Summit Eye Care
OF WISCONSIN

Patient History Information

Fill in all blanks, sign, and date

Name: _____ _____ _____
(LAST) (FIRST) (MIDDLE)

Address:_____ City: _____ State: _____ Zip Code: _____

Sex: _____ Race: _____ Date of Birth: _____ Age: _____

Home Phone: _____Cell Phone: _____ Email: _____

Preferred Contact: ❑ Text ❑ Email ❑ Phone Call Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widow

Language Spoken: _____

How were you referred to our office? _____
(Doctor, Friend/Family, Web/Radio, Drive-by)

Emergency Contact Information

Emergency Contact Name: ___ _____ Relationship to Patient: _____

Emergency Contact Phone: _____ Emergency Contact Cell/Other Phone: _____

Responsible Party Name (required if patient is a minor): _____ Relationship to Patient: _____

Insurance Policy Holder Information

Insurance Subscriber Name: _____ Subscriber Relationship to Patient: _____

Subscriber Date of Birth: _____

Medicare Beneficieries: If you are covered by Medicare, we will file claims to your primary and secondary insurance for you. You should present a valid Mediacre card. We accept assignment, but you are responsible for any deductible, co-insurance, or non-covered services.

Signature_____

Eye and Medical Care Provider Information

Current Optometrist or Ophthalmologist: _____ Date of Last Visit: _____

Primary Care Physician/Medical Doctor: _____ Phone: _____

Preferred Pharmacy_____

Conditions of Registration

Many insurance plans do not provide 100% coverage for a medical bill. Each plan has its own set of rules, exclusions, and services. It is your responsibility to be familiar with your specific benefit plan. If you are unsure of your coverage for a particular medical procedure or test, you should call the customer service telephone number on your insurance card before scheduling the appointment or procedure. Co-payments are due at the time of service for all appointments with our physicians. It is your responsibility to understand when your insurance requires a co-payment for medical services. For in-clinic testing procedures, we will process the claim through your insurance company first and if necessary, you will be billed for the co-pay later. If you have questions about your co-payments, contact your insurance company. I certify that I have read and agree to Summit Eye Care payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. A $30.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from Summit Eye Care by text or voice at the number or address stated above, including but not limited to communications about appointments, feedback, treatment and payments.

Patient/Responsible Party Signature:_____ **Date:**_____

Please see back

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PRIVACY NOTATION / CONSENT OF DISCLOSURE

By signing this authorization, I authorize Summit Eye Care to share the selected information with the following individuals (such as spouse, parent, son/daughter, etc.):

- ❑ Appointment Details
- ❑ Medication Information
- ❑ Medical/Surgical Information
- ❑ Billing/Financial Information
- ❑ Any/All Information
- ❑ Decline

Individuals authorized to receive selected information and relationship:

Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____

By signing this form, I am giving my permission to this facility to contact me for appointments, services or education that may be of interest to me. I recognize that I may sign at the time of my appointment.

Patient Name (print):_____DOB:_____
Patient Signature: _____ Date: _____
Patient Representative / Signature: _____Relationship to Patient: _____

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.

Patient Health Information Under 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. Your information may be stored electronically and if so is subject to electronic disclosure.

How We Use & Disclose Your Patient Health Information

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 or disclose your information to payors to determine whether you are enrolled or eligible for benefits. 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, arranging for legal services and to assess the care and outcomes of your case and others like it.

Special Uses and Disclosures Following a procedure, we will disclose your discharge instructions and information related to your care to the individual who is driving you home from the center or who is otherwise identified as assisting in your post-procedure care. We may also disclose relevant health information to a family member, friend or others involved in your care or payment for your care and disclose information to those assisting in disaster relief efforts.

Other Uses and Disclosures We may be required or permitted to use or disclose the information even without your permission as described below:

Required by Law: We may be required by law to disclose your information, such as 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: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health oversight: We may 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, discovery request or court order.

Law enforcement purposes: We may disclose information needed or requested by law enforcement officials or to report a crime on our premises.

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

Serious threat to health or 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 programs providing benefits for work-related injuries or illness.

Business Associates: We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.

Messages: We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods. In any other situation, we will ask for your written authorization before using or disclosing 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. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information, unless you have signed an authorization.

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

□ You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out-of-pocket for the item or service covered by the request and when the uses or disclosures are not required by law.

□ 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.

□ 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 copies.

□ You have the right to request that we amend your information.

□ You may request a list of disclosures of information about you for reasons other than treatment, payment, or health care operations and except for other exceptions.

□ You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.

Our Legal Duty We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured protected health information.

Changes in Privacy Practices We may change this Notice at any time and make the new terms effective for all health information we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information about our privacy practices, contact the person listed below.

Complaints If you are concerned that we have violated your privacy rights, 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:

Jane Moore
Practice Administrator
262-253-4000

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ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES (NPP)

A Notice of Privacy Practices (NPP) is provided to all patients. The Notice of Privacy Practices identifies: 1) How medical information about you may be used or disclosed; 2) Your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) Your rights to complain if you believe your privacy rights have been violated; and 4) Our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read and the foregoing, received a copy of the Notice of Privacy Practices if requested, and is the patient, or the patient's personal representative.

Patient Name (print):_____DOB:_____

Patient Signature: _____ Date: _____

Patient Representative (print): _____Relationship to Patient: _____

Patient Representative Signature: _____Date: _____

FOR INTERNAL USE ONLY

Employee Name (print):_____

Employee Signature: _____ Date: _____

If applicable, reason patient's written acknowledgment could not be obtained

☐ Patient was unable to sign

☐ Patient refused to sign

☐ Other _____

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REFRACTION POLICY

1. **What is a refraction?**
   Refraction is the process of determining the eye's refractive error, or need for corrective glasses and/or contact lenses.
2. **Why is it necessary?**
   Refraction is sometimes necessary depending on the patient's diagnosis and/or complaints presented that day. For example, if a patient is experiencing blurred vision or a decrease in visual acuity on the eye chart a refraction would be needed to see if this is due to a need for glasses or due to a medical problem. The refraction is an essential part of an eye exam, however, Medicare and most insurances **DO NOT** cover it. These plans consider refraction a "vision" service, not a "medical" service. These plans allow that we charge separately for that portion of the examination since it is not a covered service.
3. **What if I do not want the refraction?**
   You may decline this part of the exam. Please notify the technician **PRIOR** to the beginning of the exam that you want this step skipped. *IMPORTANT:* If you decline we may not be able to determine the cause of your decrease in vision.
4. **How much is it?**
   The charge is **$**50.00 for this service. This is in addition to the office visit copay and /or deductible which is set by your insurance carrier. As a courtesy we will bill your insurance according to the individual contracted fee schedules. However, if your insurance denies this service you will be responsible for this fee.

ACKNOWLEDGEMENT

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The copay and deductible are separate from, and not included in the refraction fee. I understand that I am responsible for this fee if I fail to decline this service before it is performed.

_____ _____/_____/_____

Patient Signature (Parent for minor) Date

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Optometry and Ophthalmology Patient Medical History Form

Patient Name: _____
Exam Date: _____
MRN:_____

Personal Ocular History

Last eye exam date: _____

Do you wear glasses?

Yes ◯ No ◯ If yes, how old are they? _____

Do you wear contact lenses?

Yes ◯ No ◯ If yes, what brand are they? _____
How old is your current pair? _____

How many years have you worn contact lenses? _____

Do you have any of the following vision concerns?

□ Blurry Vision	□ Frontal Headache	□ Double Vision
□ Eyestrain	□ Poor Night Vision	□ Distorted Vision
□ Severe Sensitivity to Light	□ Glare	□ Fluctuating Vision

Please list any additional vision concerns: _____

Do you have any of the following eye health concerns?

□ Redness	□ Tearing/Watering	□ Eye Pain
□ Burning	□ Discharge	□ Eye Soreness
□ Itching	□ Dryness	□ Flashes and/or Floaters

Please list any additional eye health concerns: _____

Have you ever been diagnosed with any of the following ocular conditions?

□ Cataracts	□ Keratoconus	
□ Glaucoma	□ Lazy Eye	□ Contact Lens Overwear
□ Macular Degeneration	□ Dry Eye	□ Retinal Condition
□ Diabetic Retinopathy	□ Eye Infection/Inflammation	□ Eye Trauma/Injury

Please list any additional diagnosed ocular conditions: _____

Have you ever had any ocular surgeries?

Yes ◯ No ◯ If yes, please list: _____

Social History

Occupation: _____

Hobbies: _____

Approximately how many hours do you spend on a computer daily? _____

Review of Systems

Please mark beside any condition you currently have.

Constitutional
□ Developmental Disabilities
□ Cancer
Type: _____
□ Unintentional Weight Loss
□ Pregnant

ENT
□ Hearing Loss
□ Sinusitis
□ Dry Mouth
□ Laryngitis

Neurological
□ Multiple Sclerosis
□ Epilepsy
□ Cerebral Palsy
□ Tumor
□ Stroke/CVA
□ Migraine

Psychological
□ Depression
□ Attention Deficit
□ Anxiety Disorder
□ Bipolar Disorder

Cardiovascular
□ Hypertension
□ Stroke/CVA
□ Heart Disease
□ Vascular Disease
□ Congestive Heart Failure

Respiratory
□ Asthma
□ Bronchitis
□ Emphysema
□ Chronic Obstruction
□ Sleep Apnea

Gastrointestinal
□ Crohn's
□ Colitis
□ Ulcer
□ Acid Reflux
□ Celiac Disease

Genitourinary
□ Kidney Disease
□ Prostate Disease/Cancer

Musculoskeletal
□ Arthritis
□ Osteoarthritis
□ Fibromyalgia
□ Muscular Dystrophy
□ Ankylosing Spondylitis
□ Osteoporosis
□ Gout

Dermatological
□ Eczema
□ Rosacea
□ Psoriasis
□ Herpes Simplex/Cold Sores
□ Herpes Zoster/Shingles

Endocrine
□ Type 2 Diabetes Mellitus
□ Type 1 Diabetes Mellitus
□ Thyroid Dysfunction
□ Hormonal Dysfunction

Hematologic/Lymphatic
□ Anemia
□ Large-Volume Blood Loss
□ Ulcer
□ High Cholesterol

Allergic/Immune
□ Environmental Allergies
□ Rheumatoid Arthritis
□ Lupus
□ Sjogren's Syndrome

Current Prescription and Non-Prescription Medications (Including Eye Drops):

_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies to medication: _____

Family History:

Please list parents, grandparents, siblings, or children – living or deceased – with the following conditions:

Glaucoma: _____
Lazy Eye: _____
Macular Degeneration: _____
Color Blindness: _____
Retinal Detachment: _____
Keratoconus: _____
Diabetes: _____
Heart Disease: _____
High Blood Pressure: _____
Kidney Disease: _____
Lupus: _____
Thyroid Disease: _____

Patient Signature: _____