Welcome to Sunset Eye Care, PC

Dr. Angela Patteson, OD

We require that all fees for professional services be paid for when they are rendered, and all materials must be paid for in full before they leave the office. Any materials ordered will require a deposit. Please check with us prior to exam to verify coverage. If you desire to have an insurance form filled out, please sign one of the releases at the bottom of this page. If any costs are incurred for the collection of past due or bad debt accounts, (including returned checks and credit card charge backs), the costs associated with collection, including attorney fees and/or courts costs, will be passed on to the patient/responsible party.

Salutation_____ **Legal Name** _____ **Preferred Name**_____

Date of Birth _____ / _____ / _____ **Name of Guardian** (if under 18) _____

Cell Phone (_____) _____ - _____ **Home Phone** (_____) _____ - _____

Mailing Address _____

City _____ **State** _____ **Zip**_____

Email Address _____

Occupation _____ **Employer**_____

Reason for today's visit_____

Do you wear: ☐ Glasses ☐ Contacts ☐ Over-the-Counter Reading Glasses ☐ Nothing

Would you like an exam or prescription for contacts lenses today? ☐ Yes ☐ No

Are you interested in Laser Vision Correction (LASIK)? ☐ Yes ☐ No

Approximate date of last eye exam _____ / _____ / _____ **Name of Previous Eye Dr:** _____

Primary Care Physician_____ **Name of Clinic**_____

Do any of the following apply to YOU?

☐ Cancer _____	☐ Stroke/CVA	☐ Rheumatoid Arthritis	☐ High/Low Cholesterol
☐ Epilepsy	☐ Heart Disease	☐ Lupus	☐ Seasonal Allergies
☐ Migraines	☐ Pregnant	☐ Hepatitis	☐ Glaucoma
☐ Depression	☐ Nursing	☐ HIV	☐ Cataracts
☐ Anxiety	☐ Asthma	☐ Diabetes Type _____	☐ Macular Degeneration
☐ High/Low Blood Pressure	☐ Arthritis	☐ Thyroid Dysfunction	☐ Retinal Detachment
☐ Latex Sensitive	☐ **Other illnesses:** _____		

☐ Tobacco Use _____ pack(s) per _____ ☐ Alcohol Use _____ drink(s) per _____

☐ **Eye Related Surgery:** type of surgery, approximate date, and eye(s): _____

_____

Medications you are currently taking:_____

_____

_____

Drug allergies: _____

Do any members of your immediate family have a history of the following?

☐ **Diabetes** dad / mom / bro / sis / son / daughter
☐ **Cancer** dad / mom / bro / sis / son / daughter
☐ **Thyroid** dad / mom / bro / sis / son / daughter
☐ **Blood Pressure** dad / mom / bro / sis / son / daughter
☐ **Heart Disease** dad / mom / bro / sis / son / daughter
☐ **Macular Degeneration** dad / mom / bro / sis / son / daughter
☐ **Cataracts** dad / mom / bro / sis / son / daughter
☐ **Glaucoma** dad / mom / bro / sis / son / daughter
☐ **Retinal Detachment** dad / mom / bro / sis / son / daughter

I acknowledge that I have read a copy of Sunset Eye Care, PC Notice of Privacy Practices.

⇒ Signed _____(guardian sign if patient is under age 18) Date _____ / _____/ _____

Assignment and Release (sign when you have insurance to file today.)

I authorize Sunset Eye Care, PC to release any information required to process my insurance claim. I also authorize my insurance benefits to be paid directly to Sunset Eye Care, PC and I understand that I am financially responsible for any services and materials determined to be non-covered.

⇒ Signed _____(guardian sign if patient is under age 18) Date _____ / _____/ _____

optomap®
ultra-widefield retinal imaging

Sunset Eye Care Optomap Consent Form

While eye exams generally include a look at the front of the eye to evaluate health and prescription changes, a thorough screening of the retina is critical to verify that your eye is healthy. Your retina (located in the back of your eye) is the only place in the body where blood vessels can be seen directly. This means that in addition to eye conditions, signs of other diseases (for example, stroke, heart disease, hypertension and diabetes) can also been seen in the retina before you notice any changes to your vision.

Getting an Optomap image is fast, painless and comfortable. The capture takes less than a second. Nothing touches your eye at any time. You simply look into the device one eye at a time (like looking through a keyhole) and you will see a comfortable green flash of light to let you know the image has been taken. Images are available immediately for review. You can see your own retina!

☐ I would like Optomap and agree to the $30 cost not covered by insurance. Under normal circumstances, dilation drops are not necessary with Optomap, but Dr. Patteson will decide if your pupils need to be dilated depending on your conditions.

☐ I decline Optomap and would prefer my eyes to be dilated which is covered by my insurance. I understand my near vision will be blurry and I will be sensitive to light for 4-6 hours. We will provide sunglasses if you did not bring sun protection with you.

☐ I decline both dilation and Optomap and understand that a complete comprehensive examination has not been performed.

Printed Name _____

Signature _____ Date _____

HIPAA 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 REVIEW IT CAREFULLY.

This notice tells you about the ways in which Sunset Eye Care, PC (referred to as "we") may collect, use, and disclose your protected health information, and your rights concerning your protected health information. Protected health information is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present, or future physical or mental health or condition, the provision of the health care to you, or the payment for that care. We are required by federal and state laws to provide you with this notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice while it is in effect. Some of the uses and disclosures described in this notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We may use and disclose your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures we may make without your authorization for payment, health care operations and treatment:

Payment: We use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to process claims or be reimbursed by another insurer that may be responsible for payment.
Health Care Operations: We use and disclose your protected health information in order to perform our planned activities, such as quality assessment activities or administrative activities, including data management or customer service. In some cases, we may use or disclose the information for determining health care insurance premiums. We may also contact you to provide appointment reminders or to offer information about treatment alternatives or other health-related benefits and services that may be of interest to you.
Treatment: We may use and disclose your protected health information to assist your health care providers (doctors, mental health practitioners, pharmacies, hospitals, ambulance services and others) in your diagnosis and treatment. For example, we may disclose your protected health information to providers to provide information about alternative treatments.
Plan Sponsor: If you are enrolled through a group health plan, we may provide summaries of claims and expenses for enrollees in a group health plan to the plan sponsor, who may also be an employer.
Enrolled Dependents and Family Members: We will mail explanation of benefits forms and other mailings containing protected health information to the address we have on record for the subscriber of the health plan.
As Required by Law: We must disclose protected health information about you when required to do so by law.
Public Health Activities: We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.
Victims of Abuse, Neglect or Domestic Violence: We may disclose protected health information to government agencies about abuse, neglect or domestic violence.
Health Oversight Activities: We may disclose protected health information to government oversight agencies (e.g., state insurance departments) for activities authorized by law.
Judicial and Administrative Proceedings: We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.
Law Enforcement: We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
Research: Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.
To Avert a Serious Threat to Health or Safety: We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Special Government Functions: We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
Health Information That is Not Protected: We may disclose health information about you that is not protected health information; that is, information used in a way that does not personally identify you or reveal who you are.

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under a health plan.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have certain rights regarding protected health information that we maintain about you.

Right to Access Your Protected Health Information: You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment, or case/medical management records. Your request to review and/or obtain a copy of your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.

Right to Amend Your Protected Health Information: If you feel that protected health information maintained by us is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend information that was not created by us, or if you ask to amend a record that is already accurate and complete.

Your Rights if a Request is Denied: If we deny your request to amend your protected health information, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision and we have the right to disagree with that statement.

Right to an Accounting of Disclosures Made by Us: You have the right to request an accounting of disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, to payment, to health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes. Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before January 01, 2014. Your request should indicate in what form you want to receive the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the same time period, we may charge for providing the accounting but we will tell you the cost in advance.

Right to Request Restrictions on the Use and Disclosure of Your Protected Health Information: You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. We may not agree to your request. If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.

Right to Receive Confidential Communications: You have the right to request that we use a certain method to communicate with you, such as paper or electronic communication, or that we send information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of this Notice: You have a right at any time to request a paper copy of this notice, even if you had previously agreed to receive an electronic copy.

Contact Information for Exercising your Rights: You may exercise any of the rights described above by contacting our Privacy Office. See the end of this Notice for the contact information.

HEALTH INFORMATION SECURITY

Sunset Eye Care, PC maintains physical, administrative and technical security measures to safeguard your information.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this notice at any time, effective for protected health information that we already have about you as well as any information that we receive in the future. We will provide you with a copy of the new notice whenever we make a material change to the privacy practices described in this notice.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with us and/or the Secretary of the Department of Health and Human Services. All complaints to Sunset Eye Care, PC must be made in writing and sent to the privacy official listed at the end of this notice. We support your right to protect the privacy of your protected health information. We will not retaliate against you or penalize you for filing a complaint.