PATIENT REGISTRATION FORM

Please Print in Blue Ink

Medical Records # (Office Use Only)	
Date:	

SCAN ID OR DRIVERS LICENSE HERE

HOME ADDRESS: (If different from ID please fill in)		
HOME PHONE Ok to leave voicemail? ☐ Yes ☐ No	**CELL PHONE** Ok to leave voicemail? ☐ Yes ☐ No	**WORK PHONE** Ok to leave voicemail? ☐ Yes ☐ No
SOCIAL #	**DATE OF BIRTH**	**SEX** ☐ Male ☐ Female
EMAIL: Ok to Email? ☐ Yes ☐ No		

SCAN MEDICAL NSURANCE CARD HERE

PRIMARY MEDICAL INSURANCE:

EMPLOYEER/SCHOOL NAME **CITY** **STATE** **ZIP**		
PRIMARY SUBSCRIBER	**SOCIAL**	**DOB**
PHONE NUMBER	**RELATIONSHIP**	

SCAN SECONDARY NSURANCE CARD HERE

SECONDARY MEDICAL INSURANCE:

If you are covered under secondary insurance, please complete the following:

EMPLOYEER/SCHOOL NAME **CITY** **STATE** **ZIP**		
PRIMARY SUBSCRIBER	**SOCIAL**	**DOB**
PHONE NUMBER	**RELATIONSHIP**	

SCAN VISION INSURANCE CARD HERE

VISION INSURANCE PLAN:

EMPLOYEER/SCHOOL NAME **CITY** **STATE** **ZIP**		
PRIMARY SUBSCRIBER	**SOCIAL**	**DOB**
PHONE NUMBER	**RELATIONSHIP**	

Please note that insurance does NOT cover any Contact Lens Fitting Evaluations

Who may we thank for referring you to our office?

☐ Friend ☐ Insurance ☐ Phone Book ☐ Social Media ☐ Other

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Medical Records # (Office Use Only)	
Date:	

Authorization and Assignment of Insurance Benefits/Release of Medical Information: I authorize and request my insurance company or companies to pay benefits directly to College Hill Eye & Optical for services rendered. I authorize the release of any medical records and/or other information required by my insurance company or its designated review agents who provide insurance benefits on my behalf, including, if applicable, my employer, employer's workman's compensation insurance company, the Social Security Administration and/or the Centers for Medicare & Medicaid Services, needed to determine benefits and to process insurance claims and secure payments of benefits to either the insured or to College Hill Eye & Optical. Additionally, I will submit fully completed claim forms as requested by my insurer or College Hill Eye & Optical.

Referrals and Authorizations: If I have an insurance plan that requires any referrals, pre-certifications and/or authorizations, I understand that it is my responsibility and not College Hill Eye & Optical's to obtain approval from my insurer for medical services prior to such services being rendered by notifying my PCP of my request and providing all required documentation. If any medical services are rendered without the proper insurance approval, I understand that this may cause reduced or rejected coverage for which I will be held responsible, and that any of these aforementioned actions do not guarantee that my insurer will pay for the claims. Any denial of claims is between the policy holder and my insurer. I understand medical services may not be rendered without the proper referral on file.

Financial Agreement: I agree that payment in full is due at the time of treatment. I understand that I may be billed separately for services rendered by other professionals in the building including, but not limited to, laboratory services. I understand that if a referral is not obtained from my insurer or if my insurer refuses to cover any or all charges for services provided, that I am responsible for and agree to pay any and all charges denied by my insurance company. Any questions or disputes concerning insurance coverage or payment of benefits are a matter between the policyholder and the insurer. Any assistance in this matter granted by College Hill Eye & Optical is given strictly as a courtesy and implies no responsibility on College Hill Eye & Optical's part for filing, follow through or confirmation. I agree that if for any reason a check is returned on my account, I will be responsible for a $25.00 returned check fee in addition to the original fee(s) for service(s). Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, not adding a dependant to insurance plan, non-payment at time of service and/or any other reasons, I agree to pay all charges within 30 days of services rendered. I understand College Hill Eye & Optical reserves the right to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance and to notify credit bureaus of my delinquencies.

Certification: I certify that the information I provided above is true and complete. I agree to inform College Hill Eye & Optical immediately of any change in insurance coverage, benefits and/or change of personal information. I permit a copy of this authorization and signature to be used in place of this original on all insurance claim and submissions, whether manual, electronic or telephonic. I understand and agree that the terms herein are reaffirmed each time services are rendered.

Your Optometry providers want to make sure that you and the other area residents have access to high-quality eye care when you need it. To ensure maximum access to eye services for all of our patients, please be aware of the following appointment policy:

Scheduled Appointments: If you cannot make your scheduled appointment, you must call us at least 24 hours in advance to let us know. This allows us enough time to offer your appointment to another patient. Failure to provide at least 24-hour notice will be considered a missed appointment. Missed Appointments: Missed appointments will be documented in your optometry record. If you miss more than one optometry appointments within a twelve-month period, you will be charged a $50 no show fee per occurrence. If you miss more than three appointments you may only be seen for routine care on a time available, walk in basis only, but must realize that appointed patients and emergencies will take priority. You will be allowed to make emergency appointments at any time. Once you reach 6 months of no missed appointments, you can begin making appointments.

Late Arrivals: We are able to accommodate patients up to 10 minutes past their appointment time. All paperwork and registration must be completed within 10 minutes of your scheduled start time in order for the doctor to see you for your appointment. If you have not arrived and completed your paperwork in time you will be given one of the following options:

- You may reschedule the appointment.
- Wait for a same-day opening in the schedule, that will permit the scheduled work to be completed, or
- If possible a portion of the scheduled work will be completed during the remaining appointment time.

Optical Orders: While payment is due at time of service, from time to time it may be appropriate to offer patients alternate payment plans. When ordering spectacles or contact lenses, at minimum half of the order total is due at the time of order and the remainder may be paid at pick-up. At no time will the amount paid be refundable because the materials (frame, lenses, etc) will have been ordered and fabricated to your prescription prior to complete payment. Orders that are not picked-up with-in one year plus one day will be discarded.

General Information: Informed consent will be obtained from all patients accessing medical, behavioral health, and/or research services/activities. Informed consent is not merely a signed document. It is an ongoing process that considers patient needs and preferences, compliance with law and regulation, and patient education. The patient and/or family, as appropriate, are given information about:

- The patient's condition;
- Proposed treatments, procedures, or research activities;
- Potential benefits and drawbacks of proposed treatments or procedures;
- Problems related to recuperation;
- Alternative treatment(s) or procedure(s);
- The physician or other practitioner primarily responsible for the patient's care;
- Others authorizing or performing procedures or treatments; and
- Any business relationships among individuals treating the patient, or between the organization and any other health facility.

Treatment, Payment and Data Agreement:

- I authorize examination and treatment for my initial and all following health visits.
- I understand I am personally responsible for all charges and deductibles. Financial assistance is available for those who qualify.
- I am personally responsible for providing accurate and current insurance information.
- I authorize a photocopy of this statement to serve as the original and the use of this signature on all insurance submissions.
- I authorize release of all information necessary to secure payments of benefits.
- I understand that Fenway Health may use data developed for and/or provided by clients to determine general characteristics of the communities it serves and that none of this information will in any way identify individual clients.

I certify that the above information is true and correct. I have received a copy of College Hill Eye & Opticals Notice of Privacy and Patient Rights and Responsibilities.

PATIENT SIGNATURE	PRINT NAME	DATE

PATIENT HEALTH HISTORY

Please Print in Blue Ink

Medical Records # (Office Use Only)	
Date:	

Although optometrists primarily treat the areas in and around the eyes, your eyes are part of your entire body. Health problems you may have, or medications that you may be taking, could affect your eyes and vision.

Please answer the following questions to the best of your ability.

PRIMARY CARE DOCTORS NAME:	PHONE NUMBER:	DATE OF LAST PHYSICAL:

MEDICAL HEALTH: PLEASE CHECK OFF ALL THAT APPLIES TO YOUR MEDICAL HEALTH

ALLERGIC/IMMUNE DISEASE
- ☐ Allergies
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Other: ________________

DIABETES/THYROID DISEASE
- ☐ Diabetes: _______ years
- ☐ Glucose Levels: ______
- ☐ HbA1C: __________
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction

MUSCLE/BONE DISEASE
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Ankylosing Spondylitis
- Other: _____________

HEART DISEASE
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Vascular Disease
- ☐ High Cholesterol
- ☐ Other: _____________

STD
- ☐ Herpes
- ☐ Chlamydia
- ☐ HIV Positive
- ☐ Other: _____________

NEUROLOGICAL DISEASE
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Other _____________

GENERAL ILLNESS
- ☐ Developmental Disability
- ☐ Weight Loss
- ☐ Fever
- ☐ Fatigue
- ☐ Trauma
- ☐ Other: _____________

BLOOD DISEASE/CANCER
- ☐ Anemia
- ☐ Large Volume Blood Loss
- ☐ Cancer:
  - ☐ Type: _______
  - ☐ Other: _____________

RESPIRATORY DISEASE
- ☐ Cigarette Smoker
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Other: _____________

PSYCHIATRIC DISEASE
- ☐ Depression
- ☐ Panic Disorder
- ☐ Schizophrenia
- ☐ Other: _____________

ANY CHANCE YOU MAY BE PREGNANT?
☐ Yes ☐ No

NUMBER OF CHILDREN: ______

Current Medications & Amounts: *(if you need to records additional medication please record on the backside)*

Medication	Amount	Medication	Amount	Medication	Amount

PATIENT HISTORY FORM

Please use Blue Ink

Medical Records # (Office Use Only)	
Date:	

Eyewear History:

- ☐ Glasses
- ☐ Single Vision/Reading
- ☐ Bifocals
- ☐ Trifocals
- ☐ Progressive/No-line
- ☐ Soft Contacts
- ☐ Scleral
- ☐ Hard/GP
- ☐ Toric Soft
- ☐ Disposable
- ☐ Overnight wear
- ☐ Other:____________________

Select each box that applies:

- ☐ Have never tried contact lenses.
- ☐ Contact lenses were not comfortable when I tried them.
- ☐ I would prefer or like to try colored contacts.
- ☐ Would you like to try contacts that change into sunglasses?
- ☐ Bifocals lens lines and head tilting is inconvenient.

Lifestyle History: *(check the box if your answer is yes)*

- ☐ Work at a Computer : Hours per Day _____
- ☐ Would like thinner lenses
- ☐ Would like to try the latest most advaned contact lenses
- ☐ Spend time outdoors
- ☐ Prefer not to wear glasses all the time

Have more than, or would like more than one type of eyeglasses or features for my needs.

- ☐ Distance/Far
- ☐ Reading/Near
- ☐ Distance+Reading
- ☐ Computer Glasses
- ☐ Sunglasses
- ☐ Multi-focal Sun
- ☐ Anti-glare
- ☐ Bluelight Blocker

Family History:

- ☐ Ambylopia
- ☐ Blindness
- ☐ Cancer
- ☐ Cataract
- ☐ Crossed eyes
- ☐ Diabetes
- ☐ Droopy lid
- ☐ Eye infections
- ☐ Eye injuries
- ☐ Eye Surgery
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High B.P.
- ☐ Keratoconus
- ☐ Kidney Desease
- ☐ LASIK
- ☐ Lazy eye
- ☐ Macular Degeneration
- ☐ Migraines
- ☐ Retina Disease
- ☐ Retina Detach
- ☐ Thyroid
- ☐ Other: ____________________

Social History:

- ☐ Computer Use
- ☐ Reading
- ☐ Tobacco Use
- ☐ Drug Abuse
- ☐ Alcohol Abuse
- ☐ Student
- ☐ Music
- ☐ Skiing
- ☐ Golf
- ☐ No alcohol/drug abuse
- ☐ Fishing
- ☐ Tennis
- ☐ Shooting
- ☐ Scuba
- ☐ Swimming
- ☐ Biking
- ☐ Non-Smoker
- ☐ Other: ____________________

Current Medications & Amounts: *(including oral contraceptives, asprin, over the counter medications and remedies)*

Medication	Amount	Medication	Amount	Medication	Amount

NOTICE OF PRIVACY PRACTICE (Patient Copy)

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.

I. Our Privacy Pledge and Duties

While we have and always will respect your privacy, a new federal law now requires us to maintain the privacy of hearing health information and other medical information (including examination, treatment and billing records) about you and to provide you with this Notice of our legal duties and privacy practices with respect to such health information.

We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change terms of our privacy notices. If we change the terms of the Notice, we will notify you during your next visit or by mail.

II. Permissible Uses and Disclosures Without Authorization

In certain situations (described in Section III below), we must obtain your written authorization in order to use and/or disclose your health information. However, here are some examples of how we might use or disclose your health information (other than highly confidential information) without first obtaining your written authorization:

A. Uses and Disclosures for Treatment, Payment or Health Care Operations

1. Treatment. Your hearing health care professional or staff member may use and disclose your health information to diagnose, assess and treat your health condition.
2. Payment. Our insurance and billing staff may disclose your health information to an insurance carrier, HMO, PPO, your employer, or other party that arranges or pays the cost of some or all of your health care, or to verify that such parties will pay for your health care.
3. Health Care Operations. Your hearing health care professional and members of the staff may use or disclose your health information for quality control purposes or for other administrative purposes to efficiently and effectively run his/her practice.
4. Appointment Reminders. Your hearing health care professional and members of the staff may need to use your name, address, phone number, and other health information to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine or at another location that you reasonably request.
5. Other Providers. Your hearing health care professional and members of the staff may use or disclose your health information to another health care provider, product manufacturer, or a hospital if it is necessary to refer you to them or they are otherwise involved in your care when such information is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection or compliance.

B. Disclosures to Relatives, Close Friends and Other Caregivers

Your hearing health care professional and members of the staff may use or disclose your health information to one of your family members, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure. If you object to such uses or disclosures, please notify your hearing health care professional.

If you are not present, you are incapacitated or in an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. We may also disclose your health information to notify such persons of your location or general condition.

C. Other Permitted Uses and Disclosures Without Your Authorization

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

1. Public Health Activities. We may disclose your health information for certain public health activities such as (i) reporting health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (ii) reporting child abuse and neglect to authorities authorized by law to receive such reports; (iii) reporting information about products or services under the jurisdiction of the U.S. Food & Drug Administration; (iv) alerting a person who may have been exposed to a communicable disease or who may otherwise be at risk of contracting or spreading a disease or condition; and (v) reporting information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.
2. Victim of Abuse, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose health information to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect or domestic violence.
3. Health Oversight Activities. We may disclose your health information to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health care programs such as Medicare or Medicaid.
4. Judicial and Administrative Proceedings. We may disclose your health information in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.
5. Law Enforcement Officials. We may disclose your health information to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.
6. Decedents. We may disclose your health information to a coroner or medical examiner as authorized by law.
7. Organ and Tissue Procurement. We may disclose your health information to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.
8. Research. We may use or disclose your health information if an Institutional Review Board approves a waiver of authorization for use or disclosure.
9. Health or Safety. We may use or disclose your health information to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.
10. Specialized Government Functions. We may use or disclose your health information to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances required by law.
11. Workers' Compensation. We may disclose your health information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.
12. As Required by Law. We may use or disclose your health information when required to do so by any other law not already referred to in the preceding categories.

III. Uses and Disclosures Requiring Your Authorization

A. Uses or Disclosure With Your Authorization. Other than the circumstances described above, any other use or disclosure of your health information will only be made with your written authorization. Additionally, you have the right to refuse to give us authorization to use or disclose your health information for purposes other than those described above. 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.

B. 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 taken an action in reliance upon such authorization before we receive your request to revoke your authorization.
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 the address given in Section VII below.

C. Marketing. We must also obtain your written authorization prior to using your health information to make you aware of products or services that you may have an interest in purchasing from time to time. We can, however, provide you with marketing materials in a face-to-face encounter without obtaining your authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without first obtaining your authorization. Additionally, we may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings.

NOTICE OF PRIVACY PRACTICE (Patient Copy)

D. Uses and Disclosures of Your Highly Confidential Information. In addition, federal and state law requires special privacy protections for certain highly confidential information about you. In order for us to disclose your highly confidential information for a purpose other than permitted by law, we must obtain your written authorization.
E. Right to Refuse Authorization. You have the right to refuse to give us an authorization to use or disclose your health information or otherwise contact you for purposes other than those set forth in Section II above. 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.
IV. Your Individual Rights
A. Your Right to Receive Confidential Communication Regarding Your Health Information. We normally provide information about your health in person, at the time you receive hearing care 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 by an alternative means of communication or at an alternative location. To help us respond to your needs, please make any requests in writing.
B. Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of your health information (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your general location and general condition. All requests for such restrictions must be made in writing. While we consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction.
C. Your Right to Inspect and Copy Your Health Information. You may request access to your health information maintained by us in order to inspect and/or copy your health information. We require your request to inspect an/or copy your health information to be in writing. If you request copies, we will charge you $10 for the first 20 pages, and .45c for each additional page. We will also charge you for our postage costs, if you request that we mail the copies to you.
D. Your Right to Amend Your Health Information. You have the right to request that we amend your health information maintained by us. 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.
E. 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 disclosures we have made of your health information for the last six years before the date of your request, provided such request does not apply to disclosures that occurred prior to April 14, 2003 . The accounting will include all disclosures except those disclosures:

- required to carry out treatment, payment and health care operations to you.
- that are incident to a permitted use or disclosure.
- made pursuant to an authorization.
- required to maintain a directory of the individuals in our facility or to individuals involved with your care.
- required for national security or intelligence purposes.
- to correctional institutions or law enforcement officers.
- made as part of a limited data set.
- made prior to April 14, 2003 .

If you request an accounting more than once during a twelve (12) month period, we will charge $1per page of the accounting statement.
V. 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 federal law.
VII. Your Right to Obtain Further Information; Complaints
If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about providing you access to your health information, please contact us. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, we will provide you with the address for the Director. 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 or request information at any time, written comments should be addressed to: Dr. John Ormando, 295 South Main St, Providence, RI 02903.VIII. Your Right to Receive a Paper Copy of this Notice
Upon written request, you may obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically.
IX. Effective Date. This Notice is effective as of April 14, 2003

YOUR ACKNOWLEDGEMENT OF THE RECIEPT OF THIS NOTICE OF PRIVACY PRACTICES WAS SIGNED ON YOUR PATIENT REGISTRATION FORM GIVEN TO YOU THE SAME DAY AS THIS FORM.