

# PRIMARY EYECARE GROUP, P.C.

205 Ward Circle

BRENTWOOD, TN 37027 · 615-373-0080

**Please complete this questionnaire carefully. The following in-depth information will enable us to provide you with complete, quality eyecare.**

Last Name \_\_\_\_\_  
First Name \_\_\_\_\_  
Street Address \_\_\_\_\_  
\_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Sex (M) or (F) \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Employer \_\_\_\_\_  
Work Phone \_\_\_\_\_

Today's Date \_\_\_\_\_  
Your Title: (circle one)  
Mr. Mrs. Miss Rev. Dr.  
Marital Status \_\_\_\_\_ S \_\_\_\_\_ M \_\_\_\_\_ Other \_\_\_\_\_

**We enjoy acknowledging those who recommend our office. Please help us in doing so.**

Referred by: Patient \_\_\_\_ If so, whom? \_\_\_\_\_  
Newspaper \_\_\_\_ Television \_\_\_\_ Radio \_\_\_\_  
Yellow Pages \_\_\_\_ Provider Book \_\_\_\_  
Another Doctor \_\_\_\_\_ If so, whom? \_\_\_\_\_

## INSURANCE INFORMATION

**Insured member or person responsible other than above party.**

Last Name \_\_\_\_\_  
First Name \_\_\_\_\_  
Street Address \_\_\_\_\_  
\_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Employer \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_

Vision Insurance Name \_\_\_\_\_  
ID# \_\_\_\_\_  
Plan/Grp.# \_\_\_\_\_  
Medical Insurance Name \_\_\_\_\_  
Plan/Grp.# \_\_\_\_\_

**Payment is expected at the time of service. Method of Payment (circle one)**

Cash Check Visa MasterCard AmEx  
Other \_\_\_\_\_

### **Medical History**

Most recent medical examination: Date \_\_\_\_\_ Doctor's Name \_\_\_\_\_  
Most recent visual examination: Date \_\_\_\_\_ Doctor's Name \_\_\_\_\_  
Medications currently used and condition being treated: (including birth control pills) \_\_\_\_\_

Have you been diagnosed as HIV Positive? Yes \_\_\_\_\_ No \_\_\_\_\_ Date \_\_\_\_\_

Do you have any allergy or sinus problems? (describe) \_\_\_\_\_

Do you or your family have a history of the following:

YOU	FAMILY	YOU	FAMILY
_____ High Blood Pressure	_____	_____ Glaucoma	_____
_____ Diabetes	_____	_____ Cataracts	_____
_____ Thyroid Condition	_____	_____ Blindness	_____
_____ Cancer	_____	_____ Hepatitis	_____

**COMPLETE EYE HEALTH AND VISION HISTORIES WILL BE TAKEN BY A MEMBER OF OUR STAFF DURING THE PRETEST PORTION OF YOUR EXAMINATION.**

*An interest charge of 18% per year or 1 ½% per month will be applied to all balances over 30 days. Patient agrees to pay all expenses of collection including reasonable attorney fees.*

X \_\_\_\_\_

**Primary Eyecare Group, P.C.**

**APPOINTMENT REMINDERS AND INFORMATION REGARDING PRODUCTS AND SERVICE ENHANCEMENTS  
HEALTH CARE INFORMATION AUTHORIZATION**

The doctors at Primary Eyecare Group, P.C., and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about new products, treatment alternatives, or other health related information that may be of interest to you. By signing this form, you are giving us authorization to contact you with these reminders and information. This contact may be made by phone, e-mail, postal services or private carriers such as UPS or Federal Express. If this contact is made by phone and you are not at home or work, a message may be left with others answering the phone or on your answering machine or voice mail.

**You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.**

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder of other information and may be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§164.524).

This notice is effective as of \_\_\_\_\_ . This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that a copy of this authorization was made available to me.

\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Authorized Provider Representative

\_\_\_\_\_  
Personal Representative (Printed)

\_\_\_\_\_  
Personal Representative Signature

\_\_\_\_\_  
Description of Personal Representative's Authority to Act for the Patient

*Notice of Privacy Practices for Protected Health Information*  
**Primary Eyecare Group, P.C.**

**THIS NOTICE DESCRIBES HOW OPTOMETRIC AND MEDICAL  
INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW  
YOU CAN GET ACCESS TO THIS INFORMATION.  
PLEASE REVIEW IT CAREFULLY.**

**Uses & Disclosures**

The following are some examples of how we might have to use or disclose your health care information:

- 1) The doctors at Primary Eyecare Group, P.C., and members of the staff may have to disclose your health information including all of your clinical records to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
- 2) Our insurance and billing staff may have to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are potentially responsible for the payment of your services.
- 3) The doctors at Primary Eyecare Group, P.C., and members of the staff may need to use your health information, examination and treatment records and your billing records for quality control purposes and other administrative purposes to efficiently and effectively run our practice.
- 4) The doctors at Primary Eyecare Group, P.C., and members of the staff may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. 164.520 (b)(1)(iii)(A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine, voicemail or e-mail.

You have the right to refuse to give us authorization to contact you to provide appointment reminders, information about treatment alternatives, or other health related information. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

## **Primary Eyecare Group, P.C.**

We have and always will respect your privacy. Other than the uses and disclosures we described above, we will not sell or provide any of your health information to any outside marketing organization.

### **Permitted Uses and Disclosures Without Your Consent Or Authorization**

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

- 1) We are permitted to use or disclose your health information if we are providing health care services to you based on the orders of another health care provider.
- 2) We are permitted to use or disclose your health information if we provide health care services to you in an emergency.
- 3) We are permitted to use or disclose your health information if we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
- 4) We are permitted to use or disclose your health information if there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.

Other than the circumstances described in the preceding four examples, any other use or disclosure of your health information will only be made with your written authorization.

### **Your Right to Revoke Your Authorization**

You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

- 1) If we have already released your health information before we received your request to revoke your authorization. 164.508(b)(5)(i).
- 2) If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims. If you wish to revoke your authorization please write to us at:

**Susan Lunsford, Office Manager  
Primary Eyecare Group, P.C.  
205 Ward Circle  
Brentwood, Tennessee 37027**

## *Notice of Privacy Practices for Protected Health Information*

### **Your Right to Limit Uses Or Disclosures**

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care from another health care provider.

### **Your Right to Receive Confidential Communication Regarding Your Health Information**

We normally provide information about your health to you in person at the time you receive optometric services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information about your health or the services that we provide at a place other than your home or, if you would like the information in a different form. To help us respond to your needs, please make any request in writing.

### **Your Right to Inspect And Copy Your Health Information**

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information to be in writing.

### **Your Right to Amend Your Health Information**

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

## *Notice of Privacy Practices for Protected Health Information*

### **Your Right to Receive An Accounting Of The Disclosures We Have Made Of Your Records**

You have the right to request that we give you an accounting of the disclosure we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except:

- ◆ Those disclosures required for you treatment, to obtain payment for your services, or to run our practice.
- ◆ Those disclosures made to you.
- ◆ Those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
- ◆ Those disclosures for national security or intelligence purposes.
- ◆ Those disclosures made to correctional officers or law enforcements officers.
- ◆ Those disclosures that were made prior to the effective date of the HIPAA privacy law.

We will provide the first accounting within any 12-month period without charge. There is a fee for any additional requests during the next 12 months. When you make your request we will tell you the amount of fee and you will have the opportunity to withdraw or modify your request.

### **Your Right To Obtain A Paper Copy Of This Notice**

If you have agreed to receive privacy notices by e-mail, you may request a paper copy of this notice at any time.

### **Our Duties**

We are required by law to maintain the privacy of your health information. We are also required to provide you with the notice of our legal duties and our privacy practices with respect to your health information.

We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change to the terms of our privacy agreement we will notify you in writing when you come in for treatment or by mail. If we make a change in our privacy terms the change will apply for all of your healthy information in our files.

## *Notice of Privacy Practices for Protected Health Information*

### **Re-Disclosure**

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

**Your Right To Complain**

You may complain to us or the Secretary of Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. While you may make an oral complaint at any time, written comments should be addressed to:

**Susan Lunsford, Office Manager  
Primary Eyecare Group, P.C.  
205 Ward Circle  
Brentwood, Tennessee 37027**

**To Contact Us**

If you would like further information about our privacy policies and practices, please contact:

**Susan Lunsford, Office Manager  
Primary Eyecare Group, P.C.  
205 Ward Circle  
Brentwood, Tennessee 37027  
(615) 373-0080**

This notice is effective as of \_\_\_\_\_. This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have received a copy of this notice.

\_\_\_\_\_  
Patient Name **(Printed)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
Authorized Provider Representative

\_\_\_\_\_  
Personal Representative (Printed)

\_\_\_\_\_  
Personal Representative Signature

\_\_\_\_\_  
Description of Personal Representative's Authority to Act for the Patient