First Name: _____ Middle Initial: _____ Last Name: _____
Nickname: _____ Sex: _____ Martial Status: Single | Married | Divorced
SS#: _____ Birth-date: _____
Full Address:_____
Primary #: _____ Cell | Home Secondary #: _____ Cell | Home
Employer: _____ Occupation: _____
E-mail: _____

Vision Insurance: VSP | EYEMED | SPECTERA | NVA | VBA | SVS | ALWAYSCARE | Other: _____
Policy Holder: _____ Policy Holder SS#: _____
Policy Holder Date of Birth: _____ Employer: _____
Relationship To Patient: _____

Medical Insurance: BCBS | CIGNA | UHC | AETNA | MEDICARE | Other: _____
Policy Holder: _____ Policy Holder SS#: _____
Policy Holder Date of Birth: _____ Employer: _____
Relationship To Patient: _____

Other than you, your insurance company, and health care providers involved in your care whom can we talk with about your health care information and/or ***release materials to such as glasses or contacts***?:

Spouse: _____ Telephone #: _____
Parent: _____ Telephone #: _____
Child: _____ Telephone #: _____
Other: _____ Telephone #: _____

**ALL POLICIES BELOW ARE ATTACHED AND SHOULD BE REVIEWED. PLEASE ASK IF YOU WOULD LIKE YOUR OWN COPY.**

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**Payment Policy: Payment in full is expected at the time professional services are rendered and/or materials are ordered. We will always file for insurance payment when applicable. YOU are responsible for knowing your own insurance benefits before your visit. You must also agree to pay for your balance in full if insurance denies your claim. Insurance quote of benefits is NOT a guarantee of payment.**

Signature: _____ Date: _____

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**HIPAA: I acknowledge that I have read and/or received Martin Eyecare's HIPAA Notice of Privacy Practices.**

Signature: _____ Date: _____

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**Satisfaction Policy: I acknowledge that I have read and/or received Martin Eyecare's Satisfaction Policy.**

Signature: _____ Date: _____

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**Contacts: I acknowledge that I have read and/or received a Contact Lens Agreement & Patient Responsibility.**

Signature: _____ Date: _____

First Name:_____ Last Name:_____

Primary Care Physician:_____ Last Eye Exam:_____

Do You Wear?: [ ] Glasses [ ] Contacts Brand:_____

Reason For Visit: [ ] Annual Exam [ ] Medical Exam [ ] Update Glasses [ ] Update Contacts

Are you experiencing any of the following symptoms with your eyes?
[ ] Distance Blur [ ] Near Blur [ ] Double Vision [ ] Vision Loss [ ] Headaches
[ ] Flashes of Light [ ] Floaters [ ] Burning [ ] Redness [ ] Dryness
[ ] Lazy Eye [ ] Twitching [ ] Foreign Body Sensation [ ] Other:_____

Medical Diagnoses, Symptoms, & Surgeries:
[ ] Glaucoma [ ] Cataracts [ ] Macular Deg. [ ] Retinal Detachment
[ ] Ret. Pigemen. [ ] PRK [ ] Lasik [ ] Eye Muscle
[ ] Other: _____

[ ] High Blood Pressure:
Diagnoses Date? _____ Ctrl BP Range? _____ Freq. Of Dr Visits:_____
[ ] High Cholesterol: Diagnoses Date?_____
[ ] Heart Trouble [ ] Other:_____

[ ] Diabetic: Type I [ ] Type II [ ]
Diagnoses Date?_____ Last A1C: _____Freq. Of Dr Visits?_____
Last BS Reading?_____ Normal BS Range?_____How Often BS Taken?_____
[ ] Insulin Dependent [ ] Thyroid Cond. [ ] Hormone Cond. [ ] Hyopglycemia
[ ] Other:_____

Please List Any Surgeries, Medical Diagnoses, or ANY Other Medical History Not Listed Above:
_____
_____

Family Medical History: * Choose ALL that apply and if it is your Maternal or Paternal Side *
[ ] High Blood Pressure - [ ] MAT [ ] PAT [ ] Macular Degeneration - [ ] MAT [ ] PAT
[ ] Diabetes - [ ] MAT [ ] PAT [ ] Retinal Detachments - [ ] MAT [ ] PAT
[ ] Glaucoma - [ MAT [ ] PAT [ ] Cataracts - [ ] MAT [ ] PAT
[ ] Other: _____

Do You Use: [ ] Cigarettes/Tobacco [ ] Alcohol [ ] Other Substances:_____

Please list below (or provides us with) ALL DRUG ALLERGIES you have:
_____
_____

Please list below (or provide us with a list to copy) ALL MEDICATIONS you are currently taking:
_____

# SATISFACTION POLICY OF MARTIN EYE CARE

## PRESCRIPTION EYEWEAR:

Every pair of eyeglasses ordered from Martin Eyecare is custom made to order. Therefore Martin Eyecare cannot refund any products that are not resalable or returnable to the manufacturer. We are happy to service our products, and guarantee their quality and workmanship. Martin Eyecare provides a limited warranty that protects against manufacturing defects in products associated with normal wearing conditions. Accidental breakage, abuse, or loss are not covered by this warranty. Warranties are only in effect for the duration offered by the manufacturer, are not extendable, and begin at the time of the order. There is a $25 charge to replace frames and/or lens under warranty. Patients are able to replace lenses in their own frame for a $40 service fee as long as the frame is from Martin Eyecare Establishment, Under 2 years old, and in usable condition. Martin Eyecare **WILL NOT BE RESPONSIBLE** to replace a patient's own frame if it is lost, damaged, broken, etc. in this process. Martin Eyecare is unable to replace or insert lenses in any outside frame brought in.

## DOCTORS CHANGES AND NON-ADAPTS:

Martin Eyecare will honor a one-time prescription change made by the Doctor up to 30 days following the original exam date. Subsequent changes will incur additional charges. In the event that a patient does not adapt to prescription progressive lenses within 30 days of the original exam date, Martin Eyecare will remake the glasses (one time only) into a standard bifocal or single vision lens at no additional charge to the patient. **NO REFUND** will be given for the price different in materials.

## CONTACT LENSES:

Many disposable contact or planned replacement contact lenses are eligible for a refund (minus a restocking fee) or credit if returned within 30 days of the original dispense date. The boxes must be unopened and in a resalable condition.

Most RGP contact lenses have a 30 day warranty from the original examdate and are returnable for a refund (minus a restocking fee) or credit.

## CONTACT LENS FOLLOW-UP EXAMS:

Contact lens examinations include a 30 day follow-up period. It is the responsibility of the patient to keep all contact lens follow-up appointments with their Martin Eyecare provider. If a patient misses or fails to keep such appointments, additional exam fees will be incurred.

## WARRANTY LIMITATIONS:

Please note warranties are available only as the manufacturer policies permit. Martin Eyecare and its providers do not have the ability to make exceptions or changes.

## HIPAA NOTICE OF PRIVACY PRACTICES OF MARTIN EYECARE

**I understand that in an attempt to protect the privacy of my identifiable health information, Martin Eyecare has established a Privacy Policy and guidelines for Privacy Practices within their office. This information details the use and/or disclosure of information contained in my personal medical/ optometric records kept for the purposes of diagnosis, treatment, payment and health care operations.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and relates to your past, present, or future physical or mental health or condition and related health care services.

**Uses and Disclosures of Protected Health Information:** Your PHI may be used and disclosed by your physician, our office staff, and other outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for vision or health services may require that your relevant PHI be disclosed to the health plan to obtain approval for any and all services.

Healthcare Options: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may call you by name in the waiting room when your physician is ready to see you. For example, we may use or disclose your PHI, as necessary, to contact you to remind you of your appointment and/or if your materials are ready for pickup.

Electronic Mail: Information stored on our computers is encrypted. Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email. When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it. The federal government provided guidance on email and HIPAA. The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required By Law, Public Health issues are required by law, Communicable Diseases; Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: required Uses and Disclosures: Under the law, we must make disclosures to you and when

required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures**: Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless Required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Your Rights**: Following is a statement of your rights with respect to your PHI.
-You have the right to inspect and copy your PHI: Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.
-You have the right to request a restriction of your PHI: This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to a family member(s) or friends who may be involved in your care of for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
-Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.
-You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively I.E. electronically.
-You may have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this notice and will inform you of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints:** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a compliant with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14,2003. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Office in person or by phone at our main phone number 615-355-6677.

**CONTACT LENS AGREEMENT AND PATIENT RESPONSIBILITY OF MARTIN EYECARE.**

Please read this information carefully, for they constitute your obligations as a contact lens patient of Martin Eyecare.

Contact lens fittings are only valid for **30 DAYS.** If you are suppose to come back for a contact check you must do so before your **30 DAYS** are up or you will get charged another fitting fee.

Contact lens fittings and evaluations are a **SEPARATE** fee from your routine eye exam. Whether or not this fee is covered is based on **your individual** insurance plan.

I am aware of proper methods of lens care and handling. I understand the importance of adhering to proper lens care procedures and the need for periodic progress evaluations. I agree to follow the recommended wearing schedule and to keep scheduled appointments. I agree to follow the recommend wearing schedule and to keep scheduled appointments. I agree to follow my doctor's advice for the safe wear of lenses. I agree to ask any questions

I understand that extended or continuous wear (overnight) contact lenses have many benefits but, as with any other drug or medical device, they are not without risks. I have been told that the risk of complications with extended or continuous wear (overnight) lenses is greater than for daily wear lenses or gas permeable lenses. I understand that not all contact lenses are designed for overnight wear and if I am fit with extended wear lenses that the maximum approved wearing time is six night in a row. It is the doctor's discretion to determine if I can safely wear extended wear contact lenses. I have also been told that a small percentage of wearers develop serious complications, including conditions that can cause permanent injury and vision loss.

I agree to follow the advice and instructions provided by my doctor and staff. I will remove my lenses if I experience eye pain, redness, discharge, sensitivity to light, or decreased vision, and call the office immediately at 615-355-6677.

I also understand that contact lenses alone do not provide adequate protection from the ultraviolet rays of the sun and that UV-Blocking sunglasses should be worn over contact lenses for outdoor activities. A contact lens prescription will be released to me after the fitting period, upon request. I understand that contact lens examination and fitting fees, as with all other professional fees, are non-refundable. Contact lens examinations include follow-up visits for 30 days after fitting exam. We will schedule your follow-up appointment; however, it is the patient's responsibility to make sure that the follow-up is completed within the 30 day time period. If you fail to keep scheduled follow-up visits during the 30 day period. If you fail to keep scheduled follow-up visits during the 30 day period, additional office visit charges may apply.