MITCHELL
FAMILY EYE CARE

Patient Information

Name: (Last) _____ (First) _____ (M) _____ Nickname: _____

Gender: Male Female Birth Date: ____/____/_____ Social Security #: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

Email Address: _____ Occupation: _____

Cell Phone:_____ Employer: _____

Text reminders? ☐Yes, please ☐No thank you Marital Status: _____

Responsible Party Information

Person responsible for patient account: _____Relation to patient: _____

Social Security #: _____ Date of Birth: ___/___/_____ Occupation: _____

Address: _____ Employer: _____

Health/Medical Insurance Information

Primary Insurance: _____ Policyholder Name: _____

Policyholder Social Security#:_____ Date of Birth:___/___/___ Relation to patient: _____

Policyholder Address (if different): _____

Secondary Insurance: _____Policyholder Name: _____

Policyholder Social Security#:_____ Date of Birth:___/___/_____ Relation to patient: _____

Policyholder Address (if different): _____

Vision Insurance Information

Vision Insurance: _____ Policyholder Name: _____

Policyholder Social Security#:_____ Date of Birth:___/___/_____ Relation to patient:_____

Financial Authorization

I hereby give consent to Mitchell Family Eye Care and/or any doctors at this location to provide eye care services to myself and/or to any party for which I am legally responsible. I understand that regardless of my insurance status, I am ultimately responsible for any charges incurred by me or by any party for which I am legally responsible.

Signed: _____ Date: _____

Information Authorization

I authorize use of this signature for all of my insurance submissions. I authorize payment of benefits directly to Mitchell Eye Care Associates and/or to my doctor. I authorize the release of any medical information necessary to process claims. I permit a copy of this authorization to be used in place of the original.

Signed: _____ Date: _____

How did you hear about our office?

☐Yellow pages ☐Internet ☐TV ☐Insurance company ☐Referred by _____ ☐Other: _____

About Your Insurance

There are two types of "insurance" you may have which will help pay for your eye care services and products. Our practice accepts both:

1. Vision care plans (such as VSP and EyeMed)
2. Medical insurance (such as Blue Cross/Blue Shield and Medicare).

- Vision care plans are not true insurance, and cover only routine vision exams along with eyeglasses and contact lenses. Vision plans only cover a basic screening for eye disease. They do not cover diagnosis, management or treatment of eye diseases.
- Medical insurance must be used if you have any eye health problem or systemic health problem that has ocular complications. Your doctor will determine if these conditions apply to you, but some are determined by your case history.
- If you have both types of plans it may be necessary for us to bill some services to one plan and other services to the other. We will use coordination of benefits to do this properly and to minimize your out-of-pocket expense.
- We will bill your insurance plan for services if we are a participating provider for that plan. We will try to obtain advanced authorization of your insurance benefits so we can tell you what is covered. If some fees are not paid by your plan, we will bill you for any unpaid deductibles, co-pays or non-covered services as allowed by the insurance contract.

I have read and agree with these policies.

_____ _____
Patient signature (parent if child) Date

Refraction Charges

One of the most important parts of your eye exam today is the refraction. That is the part of the exam by which we determine whether you can be helped in any way by a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and look for problems. While it is a precise and highly technical procedure, it is NOT a covered service by Medicare and many other insurance plans. These plans consider refraction a "vision" service not a "medical" service. Our office fee for refraction is $34, and unless your plan automatically covers the refraction charge, this fee is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

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 and understand it is due at time of service. I understand that any co-payment, coinsurance or deductible I may have are separate from and not included in the refraction fee.

Signature: _____

OR:

I decline the refraction service today. I understand that without the refraction, Dr. Mitchell may not be able to fully assess the health and function of my eyes.

Signature: _____

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Medical History Questionnaire

GT: Y N M

CL: Y N

Name: _____ Birth Date: _____/_____/_____ Today's Date: _____

Race/Ethnicity: _____ Last Eye Exam: _____

Currently wearing: ☐Glasses ☐Contact lenses Last Eye Doctor: _____

Preferred Pharmacy: _____ Current Medical Dr.:_____

(please include location) _____ Last Medical Exam: _____

Medical History

Allergies to medications? ☐Yes ☐ No If yes, please list/explain: _____

_____

Please list all medications you are currently taking (including aspirin, contraceptives, over the counter medications, supplements):

_____

_____

_____

Please list all major surgeries and/or hospitalizations:

_____

_____

Family History

Have any of your relatives, living or deceased, had any of these conditions?

Ocular Disease/Condition	Yes	No	Not Sure	Relationship to You
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Crossed eye/lazy eye	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	_____

Systemic Disease/Condition	Yes	No	Not Sure	Relationship to You
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other: _____	☐	☐	☐	_____

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you wish.

☐ Yes, I would prefer to discuss my social history directly with the doctor (check box and complete side 2)

Do you drive? ☐Yes ☐ No If yes, do you have any difficulty when driving? ☐Yes ☐No If yes, please describe:

_____

Do you use tobacco products? ☐Yes ☐No If yes, type/amount/how long:

Do you drink alcohol? ☐Yes ☐No If yes, type/amount/how long:

Do you use illicit/illegal drugs? ☐Yes ☐No If yes, type/amount/how long:

Have you ever had a blood transfusion? ☐Yes ☐No

Have you ever been exposed to or infected with any sexually transmitted disease(s)? ☐Yes ☐No

Review of Systems

Please indicate if you have problems in any of the following areas:

System	Yes	No	Not Sure
Constitutional			
Fever, Weight Loss/Gain	☐	☐	☐
Skin Disorders/Disease	☐	☐	☐
Neurological			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
Eyes			
Blurred vision	☐	☐	☐
Loss of vision/side vision	☐	☐	☐
Distorted vision/haloes	☐	☐	☐
Flashes of light	☐	☐	☐
Floaters in vision	☐	☐	☐
Dry/Sandy/Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Eye pain/soreness/aching	☐	☐	☐
Redness	☐	☐	☐
Tearing/watering eyes	☐	☐	☐
Mucous discharge	☐	☐	☐
Glare/light sensitivity	☐	☐	☐
Tired eyes	☐	☐	☐
Sties/eyelid infection(s)	☐	☐	☐
Glaucoma	☐	☐	☐
Retinal disorder/disease	☐	☐	☐
Endocrine			
Thyroid disease	☐	☐	☐
Diabetes	☐	☐	☐
Other glandular disease	☐	☐	☐
Immune System disorders	☐	☐	☐

	Yes	No	Not Sure
Ears, Nose, Mouth, Throat			
Allergies (Seasonal/Environmental)	☐	☐	☐
Sinusitis/sinus disorder	☐	☐	☐
Head cold	☐	☐	☐
Chronic cough	☐	☐	☐
Dry mouth/throat	☐	☐	☐
Respiratory			
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Vascular/Cardiovascular			
Diabetes	☐	☐	☐
Heart Problems	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Vascular Disease	☐	☐	☐
Gastrointestinal			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Genitourinary			
Kidney/bladder/genital disorder	☐	☐	☐
Bones/Joints/Muscles			
Rheumatoid Arthritis	☐	☐	☐
Other arthritic condition	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
Lymphatic/Hematologic			
Anemia	☐	☐	☐
Bleeding problems	☐	☐	☐
Psychiatric disorder/disease	☐	☐	☐

Please list any other pertinent information that you feel may be important in the care of your eyes
(including history of prior diagnoses of cataracts, high pressure in eyes, ocular growths, ocular surgery, etc):

_____

_____

_____

_____

_____

(Office use only)

GT: Y N M **GLC** **DM**

CL: Y N M

MITCHELL
FAMILY EYE CARE

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY

I hereby acknowledge that I have received a copy and/or read the (HIPPA) Health Insurance Portability and Accountability Act.

_____
(printed name)

_____ _____
(signature) (date)
(parent or legal guardian, if minor)

PERMISSION TO RELEASE MEDICAL RECORDS

I _____, hereby give permission to release any and all medical information obtained during the course of any examinations to the following individual(s):

_____ _____
(name) (relationship)

_____ _____
(name) (relationship)

_____ _____
(name) (relationship)

Signed:_____ Date:_____

NOTICE OF PRIVACY PRACTICES

Mitchell Family Eye Care
David M. Mitchell, O.D.
Lisa L. Mitchell, O.D.
425 Saint Mary St.
Thibodaux, LA 70301
PH 985-447-2393 FX 985-447-2399
Office Contact Person: Rachel Zachry

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.

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 your eyes; prescribing glasses, contact lenses, or 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 that 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 (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that 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: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for 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 governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or 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 agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a 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 the cause of death; or to funeral directors to aid in burial; or to 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 the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health 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 eye care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that 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 post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or 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 you will give us a properly completed authorization form, 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, 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 honor the 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 by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail 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 a few limited situations in which we can refuse to 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 one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies 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 that it is 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 persons who 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 one 30 day extension of 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 written request, including your reasons for the 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 have 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 of 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 one 30 day 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 written 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 already have 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 on our Web site.

COMPLAINTS

If you think that we 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 prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

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