Stacy L. Cantley, O. D.

FAMILY EYE CARE
Of Sylacauga, LLC

493 W Third Street
Sylacauga, AL 35150

Phone: 256-245-7696

Fax: 256-245-6693

PLEASE COMPLETE ENTIRE FORM IN PRINT

Patient Information:

Last Name: _____ First Name: _____ Middle: _____

Address: _____

City: _____ State: _____ Zip: _____ Home #: _____ Cell#: _____

Gender: _____ Birthdate:_____ SSN#: _____Employer_____

Emergency Contact: _____Phone#_____ Employer ph#_____

Pharmacy: _____ Email: _____ Height: _____ Weight_____

Primary Care Physician (PCP): _____

Must be filled out by PARENT if child is a MINOR

Mother's Name: _____ Father's Name: _____

D.O.B: _____ SSN#: _____ D.O.B. _____ SSN#: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Work: _____ Phone: _____ Work: _____

INSURANCE INFORMATION

(**Primary**) Insurance Company: _____ Policy Holder: _____

*Policy Holder's D.O.B: _____ Employer: _____

Contract Number: _____ Group Number: _____

(**Secondary**) Insurance Company: _____ Policy Holder: _____

*Policy Holder's D.O.B: _____ Employer: _____

Contract Number: _____ Group Number: _____

CONSENT FOR TREATMENT: I consent to necessary treatment including drugs, medicine, performance of operations and conduct of X-ray, or other studies that may be used by the optometrist, his/her nurse or staff.

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize Family Eye Care od Sylacauga, LLC to furnish medical information requested by insurance companies with whom I have coverage and public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on the job injury.

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Family Eye Care of Sylacauga, LLC of benefits otherwise payable to me including major medical insurance and payment of surgical medical benefits, but not to exceed the Family Eye Care of Sylacauga, LLC charges for these services. I understand that I am financially responsible to Family Eye Care of Sylacauga, LLC for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

GUARANTEE OF ACCOUNT: For services furnished by Family Eye Care of Sylacauga, LLC I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services hereby I hereby waive all claims of exemption under the State of Alabama and agree to pay, all if necessary, all costs of collection, including attorney's fees.

Signature: _____ Date: _____

CHIEF COMPLAINT / REASON FOR VISIT: _____

_____

List ALL medications currently taking: _____

_____

____ **Please check here if you do NOT take any medications**

List ALL known allergies: _____

_____

Occupation: _____ / School/Grade: _____

Does your Occupation or hobby require special use of your eyes? YES / NO

EYE HISTORY – Circle all that apply

- Have **YOU** ever been diagnosed with or treated for any of the following:

Headaches	Droopy Eyelid	Crossed Eyes	Floaters or Spots	Loss of side vision
Macular Degeneration	Color Blindness	Glare (light Sensitivity	Sandy/Gritty feeling	Blindness
Blurred vision	Distorted vision (halos)	Foreign Body Sensation	Detached Retina	Tired Eyes
Redness/Itching	Eye Surgery	Dryness	Burning	Loss of vision
Glaucoma	Diabetic Retinopathy	Amblyopia (lazy Eye)	Eye Pain / Soreness	Cataracts
Double Vision	Fluctuating Vision	Blurred Near Vision	Mucous Discharge	Other

____ **Please check here if NONE applies**

HEALTH HISTORY – Circle all that apply

- Have **YOU** ever been diagnosed or treated for any of the following:

Kidney Disease	Allergies	Respiratory	Psychiatric	Neurological
Gastrointestinal	Blood/Lymph	Bladder/kidney	Eye Surgery	Cancer
Stroke	Pregnant	AIDS/HIV	Endocrine (Diabetes)	Joint Pain
High Blood Pressure	Rheumatoid Arthritis	Heart Disease	High Cholesterol	Smoking
Consume Alcohol	Emphysema	Other		

FAMILY HISTORY – Circle all that apply

- Has anyone in **YOUR family** ever been diagnosed with or treated for any of the following:

Arthritis	Cancer	Lupus	Macular Degeneration	Heart Disease
Stroke	Blindness	Detached Retina	Crossed Eyes	Kidney Disease
Amblyopia (Lazy Eye)	Diabetes	Color Blindness	High Blood Pressure	
Cataracts	Glaucoma	Eye Surgery	Other	

Fill in the name and relationship of the person(s) to whom you want Family Eye Care of Sylacauga, LLC to disclose your personal health information.

1. Name: _____
   Relationship: _____

2. Name: _____
   Relationship: _____

Effective Date of Notice: April 14, 2003

NOTICE OF PRIVACY PRACTICES

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

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it**.**

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS
The most common reason why we use or disclose your health information is for treatment, payment, or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you, testing or examining you, prescribing glasses, contact lenses, or for eye medications and faxing them to be filled, showing you low vision aids, referring you to another doctor or clinic for eye care or low vision aids or services, or getting copies of your health information from another professional you may have seen before us. Examples of how we use or disclose your health information for payment purposes are asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts by ourselves or through a collection agency or attorney. "Health care operations" mean those administrative and managerial functions we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are by performing audits; internal quality assurance; personal decisions; participation in managed care plans; defense of legal matters, purging and outside storage of our records.

We routinely use our health information inside our office for these purposes without any special permission if we need to disclose your personal health information outside of our office for these reasons {we will} [we usually will not] ask you for special written permission.

We will ask for special permission in the following situations:
USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION:
In some limited situations, the law requires us to use or disclose your health information without your permission. Not all situations will apply to us; some may never come up at our office at all. Such uses of disclosures are:

- When a state or federal law mandates that certain health information be reported to a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug administration regarding drugs or medical devices;
- Disclosures to government authorities about victims of suspected abuse, neglect or domestic violence;
- Uses and disclosures for health oversight activities, such as licensing of doctors; for audits by Medicare or Medicaid for investigation of possible violations of health care laws;
- Disclosures for judicial and administrative proceedings such as in response to subpoenas or orders of courts or administrative;
- Disclosure for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Disclosure to a medical examiner to identify a dead person or to determine a cause of death; or to funeral directors to aid the organizations that handle organ or tissue donations;
- Uses or disclosures for health related research;
- Uses and disclosures to prevent a serious threat to health or safety;
- Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of families;
- Disclosures of de-identified information;
- Disclosures relating to workers compensation programs;
- Disclosures of a "limited data set" for research, public health, health care operations;
- Incidental disclosures that are unavoidable by-product of permitted uses or disclosures;
- Disclosures to "business associates" whom perform health care operations for us and who commit to respect the privacy of said information;
- Specify other uses and disclosures affected by state law.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your care.

APPOINTMENT REMINDERS
We may call or write to remind you of scheduled appointments, or it is time to make a routine appointment.
we may also call or write to notify you of other treatments or services available at our office that might help you.
Unless you tell us otherwise, we will mail you an appointment reminder on a postcard, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not at home.

OTHER USES AND DISCLOSURES
We will not make any other uses of disclosures of your health information unless you sign a written "Authorization form." The content of an "Authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically in this situation would give us a properly completes authorization for, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. if you do not sign the authorization form, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing, send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or e-mail shown at the beginning of this Notice.
- Ask us to communicate with you in a confidential way, such as phoning you at work rather than home, by mailing health information to a different address, or by e-mailing you to your personal e-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax, or e-mail shown at the beginning of this Notice.
- Ask to see or to get photocopies of your health information. By law there are few limited situations in which we can refuse to or permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation and instructions about how to get an impartial review of our denial if we send you a written notice of the extension. If you want to review or get copies of your health information, send a written request to the office contact person at the address, fax, or e-mail shown at the beginning of this Notice.
- Ask us to amend your health information if you think it's incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to the persons we know got the wrong information and others that you specify. If we do not agree, you can write a statement of your position and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law we can have a 30 day extension time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a request, including your reasons for amendment, to the office contact person at the address, fax, or e-mail shown at the beginning of this Notice.
- Get a list of the disclosures that we made of your health information within the past six years (or a shorter period if you want). By law the list will not include: disclosures for purposes for treatment; payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists; you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have a 30 extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax, or e-mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a request to the office contact person at the address, fax, or e-mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this Notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we are changing as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new Notice in our office, have copies available in our office, and post it o our web site.

COMPLAINTS

If you think we may have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax, or e-mail shown at the beginning of this Notice. If you want to you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDEMENT OF RECEIPT

I acknowledge that I received a copy of *Stacy L. Cantley O.D.,* Notice of Privacy Practices.

DATE: _____

Patient Name (printed): _____ Signature: _____