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Karlik Ophthalmology

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PATIENT INFORMATION

Name_____Date_____
(last) (first) (middle)
Address_____ Male Female
_____ Single Married Divorced Widowed
_____
(city) (state) (zip)

Social Security # _____Birthdate_____
Home Phone_____Cell Phone_____
Occupation_____Employer Name_____
If Work Related, Date of Injury_____Work Phone_____
Emergency Contact Person/Phone Number _____/_____

Name of Insurance_____
Name on the Card_____Relationship to PolicyHolder_____
If Policy Holder is not Self:
Name of Policy Holder_____
Birthdate of Policy Holder_____
SS # of Policy Holder_____
Address and Phone Number of Policy Holder (if different than yours):
_____
_____
Primary Care Physician _____Patient Pharmacy phone #_____

ASSIGNMENT OF BENEFITS:

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT.

SIGNED_____DATE_____

Patient email address:_____

Patient History Form

Name:_____Date:_____

Birth Date:_____Occupation:_____

Referred By:_____Primary Doctor_____

Reason for today's visit:_____

Please list drug allergies: If none, please check ___

Please list all medications: Check if list attached___
(prescription, over-the counter, and eye drops)

Family History: If none, please check __
Do any medical or eye diseases run in your family?
(if yes, please note relationship to patient)

Cataract	___
Glaucoma	___
Diabetes	___
High blood pressure	___
Macular degeneration	___
Lazy eye	___
Other	___

Social History: If none, please check ___
Alcohol(estimate weekly)_____
Tobacco(estimate daily)_____
Weight(change over last yr.)_____

Ocular History:
Last Eye Exam: ___yrs.___months
Glasses: ___yrs.___months
Contact Lenses: ___yrs.___mo. (soft or gas perm.)

Review of systems & Medical History:

Constitutional (fever, weight loss, other)	Yes___No___
Eyes (glaucoma, cataract, lazy eye, retinal problems, loss of vision, blurred vision, floaters, flashes)	Yes___No___
Ear/nose/mouth/throat (hearing loss, sinus, sore throat)	Yes___No___
Cardiovascular (heart problems, chest pain, irregular heart beat, high blood pressure)	Yes___No___
Respiratory (asthma, shortness of breath, coughing)	Yes___No___
Gastrointesinal (heartburn, abn. pain, diarrhea, vomiting)	Yes___No___
Genitourinary (urinary problems, blood in urine)	Yes___No___
Integumentary (skin rashes, excessive dryness)	Yes___No___
Musculoskeletal (muscle aches, joint pain, swollen joints)	Yes___No___
Neurological (numbness, weakness, headaches, stroke, paralysis)	Yes___No___
Hematologic / Lymphatic (blood disorders, prolonged bleeding, leukemia)	Yes___No___
Allergic / Immunologic (hay fever, allergies)	Yes___No___
Endocrine (diabetes, thyroid problems)	Yes___No___
Psychiatric (depression, anxiety)	Yes___No___
Surgeries, Hospitalizations, or Medical Diagnosis's (not listed above)	Yes___No___

Please explain any Yes answers:

Updates noted on back of page ____

Sig. _____

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get a paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

HOW DO WE TYPICALLY USE OR SHARE YOUR HEALTH INFORMATION?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- **May 6, 2014**
- **Chris Hanasik, Office Manager, nheakarlik@gmail.com or 412-931-8101**
- **We never market or sell personal information.**
- **Routinely, examination doorways are left open, if you desire we will close them per your request.**

I have read and understood the above Notice of Health Information Practices. I recognize that this is a Federal mandate that KARLIK OPHTHALMOLOGY must comply with.

You have my permission to discuss my medical conditions, treatments and test results with

_____ , my _____ and /or with
(printed name) (relationship)

_____ , my _____ .
(printed name) (relationship)

I would also prefer the following confidential communication to be handled in this manner;

____Home phone ____No message
____Work phone ____Call back message
____Cell phone ____Detailed message

_____ _____
(patient signature/guardian or POA) (date)

_____
(printed name of guardian or POA)