: _____ Date: _____/_____/_____

Notice of Privacy Practices: (Notice of Privacy Practices is the last page of this packet)

By signing below, I acknowledge that I have received and reviewed a copy of the "Notice of Privacy Practices" which describes how Eyesight and Surgery Associates may use and disclose my healthcare information and how I can gain access to my information.

Signature: _____Relation to Patient: _____ Date: _____/_____/_____

Refraction Service Fee

One very important part of your eye exam is the refraction. Refraction is performed to determine whether a new glasses prescription or a change to your current glasses will improve your vision. Refraction also provides us with essential medical information as we assess your eyes and look for problems. We will often perform this part of the examination once per year, or sometimes more frequently if necessary. Insurance companies are now distinguishing between medical eye care and vision eye care. Medicare and many other insurance plans DO NOT COVER the cost of refraction.

Our office fee for refraction is $50. If we know your insurance plan covers the refraction charge, we will charge the insurance company for the service. If they deny the claim, you will receive a bill for $50. If your insurance does not cover refractions, we will collect the fee today as you check out. We offer a discount if you pay this fee at the time of service. The cost for refraction with the discount is $45. Please remember that payment for refraction does not include any co-payment your plan may require for the rest of the examination.

Signature: _____Relation to Patient: _____ Date: _____/_____/_____

Information and Consent for Pupil Dilation

Part of the eye examination that we perform in this office includes Pupil Dilation. This is essential for full medical evaluation of the eye. Pupil dilation requires the placement of multiple eye drops. Side effects can last for several hours afterward. Dilation causes an inability to focus on near objects or reading material, which makes close work very difficult for many people.

Very rarely, dilation of the pupils can induce a severe type of glaucoma in people who are susceptible to this problem. We check for signs that you might be predisposed to this type of glaucoma prior to receiving dilation drops. Signs of acute glaucoma include redness, severe pain, nausea, loss of vision. If any of these occur after dilation, you should call the office immediately.

Dilation may cause difficulty driving or operating heavy machinery. These activities should only be done with great caution after dilation. Dilation may also cause some unsteadiness in walking. Please ask for assistance if you feel uncomfortable.

I understand the above issues concerning dilation of the pupils. I give my consent for pupil dilation during any and all of my visits to this office if the doctor feels it is necessary.

Signature: _____Relation to Patient: _____ Date: _____/_____/_____

I <u>refuse dilation</u> knowing that my exam will be less comprehensive. (Sign Below)

Signature: _____Relation to Patient: _____ Date: _____/_____/_____

Please continue on the next page

Medical History

Allergies: Reaction Severity

_____ _____ mild / moderate / severe

_____ _____ mild / moderate / severe

Past Ocular History: (Please mark all that apply)

□ None
□ Overall Healthy □ Cataracts □ Hyperopia (Far sighted) □ Myopia (Near sighted)
□ Amblyopia (Lazy eye) □ Diabetic Retinopathy □ Iritis □ Optic Neuritis
□ Aphakia □ Dry Eyes □ Keratoconus □ Retinal Detachment
□ Astigmatism □ Glaucoma □ Macular Degeneration
Other_____

Ocular Surgeries: (Please mark all that apply)

□ No prior ocular surgery □ Foreign Body Removal □ Punctual Plugs □ Trabeculectomy
□ Blepharoplasty □ Retinal Laser Surgery □ RK (Glaucoma surgery)
□ Cataract Surgery □ LASIK □ Strabismus Surgery □ Vitrectomy
□ Corneal Transplant □ PRK (eye muscle surgery)
Other_____

Ocular Significant Illnesses: (Please mark all that apply)

□ None
□ Overall Healthy □ Herpes □ Hypothyroidism □ Sjogrens
□ AIDS □ HIV Positive □ Lupus □ Graves Disease
□ Diabetes □ Hypertension □ Multiple Sclerosis □ Hyperthyroidism
□ Rheumatoid Arthritis
Other_____

Current Eye Medications: (Please list)

_____

_____

Systemic Illnesses:

□ No history of illnesses □ Congestive Heart Failure □ Hepatitis □ Lung Disease
□ Anemia □ COPD □ High Blood Pressure □ Lupus
□ Arthritis □ Diabetes □ High Cholesterol □ Migraine
□ Arrhythmia □ Eczema □ HIV □ Polymyalgia
□ Asthma □ Fibromyalgia □ Kidney Disease □ Psychiatric Disorder
□ Bleeding Disorder □ Headache □ Kidney Stones □ Skin Cancer
□ Cancer □ Hearing Loss □ Liver Disease □ Stroke
□ Thyroid Disease
Other_____

General Surgeries / Operations: (Please list)

_____

_____

Current Other Medications: (Please list)

_____

_____

Infections: (Please mark all that apply)

□ None
□ Overall Healthy □ Herpes Simplex □ HIV / AIDS □ Syphillis
□ Chicken Pox □ Herpes Zoster / Shingles □ Meningitis □ Toxoplasmosis
□ Hepatitis A / B / C □ Histoplasmosis □ MRSA □ Wound Infection

Other_____

Family History:

□ None
□ Arthritis □ Diabetes □ Kidney Disease □ Stroke
□ Blindness □ Glaucoma □ Lazy Eye □ TB
□ Cancer □ Heart Disease □ Macular Degeneration
□ Cataracts □ High Blood Pressure □ Retinal Disease
□ Other_____

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ current some day smoker □ former smoker □ never smoked

Alcohol Use: □ Yes □ No If yes how much and how often? _____

Drug Use: □ Yes □ No If yes what and how often? _____

Please turn paper over and continue on the other side

Review of Systems: (Please mark all that apply)

Eyes
- □ None
- □ Previous Surgery
- □ Contact Lens
- □ Pain
- □ Double Vision
- □ Glaucoma
- □ Cataracts
- □ Macular Degeneration
- □ Dry Eyes
- □ Flashes
- □ Floaters

Ear, Nose, and Throat
- □ None
- □ Hard of Hearing
- □ Ringing in Ears
- □ Vertigo

Cardiovascular
- □ None
- □ Chest Pain
- □ Dizziness
- □ Fainting Spells
- □ Shortness of Breath
- □ Irregular Heart Beat
- □ Difficulty Lying Flat

Constitutional
- □ None
- □ Fatigue / Weakness
- □ Fever
- □ Weight Gain / Loss

Respiratory
- □ None
- □ Cough
- □ Congestion
- □ Wheezing
- □ Asthma

Gastrointestinal
- □ None
- □ Heartburn
- □ Nausea / Vomiting
- □ Jaundice / Hepatitis

Genito-Urinary
- □ None
- □ Pain / Difficulty
- □ Blood in Urine
- □ History of Kidney Stones
- □ History of STD's

Psychiatric
- □ None
- □ Anxiety / Depression
- □ Mood Swings
- □ Difficulty Sleeping

Endocrine
- □ None
- □ Increased Thirst
- □ Increased Hunger
- □ Increased Urination
- □ Increased Sweating
- □ Fingernail Changes

Blood / Lymphnodes
- □ None
- □ Easy Bruising
- □ Gums Bleed Easy
- □ Prolonged Bleeding
- □ Heavy Aspirin Use

MusculoSkeletal
- □ None
- □ Stiffness
- □ Arthritis
- □ Joint Pain / Swelling

Skin
- □ None
- □ Rash / Sores
- □ Lesions
- □ Hives / Eczema

Neurological
- □ None
- □ Seizures
- □ Weakness / Paralysis
- □ Numbness
- □ Tremors

Immunologic
- □ None
- □ Hives
- □ Itching
- □ Runny Nose
- □ Sinus Pressure

Additional Important Information:

_____
_____
_____
_____
_____
_____
_____

Notice of Privacy Practices

This notice describes how Eyesight and Surgery Associates (ESSA) may use and disclose your healthcare information and how you can obtain access to this information. Please review it carefully. Eyesight and Surgery Associates is required by law to maintain the privacy of your protected health information, either created by this office, or received from another healthcare provider.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. This notice describes those legal duties and privacy practices. ESSA will abide by the terms of this Notice or the Notice currently in effect at the time of the use or disclosure of your protected health information. This notice is prepared in accordance with the Health Insurance Portability and Accountability Act, 45 CFR 164.5.20. ESSA reserves the right to change the terms of this notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice at any time.

Use and Disclosures of Your Protected Health Information not requiring Your Consent
ESSA may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations outlined below. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment may include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes, or home health agencies

For example, ESSA may determine that you require the services of a specialist. In referring you to another doctor, ESSA may share or transfer your healthcare information to that doctor.

Payment activities may include:

- Activities undertaken by ESSA to obtain reimbursement for services provided to you
- Determining your eligibility for benefits or health insurance coverage
- Managing claims and contacting your insurance company regarding payment
- Collection activities to obtain payment for services provided to you
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges
- Obtaining pre-certification and pre-authorization of services to be provided to you

For example, ESSA will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis and services provided to you.

Healthcare operations may include:

- Contacting healthcare providers and patients with information about treatment alternatives
- Conducting quality assessment and improvement activities
- Conducting outcomes evaluation and development of clinical guidelines
- Protocol development, case management, or care coordination
- Conducting or arranging for medical review, legal services, or auditing functions.

For example, ESSA may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

ESSA may contact you, by telephone, mail, or email, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to your family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations with ESSA are permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

As permitted or required by law
In certain circumstances, we may be required to report individual health information to legal authorizes, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence, or certain physical injuries. We are required to report gunshot wounds, or any other wounds to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime.
Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.

For public health activities
We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure.
We may report to the state epidemiologist the name of any persons known to have been significantly exposed to a patient who test positive for HIV
We are required by law to report suspected child abuse, neglect, and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, to the Food and Drug Administration when required by federal law. We may disclose healthcare records, except for HIV test results, for reporting elder abuse or neglect,

provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

For health oversight activities
We may disclose healthcare records, including treatment records, in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring, and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.

Judicial and Administrative Proceedings
Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.

For activities related to death
We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.

To avoid a serious threat to health or safety
We may report a patient's name and other relevant date to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information including, records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.

For workers compensation
We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

ESSA will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorizations at any time, except to the extent that Eyesight and Surgery Associates has taken action in reliance thereon. Any revocation must be in writing.

Your Rights Regarding Your Protected Health Information
You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information from ESSA to carry out treatment, payment, or healthcare operations. You must request such restrictions in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restrictions, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information complied for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. ESSA may deny an access under other circumstances, in which case you have the right to have a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that ESSA, send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that ESSA not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable request by you.

You have the right to request that ESSA amend portions of your healthcare records, as long as we maintain such information. You must submit this request in writing, and under certain circumstances, the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by ESSA, for the six years prior to the date the request, beginning with disclosures made after April 14, 2003. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request and receive a paper copy of this notice, if you had previously received or agreed to receive the Notice electronically.

Any person or patient may file a complaint with, and/ or the Secretary of Health and Human Services if they believe there privacy rights have been violated. To file a complaint with ESSA, please contact the Privacy Officer at the following:

Privacy Officer
Eyesight and Surgery Associates
299 Carew Street
Suite 201
Springfield, MA 01104
(413)736-1833

It is the policy of Eyesight and Surgery Associates that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice of Privacy is effective April 14, 2013.