WILDWOOD EYECARE
1545 Powers Ferry Rd., Suite 240, Marietta, GA 30067
Phone: 770-952-6412 Fax: 678-369-7212

PATIENT INFORMATION & HISTORY

Name _____ **Nickname** _____ **Date** _____

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

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Birthdate _____ **Age** _____ **Social Security #** _____ **E-mail**_____

Please circle: Male / Female Married / Single **Occupation** _____ # **Computer hours/day** _____

Employer _____ **Employment Status**: Full-time / Part-time / Self-employed / Retired / Full-time Student

Vision Insurance _____ **Medical Insurance**_____

Primary Insured Member: **Name** _____ **Birthdate**_____ **SSN #** _____

Medical Doctor _____ **Pharmacy**_____ **Pharmacy Phone #**_____

Previous Eye Dr. _____ **Last Eye Exam** _____ **How did you hear about us?** Insurance/Friend/Other_____

List of Family Members At Practice:_____

Reason for visit: Glasses / Contact Lenses / Eye Infection / Eye Injury / Eye Health Exam / Referral / Other _____

Do you have any known **allergies** (medical or environmental)? □ No □ Yes _____

Are you taking any **medications**? □ No □ Yes **(Please List)**_____

_____

Please check any of the following that apply to yourself:

Amblyopia / Lazy Eye	____	Retinal Disease	____	Cancer	____ what type? _____
Cataracts	____	HIV Positive	____	Diabetes Type I	____
Glaucoma	____	Anemia	____	Diabetes Type II	____
Macular Degeneration	____	Arthritis	____	Heart Disease	____
High Blood Pressure	____	Kidney Disease	____	High Cholesterol	____
Multiple Sclerosis	____	Migraines	____	Respiratory Problems	____ what type?

_____
Other _____

Have you had any eye injuries or eye surgeries? _____ if so, please explain _____

Please check if any of your family members have the following:

Cancer	____	Hypertension	____
Diabetes Type I	____	Macular Degeneration	____
Diabetes Type II	____	Glaucoma	____

Do you wear glasses? No / Yes How old are the present glasses? _____ What type? Single vision / Bifocal / Trifocal / Progressive /Readers

Do you wear contact lenses? No / Yes How old are your current contacts? _____ How often do you dispose your contacts? _____

What brand of contacts do you wear? _____ Do you sleep in them? No / Yes How many nights a week? _____

What solutions do you use? _____ Are you experiencing any problems with contacts? Dryness / Discomfort / Redness / Blurred vision

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Social History:
Do you currently smoke or use chewing tobacco? No / Yes

You May Opt Out of Completing The Next 3 Questions:
Preferred Language (*Select One):* □ English □ Spanish □ Other: _____ □ Opt Out

Race: (*select One):* □ American Indian or Alaska Native □ Asian □ African American □ Hispanic
□ Native Hawaiian □ Other Pacific Islander □Caucasian □ Opt Out

Ethnicity (*Select One):* □ Hispanic or Latino □ Native Hawaiian □ Other Pacific Islander □ Not Hispanic/Latino □ Opt Out

DILATION

Evaluating the health of the back of the eye each year is a very important part of a comprehensive eye exam**.**
Due to COVID-19, unless medically necessary, we currently are discouraging against dilation to decrease patient time in office. We are recommending Optos Retinal Imaging to evaluate your eye health.

Optos Retinal Imaging: A quick and efficient way of monitoring your eye health without using drops. The Optos also allows the doctors to keep a digital photo of your eyes each year and may be used as a comparison in the future. The cost for this service is **$39.00** and not covered by any insurance. ****SELECTION BELOW REQUIRED****

_____ I choose to have the Optos Retinal Imaging today for an **additional $39.00 charge**.

_____ I do NOT choose to have the Optos Retinal Imaging and understand my Dr. may dilate my eyes.

STATEMENT OF FINANCIAL POLICY

As a service to you, this office offers several means of payment for the services and materials which you may require. It is customary to pay the Professional fees at the time of the examination.
***Eyeglass lenses are a custom prescription item, there are NO refunds for eyewear cancelled after lab work has started.**
You are responsible for any co-pays, co-insurances, deductibles and other non-covered services or materials the day services are rendered. If you are being seen for any ongoing medical condition, co pays are due at each and every visit. Our office accepts cash, personal checks, debit cards, MasterCard, Visa, Discover and American Express.

If you do not cancel or reschedule your appointment with at least **24 hours notice**, you will be subject to a **$25 "no-show"** service charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it.

Vision plans only cover routine vision wellness exams, eyeglasses and contact lenses. Medical eye exams (the diagnosis and treatment of eye health problems) and additional procedures (i.e. fundus photos, visual fields, OCTs) are billed to medical insurance.
Please note that there will be a **$25 charge for any returned checks.**
If we are not informed of insurance benefits before services are rendered, we will not be able to file your claim. Loss of benefits may result.

INSURANCE AUTHORIZATION

- I certify that I have read and understand the above information to the best of my knowledge and that the questions have been accurately answered.
- I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me.
- I understand that my insurance carrier may pay less than the actual bill for services and **I agree to be responsible for payment of all services rendered to me or my dependents.**
- 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 eye care to third party payers and/or health care practitioners according the HIPPA Privacy Laws.

By my signature below, I do hereby voluntarily consent to treatment by optometrist of the practice for an eye exam & to any related diagnostic procedures & treatments necessary in the judgement of the optometrist. I acknowledge that eye exams are not always routine in nature, and at the discretion of my optometrist, my medical insurance may be billed accordingly.

Patient Signature: _____ Date: _____

WILDWOOD EYECARE
DR. NICOLE MARDAK
DR. HEATHER ZUTAUT
DR. STUART TASMAN

ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____
_____
_____

WILDWOOD EYECARE
DR. NICOLE MARDAK
DR. HEATHER ZUTAUT
DR. STUART TASMAN

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practiced that are described in this Notice while it is in effect. This Notice takes effect, April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practice and new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice to make the new Notice available upon request.

You may request a copy of our Notice at any time. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information within 60 days. For more information about our privacy practices, or for additional copies of this Notice please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare providers providing treatment to you

Payment: We may use and disclose your health information to obtain payment for serviced we provide you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operation. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. If you pay out of pocket for services or health care items, you may ask us not to share those services and information with your health insurer. You may opt out if asked to participate in fundraising efforts of any sort.

To Your Family and Friends: We must disclose your health information to you, as described in Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment of your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use of disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstance, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to

the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody or protected health information of inmate or patient under certain circumstances.

PATIENT RIGHTS
Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide you copies in format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, will charge you $25.00 for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instance in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, of the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restriction, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alterative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Serviced. We will provide you with the address to file your complaint with us or with the U.S. Department of Health and Human Serviced upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Nicole Mardak or Dr. Heather Zutaut
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