MEDICAL HISTORY

Name _____ Date _____/_____/_____
Address _____ Phone _____
City_____ State _____ Zip_____ Cell Phone _____
Guardian (if applicable)_____ Email _____
Birthdate _____/_____/_____ Last Eye Exam _____/_____/_____ Occupation _____
Do you have vision insurance? ❒ No ❒Yes If yes, insurance carrier _____
Do you have health insurance? ❒ No ❒Yes If yes, insurance carrier _____
Do you have medicare? ❒ No ❒Yes

Medical History

List medications you take (including oral contraceptives, aspirin, over-the-counter medications, and home remedies)

_____

_____

_____

Check any of the following that you have had: ❒ age-related macular degeneration ❒ inflammatory disorder
❒ cataract ❒ strabismus ❒ kerataconus ❒ amblyopia ❒ glaucoma suspect ❒ glaucoma ❒ surgery
❒ retinal degeneration/hole/detachment ❒ patching ❒ eye injury

Are you pregnant and/or nursing? ❒ No ❒ Yes
Do you wear glasses? ❒ No ❒ Yes If yes, how old is your present pair of lenses? _____
Do you wear contact lenses? ❒ No ❒ Yes If yes, what brand? _____
Type of contact lenses: ❒ Rigid ❒ Soft ❒ Extended Wear ❒ Other Are they comfortable? ❒ No ❒ Yes

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	Yes	No	?	Relationship
Thyroid Disease	❒	❒	❒	_____
Diabetes	❒	❒	❒	_____
Hypertension	❒	❒	❒	_____
Cancer	❒	❒	❒	_____
Strabismus	❒	❒	❒	_____
Cataract	❒	❒	❒	_____
Glaucoma Suspect	❒	❒	❒	_____
Amblyopia	❒	❒	❒	_____
Severe Myopia	❒	❒	❒	_____
Macular Degeneration	❒	❒	❒	_____
Retinal Detachment/Disease	❒	❒	❒	_____
Glaucoma	❒	❒	❒	_____
Severe Hyperopia	❒	❒	❒	_____
Other	❒	❒	❒	_____

Social History – This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❒ Yes, I prefer to discuss my Social History information directly with the doctor.

Do you drive? ❒ No ❒ Yes If yes, do you have visual difficulty when driving? ❒ No ❒ Yes If yes, please describe:

_____

Do you use tobacco products? ❒ No ❒ Yes If yes, type/amount/how long _____
Are you a ❒ Former Smoker ❒ Current Occasional Smoker ❒ Current Everyday Smoker
Do you drink alcohol? ❒ No ❒ Yes If yes, type/amount/how long _____
Do you use illegal drugs? ❒ No ❒ Yes If yes, type/amount/how long _____

– OVER –

Name _____ Date _____/_____/_____

Review of Systems

Do you currently, or have you ever had, any problems in the following areas:

	Yes	No
Eyes		
Itching	❒	❒
Diplopia	❒	❒
Burning	❒	❒
Mattering	❒	❒
Loss of Vision	❒	❒
Photophobia	❒	❒
Red	❒	❒
Floaters	❒	❒
Loss of Sharpness	❒	❒
Flashes	❒	❒
Tearing	❒	❒
Other_____		
Constitutional		
Developmental Disorders	❒	❒
Cancer	❒	❒
Fatigue Syndrome	❒	❒
Other_____		
Ear, Nose, Mouth, Throat		
Sinusitus	❒	❒
Dry Mouth	❒	❒
Hearing Loss	❒	❒
Laryngitis	❒	❒
Other_____		
Neurological		
Epilepsy	❒	❒
Multiple Seizures	❒	❒
Tumor	❒	❒
Cerebral Palsy	❒	❒
Stroke/CVA	❒	❒
Migraine	❒	❒
Other_____		
Psychiatric		
Depression	❒	❒
Bipolar	❒	❒
Anxiety	❒	❒
Attention Deficit	❒	❒
Other_____		
Vascular/Cardiovascular		
Vascular Disease	❒	❒
Stroke	❒	❒
Heart Disease	❒	❒
High Blood Pressure	❒	❒
Congestive Heart Failure	❒	❒
Other_____		
Respiratory		
Cigarette Smoker	❒	❒
Bronchitis	❒	❒
COPD	❒	❒
Emphysema	❒	❒
Asthma	❒	❒

	Yes	No
Respiratory (continued)		
Sleep Apnea	❒	❒
Other_____		
Gastrointestinal		
Celiac Disease	❒	❒
Crohn's Disease	❒	❒
Ulcer	❒	❒
Colitis	❒	❒
Acid Reflux	❒	❒
Other_____		
Genitourinary		
Kidney Disease	❒	❒
STD - Herpetic/Chlamydia	❒	❒
Prostate Disease/Cancer	❒	❒
Pregnant/Nursing	❒	❒
Other_____		
Musculoskeletal		
Arthritis	❒	❒
Ankylosing Spondylitis	❒	❒
Fibromyalgia	❒	❒
Muscular Dystrophy	❒	❒
Osteoarthritis	❒	❒
Gout	❒	❒
Other_____		
Integumentary		
Herpes Simplex/Cold Sores	❒	❒
Herpes Zoster/Shingles	❒	❒
Rosacea	❒	❒
Psoriasis	❒	❒
Eczema	❒	❒
Other_____		
Endocrine		
Diabetes Type II	❒	❒
Thyroid Dysfunction	❒	❒
Hormonal Dysfunction	❒	❒
Diabetes Type I	❒	❒
Other_____		
Hematologic/Lymphatic		
Large Volume Blood Loss	❒	❒
Anemia	❒	❒
Ulcer	❒	❒
High Cholesterol	❒	❒
Other_____		
Allergic/Immunologic		
Environmental Allergies	❒	❒
Lupus	❒	❒
Rheumatoid Arthritis	❒	❒
Drug Allergies	❒	❒
If yes, what drug?_____		
Sjogrens Syndrome	❒	❒
Other_____		

If you answered yes to any of the above, or have a condition not listed, please explain:

_____

_____

_____

Doctor's Signature_____ Date _____/_____/_____

CLEAR LAKE EYE CENTER

Jacqueline S. Brending, O.D. | Rachel Chen, O.D.
17040 Highway 3, Webster, TX 77598
281-338-8474 (voice) 281-338-4795 (fax)

Appointment Time Today: _____ Arrival Time: _____

First Name: _____ Last Name: _____

We are now making greater use of e-mail to communicate with our patients. To help us provide the most prompt service possible, please enter your current e-mail address below:

_____

NOTE: All patient information is kept strictly confidential. Your address is NEVER shared.

If we have something important to tell you or we can't contact you otherwise, would you like a text message sent to your cellular phone?

No _____ Yes ____ Cell Phone: _____

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PATIENT CONSENT FORM

I allow release of medical information to the following: (Please check all that apply)

☐ No one except myself

☐ Spouse: _____

☐ Other: _____

I allow the following person(s) to pick up prescriptions, glasses, and/or contacts on my behalf, with appropriate ID:

_____

_____

Some plans allow use of Internet to check drug formulary benefits. This information may help your physician to prescribe drugs that are preferred on your plan or are less expensive for you. It also helps your physician send your mail-order prescriptions via the Internet.

☐ **I allow use of Internet to check formulary benefits.** (Please check if you consent.)

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my care):
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I also have been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time, and that I may contact you at any time to obtain the most current copy of this notice.

I have read and received a copy of Clear Lake Eye Center's policies.
I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date that I revoke this consent is not affected.

Signed this _____day of _____, 20____.

Print Patient Name: _____. Relationship to Patient: _____.

Signature:_____.

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INSURANCE NOTICE

_____ **Clear Lake Eye Center conveniently accepts most vision insurance carriers and some medical insurance carriers. We provide high quality care and high quality materials; we want the best for you because you mean so much to us. Usually, most insurance carriers have portions of the price of the exam, frame, lens, or contacts that are not covered as part of the benefits. This portion is a co-payment; the total of the co-payment and the plan payment equal the total price for the services you receive. The co-payment is due when the service is ordered.**

_____ **For some services however, your plan pays only a portion of the total cost of the service you receive. For example, you might need to order contacts and the total cost exceeds the amount your plan will cover. The amount that your insurance will not cover is due when the service is ordered.**

_____ **Some services have no plan benefit included in the price. For these services, you must pay in full when the service is ordered.**

_____ **It is your responsibility to make sure your doctor is a contracted provider with your current insurance plan before each visit. Once services have been rendered and payment has been made, we can only provide you with a detailed receipt of your visit. If you discover you have an insurance allowance at a later time, you will need to file for services through your insurance company.**

_____ **By signing this form, you agree that you have read this in full, and that you agree to pay the portion your insurance has mapped out in your plan benefit, your co-pay. You also agree to meet any portion of the final bill that is not covered in your plan. Finally, you agree to pay when the service is offered.**

Primary Insured Name: _____

Primary Insured SSN#: _____

Primary Insured Date of Birth: _____

Patient Name: _____

Patient's Date of Birth: _____

Address: _____

City:_____ State: _____ Zip Code:_____

Home#: _____ Mobile#: _____

Email: _____

Patient Signature:_____

Date: _____

If Minor (Under 18 years)

Guardian Signature: _____

Date: _____

Patient's Relationship to Insured:

Self

Spouse

Child

Other

Employment Status of Patient:

Full Time

Part Time

Student

Retired

Marital Status of Patient:

S M D W

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CANCELLATION POLICY

Thank you for choosing us as you eye care provider. We pride ourselves on being easily accessible. On most days, we offer the availability of same-day appointments for patients that need acute care. This requires a partnership between the doctors and staff at Clear Lake Eye Center and our patients. When patients do not tell us in advance that they are unable to meet their scheduled appointment, other patients are prevented from being seen at that time.

The following is a copy of our cancellation policy. Please read it, ask us any questions you may have, and sign in the space provided. Once the signed document is scanned into your chart, the original will be returned to you.

- Cancellations must be made at least four hours ahead of your appointment time.
- Notification should be made via the 24-hour office voicemail if the cancellation occurs before the start of office hours.
- No claims will be made to insurance companies if the patient is not seen in the office.
- Patients who skip their appointments will be charged $25.00. This is a universal charge that is applied equally to all patients, regardless of their insurance status.
- Patients who cancel their appointment, but fail to provide four hours of advance notice will also be charged $25.00. This is a universal charge that is applied equally to all patients, regardless of their insurance status.
- Payment of this fee will be expected from the patient rather than the insurance company, and must be made before the patient will be scheduled for further appointments.
- Patients who skip appointments or cancel without four hours of notice will also be restricted from rescheduling routine-appointments for a period of two weeks. Acute-care appointments may be allowed to reschedule, at the discretion of the doctor.

I have read and agree to adhere to the Cancellation Policy described above.

_____ _____ _____

Printed Name Date of Birth Date

_____

Signature

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Clear lake Eye Center make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that: **(check one)**

____ **I have read and understood Clear Lake Eye Center's Notice of Privacy Practices and agree to continue my care with Clear Lake Eye Center under those terms.**

_____ I have read and understood Clear Lake Eye Center's Notice of Privacy Practices and do not wish to continue my care with Clear Lake Eye Center under those terms.

_____ The notice of Privacy Practices could not be read due to the emergent nature of the care of other reasons described as:

_____

_____

I have read and understand this form. I am signing it voluntarily. I am aware that I may request a copy of the Notice of Privacy Practices.

_____ _____

Patient Signature **Date**

If You are signing as a personal representative of the patient, please indicate your relationship

_____ _____

Representative Signature **Relationship to Patient**

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NOTICE OF PRIVACY PRACTICES

Mikel Wiseman, Privacy Official

We respect our legal obligation to keep health information that might identify you private. We are obligated by law to provide you with notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reasons we would use or disclose your health information is for treatment, payment, or business operations. We routinely use and disclose your medical information within the office on a daily basis. We do not need specific permission to use or disclose your medical information in the following matters, although you have the right to request that we do not.

Examples of how we might use or disclose health information for treatment purposes might include:
Setting up or changing appointments including leaving messages with those at your home or office who may answer the phone or leaving messages on answering machines, voicemails, or emails; prescribing glasses, contact lenses, or medications as well as relaying this information to suppliers by phone, fax or other electronic means including initial prescriptions and requests from suppliers for refills; notifying you that your ophthalmic goods are ready, including leaving messages with those at your home or office who may answer the phone, or leaving messages on answering machines, voicemails or emails; referring you to another doctor for care not provided by this office; obtaining copies of health information from doctors you have seen before us; discussing your care with you directly or with family or friends you have inferred or agreed may listen to information about your health; sending you postcards or letters or leaving messages with those at your home who may answer the phone or on answering machines, voicemails or emails reminding you it is time for continued care.

Examples of how we might use or disclose health information for payment purposes might include:
Asking about your vision or medical insurance plans or other sources of payment; preparing and sending bills to your insurance provider or to you; providing any information required by third party payors in order to insure payment for services rendered to you; collecting unpaid balances either ourselves or through a collection agency, attorney, or district attorney's office.

Examples of how we might use or disclose health information for business operations might include:
Financial or billing audits; internal quality assurance programs; participation in managed care plans; defense of legal matters; business planning; certain research functions; informing you of products or services offered by our office; compliance with local, state, or federal government agencies request for information; oversight activities such as licensing of our doctors; Medicare or Medicaid audits.

USES AND DISCLOSURES FOR OTHER REASONS NOT NEEDED PERMISSION

In some other limited situations, the law allows us to use or disclose your medical information without your specific permission. Most of these situations will never apply to you but they could.

- When a state or federal law mandates that certain health information be reported for a specific purpose
- For public health reasons, such as reporting of a contagious disease, investigations or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices
- Disclosures to government or law authorities about victims of suspected abuse, neglect, domestic violence, or when someone is or suspected to be a victim of a crime
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of the courts or administrative hearings
- Disclosures to a medical examiner to identify a deceased person or determine cause of death or to funeral directors to aid in burial
- Disclosures to organizations that handle organ or tissue donations
- Uses or disclosures for health related research

- Uses or disclosures to prevent a serious threat to health or safety of an individual or individuals
- Uses or disclosures to aid military purposes or lawful national intelligence activities
- Disclosures of de-identified information
- Disclosures related to workman's compensation claim
- Disclosures of a "limited data set" for research, public health, or health care operations
- Incidental disclosures that are an unavoidable by-product of permitted uses and disclosures
- Disclosures to business associates who perform health care operations for CLEAR LAKE EYE CENTER and who commit to respect the privacy of your information
- Unless you object, disclosure of relevant information to family members or friends who are helping you with your care or by their allowed presence cause us to assume you approve their exposure to relevant information about your health

USES OR DISCLOSURES TO PATIENT REPRESENTATIVES

It is the policy of CLEAR LAKE EYE CENTER for our staff to take phone calls from individuals on a patient's behalf requesting information about making or changing an appointment; the status of eyeglasses, contact lenses, or other optical goods ordered by or for the patient. CLEAR LAKE EYE CENTER staff will also assist individuals on a patient's behalf in the delivery of eyeglasses, contact lenses, or other optical goods. During a telephone or in person contact, every effort will be made to limit the encounter to only the specifics needed to complete the transaction required. No information about the patient's vision or health status may be disclosed without proper patient consent. CLEAR LAKE EYE CENTER staff and doctors will also infer that if you allow another person in an examination or treatment room with you while testing ins performed or discussions held about your vision or health care that you consent to the presence of that individual.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written *Authorization for Release of Identifying Health Information*. The content of this authorization is determined by federal law. The request for signing an authorization may be initiated by CLEAR LAKE EYE CENTER or by you as the patient. We will comply with your request if it is applicable to the federal policies regarding authorizations. If we ask you to sign an authorization, you may decline to do so. If you do not sign the authorization, we may not use or disclose the information we intended to use. If you do elect to sign the authorization, we may revoke it at any time. Revocation requests must be made in writing to the Privacy Officer named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your personal health information.

You may ask us to restrict our uses and disclosures for purposes of treatment (except in emergence care), payment, or business operations. This request must be made in writing to the Privacy Officer named at the beginning of this Notice. We do not have to agree to your request, but if we agree, must honor the restrictions you ask for.
You may ask us to communicate with you in a confidential manner. Examples might be
Only contacting you by telephone at your home or using some special email address. We will accommodate these requests if they are reasonable and if you agree to pay any additional cost, if any, incurred in accommodating your request. Requests for special communication requests must be made to the Privacy Officer named at the beginning of this Notice.

You may ask to review or get copies of your health information. There are very few limited situations in which we may refuse your access to your health information. For the most part we are happy to provide you with the opportunity to either review or obtain a copy of your medical information. All requests for review or copy of medical information must be made in writing to the Privacy Officer named at the beginning of this Notice. While we usually respond to these requests in just a day or so, by law we have fifteen (15) Business days to respond to your request. We may request an additional thirty (30) day extension in certain situations.

You may ask us to amend or change your health care information if you think it is incorrect or incomplete. If we agree, we will make the amendment to your medical record within thirty (30) days of your written request for change sent to the Privacy Officer Named at the beginning of this Notice. We will then send the corrected information to you or any other individual you feel needs a copy of the corrected information. If we do not agree, you will be notified in writing of our decision. You may then write a statement of your position and we will include it in your medical record along with any rebuttal statement we may wish to include.

You may request a list of any non-routine disclosures of your health information that we might have made within the past six (6) years (or shorter period if you wish). Routine disclosures would include those used your treatment, payment, and

business operations of CLEAR LAKE EYE CENTER. These routine disclosures will not be included in your list of disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you must pay for them in advance at a fee of $20.00 per list. We will usually respond to your written request (made to the Privacy Officer named at the beginning of this Notice) within thirty (30) days but we are allowed one thirty (30) day extension if we need the time to complete your request.

You may obtain additional copies of this Notice of Privacy Practices from our business office.

CHANGING OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by these terms of this Notice of Privacy Practices until we choose to change the Notice. We reserve the right to change this Notice at any time. If we change this Notice, the new privacy practices will apply to your existing health information as well as any additional information generated in the future. If we change this Notice, we will post a new Notice in our office.

COMPLAINTS

If you think that anyone at CLEAR LAKE EYE CENTER has not respected the privacy of your health information, you are free to complain to the Privacy Officer named at the beginning of this Notice. We are more than happy to try to resolve any concern you may have in writing or by phone. You may also file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you if you make such a complaint.