RINEHART FAMILY EYE CARE

As a new patient to our practice, we would like to offer a warm welcome and our thanks for choosing us to provide your eye health and vision care. In order for us to establish your file, and provide the most beneficial use of your time with us, the doctor has asked you to complete the following tasks and bring the results to your appointment. The doctor needs this information in order to give you the best care possible.

- □ **Completed Welcome to the Office Form**: This diagnostic information includes personal and family information needed to establish your file, as well as your current eye health and vision status. Your responses will guide our doctors and staff, and remind us to address any significant issues during your visit.

- □ **Completed Medical and Eye Health History:** Since many general health conditions may be associated with visual symptoms and/or eye health problems, this important record (now required by state health boards and virtually any medical and optical insurance plans) will allow us to care for you as a "whole person" rather than just a pair of eyes. This form includes a complete list of prescription and non-prescription medication, which may be brought in as a separate list for us to photocopy if you prefer.

- □ **Insurance cards or claim forms:** For any optical and/or medical insurance you may be covered by. (Even for "routine" visits, if a medical eye condition is discovered during your examination we can submit a claim to your health insurance for the medical evaluation portion of your examination.)

- □ **Eyeglasses:** Please bring ALL pairs of eyeglasses you currently use, including prescription or non-prescription reading glasses, sunglasses, etc. We have instruments to compare the optical power of your old lenses with your new exam findings, thus enabling us to determine and explain how your vision has changed over time. We can also evaluate the condition and fit of your current eyewear.

- □ **Contact Lenses:** It is best to wear your current contacts to your appointment if possible. Next best is to bring them along in your case. If you wear planned replacement or disposable lenses, it is very helpful if you bring along your cartons or lens packets that indicate the lens series, power, manufacture, etc.

- □ **Eye drops, ointments, etc:** Please place any eye drops or ointments that you use in a small bag and bring it along with you. Your doctor will review whether these or appropriate or if a better option is available.

- □ **Dilation Explained**: The doctor may need to use drops to dilate your eyes in order to fully evaluate their internal health. This has the effect of temporarily increasing sensitivity to light and causing "fuzzy" vision at a near (reading) distance. Therefore, if you want new eyewear or feel you may need to select new eyewear, please come 15 to 20 minutes before your appointment time in order to look at our frame selection.

Completing the task list for the items that apply to you will assure you of receiving the most thorough and professional care possible and in a very efficient manner. We look forward to your visit!

7801 Glenlivet West Road, Fogelsville, PA 18051
Phone: (610)-841-4944 | Fax: (610)-841-4948
www.rinehartfamilyeye.com

RINEHART
FAMILY EYE CARE, PC
For Vision. For Health. For Life.

WELCOME TO OUR OFFICE

Today's Date _____

Patient Information

Last _____
First _____ MI _____
Street _____
City _____ State _____
Zip Code _____
Date of Birth _____ Age _____
Sex M F
Home Phone _____
Work Phone _____
Cell Phone _____
Email Address _____
How do you prefer to be contacted?
(Indicate #1 and #2 Choice):
Home #___Work #___Cell #___Text___Email___
Patient's SSN _____
Employer (or School) _____
Occupation (or Grade) _____
Spouse (or Parent's Name) _____
Spouse (or Parent's Work) _____

What is the major purpose of this visit?

_____

Any problems with your current contact lenses or glasses?_____

_____

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?
Name of friend or relative _____
If not referred, how did you choose our office?
❑ Another Dr.
❑ Insurance List
❑ Saw Sign/Building
❑ Newspaper/Radio/TV
❑ Yellow Pages: Which directory? _____
❑ Web Page: Which Web Site? _____
❑ Other _____

The mission of Rinehart Family Eye Care is to contribute to a lifetime of healthy vision, proving each patient with the highest quality vision care and consequent quality of life. We will seek continuing education to remain at the forefront of our profession and will offer the latest eye care technology, professional services, and products. The visual needs and wellness of each patient will always be our first priority. Everything we do shall communicate this.

Insurance Information

Vision Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

Primary Medical Insurance_____
Subscriber Name_____
Subscriber SSN_____
Subscriber Birth Date_____

Do you participate in a flex spending account?
❑ Yes ❑ No
How will you settle your account today?
❑ Cash ❑ Check ❑ Credit Card

Lifestyle Questions

Do you……(check box if your answer is yes)
❑..work at a computer?
❑..think you might benefit from thinner, lighter lenses?
❑..have interest in a "test drive" of the latest contact lens designs
❑..spend time outdoors? How much? __Hrs/week
❑..have prescription sunwear?
❑..prefer not to wear your glasses at times?
❑..have more than 1 pair of current Rx eyewear?
❑..have children?
❑..have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

❑ Blurry Vision
❑ Cataracts
❑ Crossed eye/Eye turn
❑ Eye Infections
❑ Flash of light
❑ Glaucoma
❑ Headaches
❑ Itchiness
❑ Macular Degeneration
❑ Retinal Detachment
❑ Tearing
❑ Uncomfortable glasses
❑ Burning
❑ Corneal Abrasions
❑ Double Vision
❑ Eye Injury
❑ Floaters/Spots
❑ Grittiness
❑ Iritis/Uveitis
❑ Lazy Eye
❑ Occasional dryness
❑ Sunlight Sensitivity
❑ Trouble seeing at night
❑ Other eye disorders_____

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician_____
Town_____
CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)_____
_____
_____
Allergies to medications? ❑ Yes ❑ No
If so, what medications?_____
_____
Do you: Use cigarettes/tobacco: ❑ Yes ❑ No
If yes, how often:_____
Drink alcohol: ❑ Yes ❑ No
If yes, how often:_____
Use other substances? ❑ Yes ❑ No
Previous history of blood transfusion: ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Are you currently pregnant?	❑	❑
Asthma	❑	❑
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Cancer	❑	❑
Cholesterol	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Eczema/Rashes	❑	❑
Fatigue	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Integumentary (Skin)	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sexually transmitted disease	❑	❑
Sinus	❑	❑
Thyroid	❑	❑
Unusual weight losses/gains	❑	❑
Vertigo/Dizziness	❑	❑

RINEHART
FAMILY EYE CARE, PC
For Vision. For Health. For Life.

Patient Eye History

Date of Last Eye Exam_____
By Whom?_____

Previous history of eye surgery? ❑ Yes ❑ No

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?_____
Solutions used_____

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No

Would you prefer clear contact lenses or colored contact lenses? ❑ Clear ❑ Colored

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
❑ No ❑ Yes (Please check boxes)

	Relationship (Mother's or Father's side)
Blindness	❑_____
Cataracts	❑_____
Corneal Problems	❑_____
Diabetes	❑_____
Glaucoma	❑_____
Heart Disease	❑_____
Lazy Eye	❑_____
Macular Degeneration	❑_____
Retinal Problems	❑_____

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Rinehart Family Eye Care.

If your insurance company has not reimbursed our office in full within 60 (or 90) days, you are responsible for providing payment in full to Rinehart Family Eye Care.

Optomap Retinal Exam

Doctors Scott and Nicole Rinehart are proud to present patients with **the most highly advanced technology in retinal screening today**. Our doctors are concerned about retinal problems such as **macular degeneration, glaucoma, retinal holes, retinal detachments, and diabetic retinopathy**. All of these can lead to loss of vision or blindness. Additionally, systemic diseases such as high blood pressure and diabetes can be detected during a retinal exam. Because we continuously strive to provide our patients the very best in eye care services, we recommend this following test as an enhancement to your basic examination.

Optomap Retinal Exam, which provides:

- The ability to review your Optomap images with your Doctor during your exam.
- An eye wellness scan
- An annual, permanent record for your medical file, which gives your Doctor a better way to compare and look for change year after year.

The Optomap Retinal Exam is fast, easy, and comfortable, and **does not require dilating drops**. (You will not have blurred vision or light sensitivity). It is **recommended for all patients**.

*The fee for the Optomap is $95. However, if a medical diagnosis is not found, as a courtesy, you will be charged $40.

*If a medical diagnosis is found, your insurance may be billed upon your request. If your insurance is billed, you will be responsible for your co-insurance and any deductible that may apply.

I choose to: _____Accept _____Decline

I wish my insurance to be billed: _____Yes _____No
(applies to scans with medical diagnosis only)

Print Name:_____

Signature:_____ Date:_____

Rinehart Family Eye Care, PC

www.rienhartfamilyeye.com

Insurance Release

It is hereby agreed and understood that Rinehart Family Eye Care will **ONLY** submit to Insurance provided at the time of your visit. Incorrect insurance provided at the time of your visit will result in you being responsible for the visit in full.

Routine vision is through your Vision Provider and ANY testing will go through your Medical Insurance (**NOT ROUTINE**).

If for **ANY** reason a referral is required by your Insurance, **YOU** are responsible for contacting your Primary Care Physician **PRIOR** to your visit with our office. If your referral is not present for your visit, you will be responsible for payment in full at the time of service.

It is hereby agreed and understood that if for any reason your Insurance denies your claim **YOU** will be responsible for payment in full at the time of receipt.

Print Patient Name: _____

Patient's Signature: _____

ATTENTION ALL CURRENT AND PROSPECTIVE CONTACT LENS WEARERS

If you wish to obtain a new or updates contact lens prescription there **WILL BE** an **EVALUATION/FITTING FEE** charged at the time of your visit. The fee varies based on the type of lenses you are fitted with, and is determined by the Doctor that day.

MOST INSURANCE COMPANIES DO NOT COVER THIS FEE

If you have any questions or concerns, please speak with our front desk **PRIOR** to your exam.

Patients Signature: _____

(Signature of Parent or Guardian if Patient is under 18)

Date: _____

Rinehart Family Eye Care, PC
7801 Glenlivet West Drive
Phone: *610-841-4944*
Fax: *610-841-4948*
Email: *contactus@rinehartfamilyeye.com*

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name_____

Patient number _____

Patient address _____

Patient phone number _____

I authorize the professional office of my optometrist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released [name(s) or class(es) of recipients]:

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated _____ Patient signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____

Source of Authority _____

Effective date of notice: _____

NOTICE OF PRIVACY PRACTICES

Rinehart Family Eye Care, PC
7801 Glenlivet West Drive
Phone: *610-841-4944*
Fax: *610-841-4948*
Email: *contactus@rinehartfamilyeye.com*

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 not 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 contact person at the address or phone number shown at the beginning of this Notice.

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ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Rinehart Family Eye Care's Notice of Privacy Practices.

Patient name _____

Signature _____ Date:_____

RINEHART FAMILY EYE CARE, PC

7801 Glenlivit West Drive

Fogelsville, Pa. 18051

Communication Consent

Patient Name: _____ Date:_____

The office policy of Rinehart Family Eye Care, PC and staff is not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, and/or cell phone. Also, information will not be left with an unauthorized person who may answer the telephone.

I authorize Rinehart Family Eye, PC and or/ their staff to leave medical information pertaining to my care by the following methods and will assume full responsibility to notify this office wheneber this information changes.

Home Telephone	( )	Yes	( )	No
Answering Machine	( )	Yes	( )	No
Work Telephone	( )	Yes	( )	No
Voice Mail	( )	Yes	( )	No
Cell Phone/ Voice Mail	( )	Yes	( )	No
Fax Medical Records to another Entity	( )	Yes	( )	No
Send Medical Records via secure Email	( )	Yes	( )	No

If you would like to have information released to someone other than yourself please complete the following:

Spouse:_____

Parent: _____

Other: _____

AUTHORIZATION

Print Name:_____

Patient/Guardian Signature: _____