CLIFTON
—EYE CENTER—

Patient Information (*Please Print*)

Prefix ____Mr. ____Mrs. ____Ms. _____Dr. _____Rev. ____Child
First Name_____**Last Name** _____ **Middle Initial**_____
Nickname _____ **Date of Birth** _____ (mm/dd/yyyy)
Address _____
City _____ **State** _____ **Zip** _____ **SSN** _____
Cell Phone ( )_____ **Work Phone** ( )_____ **DL #** _____
Home Phone ( )_____ **E-Mail** _____
Preferred Contact # _____ **Sex** _____ Male _____ Female
Are you? (circle one) Minor Single Married Divorced Widowed
Are you? (circle one) Employed Retired Full-Time Student Part-Time Student
Occupation _____
Employer/School Name _____

Emergency Contact Name _____ **Phone** _____
Relationship to patient _____

How did you hear about us? ____ INSURANCE CO. _____WEBSITE ____FACEBOOK
____ ANOTHER PATIENT (IF SO, WHO?) _____

PRIMARY INSURED'S INFORMATION
Name of Primary Insured _____
Relationship to patient _____ Phone # _____
Address _____ City _____ State ____ Zip_____
Birthdate _____ Social Security # _____
Name of employer_____Work Phone # _____
Employer's Address _____ City_____ State_____
Zip _____
Insurance Co. _____ Member #_____
Group #_____

Do You Have Additional Insurance? ____ No ____Yes
If Yes, Please complete the following:
Name of insured _____ Relationship to patient _____
Birthdate_____ Social Security # _____ Date employed _____
Name of employer_____ Work Phone # _____
Address_____ City_____ State_____ Zip_____
Insurance Co. _____ Member # _____

MEDICAL HISTORY RECORD

Reason for Today's Exam: _____

Last Eye Exam: _____ **Last Eye Doctor:** _____ **Primary Care Doctor:** _____

Current Medications: _____

Allergic to any medication: _____ **Pharmacy Used:** _____

Please check any condition that applies to yourself or any members of your immediate family

	Self	Family
Diabetes	____	____
High Blood Pressure	____	____
Heart Problems	____	____
High Cholesterol	____	____
Asthma/COPD/Emphysema	____	____
Auto- Immune Diseases	____	____
Anemia	____	____
Arthritis	____	____
Thyroid Problems	____	____
Eczema/Rosacea	____	____
Headaches/Migraines	____	____
Cancer	____	____
Ear/Nose/Throat	____	____
Kidney/Bladder	____	____
Anxiety/Depression	____	____
Seizures	____	____
HIV	____	

	Self	Family
Glaucoma	____	____
Cataracts	____	____
Macular Degeneration	____	____
Retinal Detachment	____	____
Flashes/Floaters	____	____
Blindness	____	____
Lazy Eye/Amblyopia	____	____
Eye Injury/Surgery	____	____
Itching Eyes	____	____
Eyes Water	____	____
Dry Eyes	____	____
Eyes Burn	____	____
Eye Turn/Strabismus	____	____
Double Vision	____	____
Temporary Vision Loss	____	____
Pregnant	____	
Given Birth in last 6 mos.	____	

Other ailments or diagnosis not listed above: _____

Do you drink alcohol? YES / NO **If yes, how much per week?** _____

Do you use tobacco products? YES / NO **If yes, how much per week?** _____

Do you use recreational drugs? YES / NO **If yes, what do you use and how often?** _____

Do you currently wear glasses: ___ Full-time ___Reading/Near work ___Work/Safety ___Computer Work
____ Distance only ____Other/Explain_____

Do you wear contact lenses? ____Yes ____No **If so, what style:** ____ Soft ____Extended wear ____Bifocal
____Gas Permeable ____Colors ____Astigmatism ____Disposable ____Unsure

Are you interested in wearing contact lenses? ____ Yes ___No **OR laser vision correction?** ____Yes ____No

Do you work at a computer or video display terminal? ___Yes ___No

What hobbies or sports do you participate in? _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eyecare to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor insurance benefits otherwise payable to me. I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all uncovered services rendered on my behalf or my dependents.

I understand if I have an unpaid balance at Clifton Eye Center and do not make satisfactory payment arrangements, my account may be placed with a collection agency. I will be responsible for the reimbursement of any fees from the collection agency, including all cost and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during the collection efforts. In order for Clifton Eye Center or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Clifton Eye Center and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using my email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and /or use of an automatic dialing device as applicable.

X _____ ***DATE*** _____

SIGNATURE OF PATIENT (Or parent if patient is a minor)

SHARING YOUR PERSONAL/MEDICAL INFORMATION

PLEASE NOTE THAT DUE TO HIPAA LAWS WE WILL NOT SHARE YOUR INFORMATION WITH ANYONE WITHOUT YOUR CONSENT. THIS MAY INCLUDE YOUR SPOUSE OR CHILDREN. IF YOU WOULD LIKE ANYONE TO HAVE ACCESS TO YOUR INFORMATION PLEASE FILL OUT THE INFORMATION BELOW.

I, _____ (pt. name), ALLOW CLIFTON EYE CENTER TO SHARE MY INFORMATION WITH THE PERSON(S) LISTED BELOW.

1) NAME_____
   RELATIONSHIP TO PATIENT_____
   PLEASE CHECK ALL THAT APPLY:
   HEALTH INFORMATION_____ OK TO PICK UP MATERIALS_____
   FINANCIAL INFORMATION_____

2) NAME_____
   RELATIONSHIP TO PATIENT_____
   PLEASE CHECK ALL THAT APPLY:
   HEALTH INFORMATION_____ OK TO PICK UP MATERIALS_____
   FINANCIAL INFORMATION_____

3) NAME_____
   RELATIONSHIP TO PATIENT_____
   PLEASE CHECK ALL THAT APPLY:
   HEALTH INFORMATION_____ OK TO PICK UP MATERIALS_____
   FINANCIAL INFORMATION_____

4) NAME_____
   RELATIONSHIP TO PATIENT_____
   PLEASE CHECK ALL THAT APPLY:
   HEALTH INFORMATION_____ OK TO PICK UP MATERIALS_____
   FINANCIAL INFORMATION_____

********PATIENT SIGNATURE(no minors):_____***

********DATE:_____***

NOTICE OF PRIVACY PRACTICES

Clifton Eye Care. This Notice describes how much medical information about you may be used and disclosed and about how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information. Under the federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information. We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations. *Treatment:* We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcome of your case and others like it.

Special Uses. We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Research: We may use or disclose information for approved medical research.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious Threat to Health and Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensation: We may release information about you for workers compensation or similar program providing benefits for work-related injuries or illness. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about your legal duties and privacy practices regarding protected health information and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices

We may change our policies at any time. Before we make significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person below.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact:

Clifton Eye Center
Deana Clifton, O.D.
1000 Chinaberry Drive, Suite 302
Bossier City, LA 71111
(318)-550-5815

I, _____ hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____

Date: _____

If not signed, reason why acknowledgement was not obtained:_____

Staff Witness: _____

Date: _____

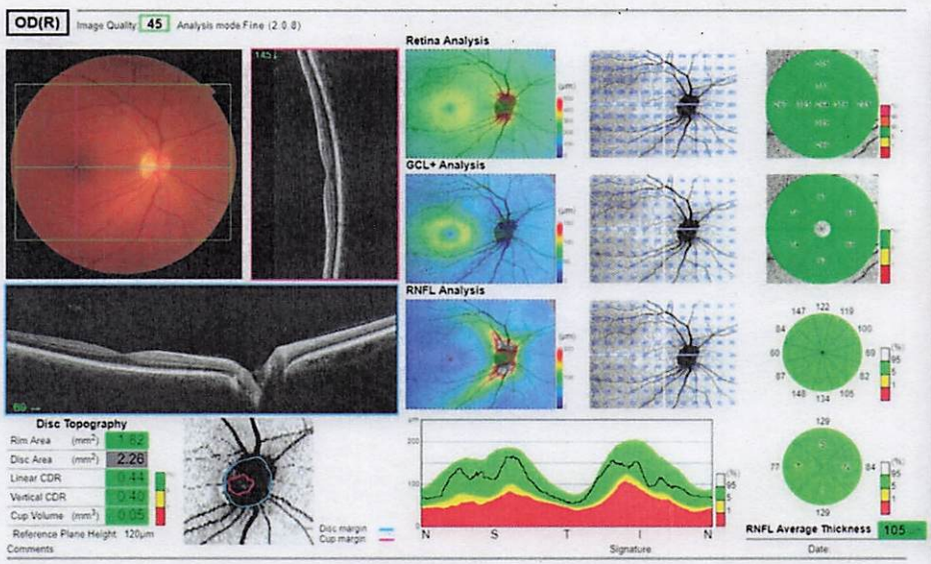
Advanced Technology Imaging Consent

Our state-of-the-art Topcon Maestro Robotic Optical Coherence Tomography + High Resolution Fundus imaging system further enhances your doctor's ability to detect and manage ocular diseases such as macular degeneration, glaucoma and diabetic retinopathy.

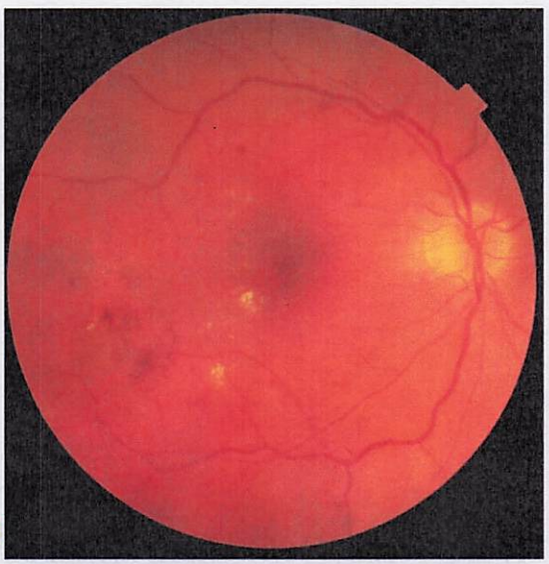
Analyzing these high-definition images and precise data is an excellent technique for diagnosing and monitoring eye disease. In some patient's, systemic disease may be diagnosed by this advanced imaging technology.

Imaging performed today establishes a baseline for future examinations. This makes it possible for the doctor to detect any changes in your eyes over time with extreme precision. It is now our recommendation that all patients receive retinal imaging during eye examinations at Clifton Eye Center.

Insurance will not cover the cost of these advanced screening tests.



3D-OCT REPORT WITH FUNDUS- HEALTHY EYE



FUNDUS PHOTO- DIABETIC RETIOPATHY

___ I accept these advanced diagnostic procedures **$44.00**

___ I decline the advanced imaging optical coherence tomography against my doctor's recommendation.

_____ (Print Patient Name) Date_____

PLEASE NOTE: If your comprehensive exam uncovers evidence of an underlying ocular condition, the doctor may require this and further testing in order to document and manage the condition in the future. These tests may or may not be covered by your medical insurance.

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CLIFTON
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ABOUT YOUR INSURANCE

Most people have vision insurance and medical insurance. They are very different in terms of the services they cover and it is important for our patients to understand those differences.

Vision insurance (i.e.- VSP, etc.) is mainly designed to determine a prescription for glasses, to help pay for glasses or contact lenses, and to cover a routine evaluation of the health of the eyes in a healthy patient that has no particular problems or symptoms. It is not equipped to deal with and does not cover medical conditions and/or treatment plans.

When a medical diagnosis or condition is present that affects your eyes, such as high blood pressure, high cholesterol, or diabetes, etc or if you have an eye problem such as an infection (pink eye), dry eyes, allergy, cataracts, etc, we must file with your medical insurance (i.e.-Medicare, BCBS, United Healthcare, etc.), and the co-pays and deductibles for that insurance will apply.

Insurance carriers set these rules and our office is obligated to follow them. In most cases, there is no way to know prior to the examination which type of insurance our office will be able to file for you. We make every effort to be on as many insurance company's panels for your convenience, and we will file those claims for you. In the event that we do not accept your medical or vision insurance, we will provide you with an itemized receipt so that you may file a claim with your insurance yourself for reimbursement. If you have any questions, please let us know.

I understand the information I have just read about the difference between vision and medical insurance and I authorize Clifton Eye Center to file my claim with the appropriate insurance based on the reason for my visit and the results of my examination.

Sign: _____ **Date:** _____

(Parent signature if patient is a minor)