



Patient Information *(Please Print)*

Prefix ____ Mr. ____ Mrs. ____ Ms. ____ Dr. ____ Rev. ____ Child
First Name _____ Last Name _____ Middle Initial ____
Nickname _____ Date of Birth _____ (mm/dd/yyyy)
Address _____
City _____ State _____ Zip _____ SSN _____
Cell Phone () _____ Work Phone () _____ DL # _____
Home Phone () _____ E-Mail _____
Preferred Contact # _____ Sex ____ Male ____ Female
Are you? (circle one) A Minor Single Married Divorced Widowed
Are you? (circle one) Employed Retired Full-Time Student Part-Time Student
Occupation _____
Employer/School Name _____

Emergency Contact Name _____ Phone _____
Relationship to patient _____

How did you hear about us? ____ INSURANCE CO. ____ WEBSITE ____ FACEBOOK
____ ANOTHER PATIENT (IF SO, WHO?) _____

PRIMARY INSURED'S INFORMATION

Name of person responsible for this account? _____
Relationship to patient _____ Phone # _____
Address _____ City _____ State ____ Zip _____
Birthdate _____ Social Security # _____ Date Employed _____
Name of employer _____ Work Phone # _____
Employer's Address _____ City _____ State _____
Zip _____
Insurance Co. _____ Member ID _____
Group # _____

Do You Have Additional Insurance? ____ No ____ Yes

If Yes, Please complete the following:

Name of insured _____ Relationship to patient _____
Birthdate _____ Social Security # _____ Date employed _____
Name of employer _____ Work Phone # _____
Address _____ City _____ State ____ Zip _____
Insurance Co. _____ Member # _____

MEDICAL HISTORY RECORD

Reason for Today's Exam: _____

Last Eye Exam: _____ Last Eye Doctor: _____ Primary Care Doctor: _____

Current Medications: _____

Allergic to any medication: _____ Pharmacy Used: _____

Please check any condition that applies to yourself or any members of your immediate family

	Self	Family		Self	Family
Diabetes	_____	_____	Glaucoma	_____	_____
High Blood Pressure	_____	_____	Cataracts	_____	_____
Heart Problems	_____	_____	Macular Degeneration	_____	_____
High Cholesterol	_____	_____	Retinal Detachment	_____	_____
Asthma/COPD/Emphysema	_____	_____	Flashes/Floaters	_____	_____
Auto- Immune Diseases	_____	_____	Blindness	_____	_____
Anemia	_____	_____	Lazy Eye/Amblyopia	_____	_____
Arthritis	_____	_____	Eye Injury/Surgery	_____	_____
Thyroid Problems	_____	_____	Itching Eyes	_____	_____
Eczema/Rosacea	_____	_____	Eyes Water	_____	_____
Headaches/Migraines	_____	_____	Dry Eyes	_____	_____
Cancer	_____	_____	Eyes Burn	_____	_____
Ear/Nose/Throat	_____	_____	Eye Turn/Strabismus	_____	_____
Kidney/Bladder	_____	_____	Double Vision	_____	_____
Anxiety/Depression	_____	_____	Temporary Vision Loss	_____	_____
Seizures	_____	_____	Pregnant	_____	_____
HIV	_____	_____	Given Birth in last 6 mos.	_____	_____

Other ailments or diagnosis not listed above: _____

Do you drink alcohol? YES / NO If yes, how much per week? _____

Do you use tobacco products? YES / NO If yes, how much per week? _____

Do you use recreational drugs? YES / NO If yes, what do you use and how often? _____

Do you currently wear glasses: ___ Full-time ___ Reading/Near work ___ Work/Safety ___ Computer Work
___ Distance only ___ Other/Explain _____

Do you wear contact lenses? ___ Yes ___ No If so, what style: ___ Soft ___ Extended wear ___ Bifocal
___ Gas Permeable ___ Colors ___ Astigmatism ___ Disposable ___ Unsure

Are you interested in wearing contact lenses? ___ Yes ___ No OR laser vision correction? ___ Yes ___ No

Do you work at a computer or video display terminal? ___ Yes ___ No

What hobbies or sports do you participate in? _____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eyecare to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor insurance benefits otherwise payable to me. I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all uncovered services rendered on my behalf or my dependents.

X _____ Date: _____

SIGNATURE OF PATIENT (Or parent if patient is a minor)

NOTICE OF PRIVACY PRACTICES

Clifton Eye Care. This Notice describes how much medical information about you may be used and disclosed and about how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information. Under the federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information. We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations. Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcome of your case and others like it.

Special Uses. We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Research: We may use or disclose information for approved medical research.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious Threat to Health and Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensation: We may release information about you for workers compensation or similar program providing benefits for work-related injuries or illness. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about your legal duties and privacy practices regarding protected health information and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices

We may change our policies at any time. Before we make significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person below.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact:

Clifton Eye Center

Deana Clifton, O.D.

1000 Chinaberry Drive, Suite 302

Bossier City, LA 71111

(318)-550-5815

I, _____ hereby acknowledge receipt of the
Notice of Privacy Practices given to me.

Signed: _____

Date: _____

If not signed, reason why acknowledgement was not obtained: _____

Staff Witness: _____

Date: _____



ABOUT YOUR INSURANCE

Most people have vision insurance and medical insurance. They are very different in terms of the services they cover and it is important for our patients to understand those differences.

Vision insurance (i.e.- VSP) is mainly designed to determine a prescription for glasses, to help pay for glasses or contact lenses, and to cover a routine evaluation of the health of the eyes in a healthy patient that has no particular problems or symptoms. It is not equipped to deal with and does not cover medical conditions and/or treatment plans.

When a medical diagnosis or condition is present that affects your eyes, such as high blood pressure, high cholesterol, or diabetes, etc. or if you have an eye problem such as an infection (pink eye), dry eyes, allergy, cataracts, etc., we must file with your medical insurance (i.e.-Medicare, BCBS, United Healthcare, etc.), and the co-pays and deductibles for that insurance will apply.

Insurance carriers set these rules and our office is obligated to follow them. In most cases, there is no way to know prior to the examination which type of insurance our office will be able to file for you. We make every effort to be on as many insurance company's panels for your convenience, and we will file those claims for you. In the event that we do not accept your medical or vision insurance, we will provide you with an itemized receipt so that you may file a claim with your insurance yourself for reimbursement. If you have any questions, please let us know.

I understand the information I have just read about the difference between vision and medical insurance and I authorize Clifton Eye Center to file my claim with the appropriate insurance based on the reason for my visit and the results of my examination.

Sign: _____ Date: _____
(Parent signature if patient is a minor)

SHARING YOUR PERSONAL/MEDICAL INFORMATION

PLEASE NOTE THAT DUE TO HIPAA LAWS WE WILL NOT SHARE YOUR INFORMATION WITH ANYONE WITHOUT YOUR CONSENT. THIS MAY INCLUDE YOUR SPOUSE OR CHILDREN. IF YOU WOULD LIKE ANYONE TO HAVE ACCESS TO YOUR INFORMATION PLEASE FILL OUT THE INFORMATION BELOW.

I, _____ (pt. name), ALLOW CLIFTON EYE CENTER TO SHARE MY INFORMATION WITH THE PERSON(S) LISTED BELOW.

1) NAME _____

RELATIONSHIP TO PATIENT _____

PLEASE CHECK ALL THAT APPLY:

HEALTH INFORMATION _____ OK TO PICK UP MATERIALS _____

FINANCIAL INFORMATION _____

2) NAME _____

RELATIONSHIP TO PATIENT _____

PLEASE CHECK ALL THAT APPLY:

HEALTH INFORMATION _____ OK TO PICK UP MATERIALS _____

FINANCIAL INFORMATION _____

3) NAME _____

RELATIONSHIP TO PATIENT _____

PLEASE CHECK ALL THAT APPLY:

HEALTH INFORMATION _____ OK TO PICK UP MATERIALS _____

FINANCIAL INFORMATION _____

4) NAME _____

RELATIONSHIP TO PATIENT _____

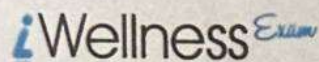
PLEASE CHECK ALL THAT APPLY:

HEALTH INFORMATION _____ OK TO PICK UP MATERIALS _____

FINANCIAL INFORMATION _____

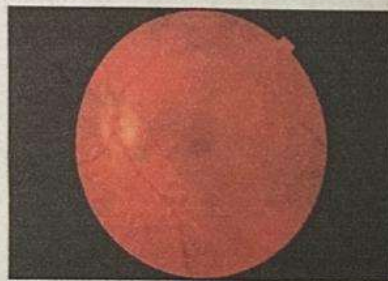
******PATIENT SIGNATURE**(no minors): _____

******DATE**: _____

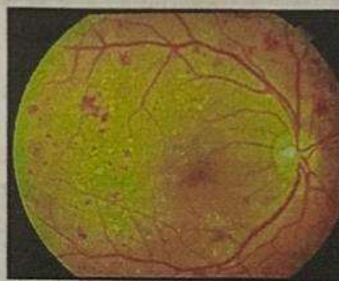


Sight threatening diseases such as **glaucoma, macular degeneration, diabetic retinopathy and others often have no outward signs or symptoms**, which is why eye exams, including a thorough retinal evaluation, are important to protect vision. In an effort to provide a more thorough eye exam, our practice has incorporated the **iWellnessExam™ SD- OCT retinal scan and Digital retinal photography** as part of your eye exam today.

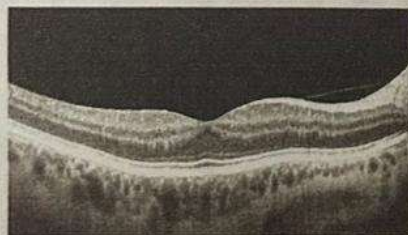
Our technician will perform these two tests before you go into the exam room and Dr. Clifton will review these with you during your examination today. These two tests will become a part of your permanent patient record. Any questions you have about these tests can be discussed during your examination with Dr. Clifton.



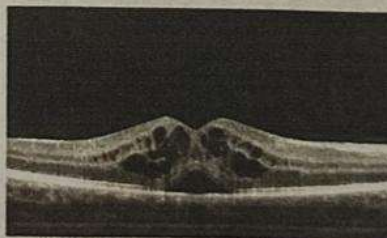
Normal retinal photo



Abnormal retinal photo



Normal retinal cross section
iWellness OCT



Diseased retina visible to
iWellness OCT exam

Insurance is designed to cover basic eye exams only. It does not cover procedures such as Digital Retinal Imaging or the iWellness OCT retinal scan. Dr. Clifton recommends this examination to patients to insure you receive the most thorough exam possible.

_____ Yes, I choose to get iWellness OCT retinal scan AND Digital Retinal Photography as a part of my eye examination. **(\$44.00)**

_____ Yes, I choose the iWellness OCT retinal scan ONLY. **(\$24.00)**

_____ Yes, I choose the Digital Retinal Photography ONLY. **(\$24.00)**