'ike pono | see clearly

34 W Kawailani Street, Hilo, Hawaii 96720 • (808) 935.8887 • eyecareHI.com • info@eyecareHI.com

PATIENT REGISTRATION

Patient Name:_____ Date of Birth:_____
(Last) (First) (MI)

Name preferred to be called:_____ Sex: ☐ M ☐ F

Primary Care Provider: _____ SS# (Last Four):_____

Hobbies:_____

Mailing Address:_____ Second Address Line: _____

City:_____ State:_____ Zip Code:_____

Cell Phone #: _____ Work Phone #: _____ Home Phone #:_____

Email: _____

Preferred method of contact: ☐ home ☐work ☐cell ☐email* (to receive contact via email please see our Email Consent Form attached)

Employer:_____ Occupation:_____

How did you hear about our office? ☐ Referred by: _____ ☐ Google Search ☐Facebook Ad ☐ Social Media ☐ Insurance Provider List ☐ Phone book ☐Other: _____

Name of Primary Insurance:_____ Name of Secondary Insurance:_____

Insurance Subscribers Name:_____
Insurance Subscribers Date of Birth:_____ Insurance Subscribers SS # (last 4):_____
Insurance Subscribers Address (if different from above):_____

In case of emergency please contact:_____ Relationship:_____
Primary Phone #:_____ Cell Phone #:_____ Work Phone #:_____

NO SHOW POLICY- I understand that a $30 fee will be accessed to me if I do not give **24-hour** notice to cancel any appointment _____ (Initial)

PATIENT OCULAR AND MEDICAL HISTORY

PAST OCULAR HISTORY
Do you currently, or have ever had any problems in the following areas (check all that apply):

- ☐ Glaucoma
- ☐ Glaucoma Suspect
- ☐ Cataracts
- ☐ Age Related Macular Degeneration
- ☐ Ocular Surgery
- ☐ Patching
- ☐ Inflammatory Disorder
- ☐ Strabismus
- ☐ Other: _____
- ☐ Amblyopia
- ☐ Retinal Degeneration
- ☐ Retinal Hole
- ☐ Retinal Detachment
- ☐ Keratoconus
- ☐ Injury
- ☐ Dry Eye
- ☐ Nystagmus
- ☐ NONE

.....

SOCIAL HISTORY
Do you drink alcohol? ☐ NO ☐YES Do you use tobacco products? ☐ NO ☐YES

.....

REVIEW OF SYSTEMS (other medical conditions that may have effect upon the eyes)
Do you currently, or have ever had any problems in the following areas (check all that apply):
If you have a condition that is not listed below, please enter under its appropriate category

CONSTITUTION
- ☐ Fatigue Syndrome
- ☐ Cancer
- ☐ Other: _____

GENITOURINARY (GU)
- ☐ Kidney disease
- ☐ STD
- ☐ Other: _____

EAR, NOSE, THROAT
- ☐ Hearing loss
- ☐ Dry mouth
- ☐ Other: _____

MUSCULOSKELETAL
- ☐ Osteoarthritis (bone pain)
- ☐ Arthritis (joint pain)
- ☐ Gout
- ☐ Other: _____

NEUROLOGICAL
- ☐ Multiple Sclerosis
- ☐ Seizures
- ☐ Brain Tumor
- ☐ Stroke/ CVA
- ☐ Migraine/Headache
- ☐ Other: _____

ENDOCRINE
- ☐ Type 2 Diabetes Mellitus
- ☐ Type 1 Diabetes Mellitus
- ☐ Other: _____

PSYCHIATRIC

- ☐ Mental Illness (Depression, Anxiety, Bipolar Disorder)
- ☐ Attention Deficit
- ☐ Other: _____

CARDIOVASCULAR

- ☐ Hypertension
- ☐ Heart disease
- ☐ Other: _____

RESPIRATORY

- ☐ Asthma
- ☐ Emphysema
- ☐ Sleep apnea
- ☐ Other: _____

.....

MEDICATIONS

Please list any medications you take regularly along with their purpose:

_____
_____
_____
_____
_____

.....

ALLERGIES

Do you have allergies to medicine? ☐ NO ☐YES
Details:_____

Do you have any environmental allergies? ☐ NO ☐YES
Details:_____

WAIVER OF BENEFITS ACKNOWLEDGEMENT

I, _____, understand and agree that any services provided by Eye Care Hawaii not covered by my medical health care benefits are my financial responsibility. I further agree that I am fully responsible for paying anything I order, such as contact lens or glasses, that are not covered by my vision plan.

I certify that I have read the form or have had it read to me, and that I understand its contents.

_____ _____

Signature of Patient/Guardian Date

YOUR SAFETY IS IMPORTANT TO US

Once your eyes have been dilated, the following may occur for a period of time:

- Light sensitivity
- Glare
- Blurred Vision
- Difficulty walking due to blurred vision
- Difficulty Driving due to blurred vision

Wearing dark glasses after dilation helps to ease some of these challenges, so....

PLEASE BRING DARK GLASSES WITH YOU TO ALL OF YOUR EYE EXAMS

Most patients drive themselves after having their eyes dilated, but it is important to remember that you will be sensitive to light and your vision may be blurry. You should wear sunglasses after your exam. Your safety is important, so if you do not feel comfortable driving, you should arrange for someone to drive you home. Additionally, we strongly recommend that you avoid operating dangerous machinery. Moreover, please be careful generally; pay extra attention to your normal daily activities, such as walking, to avoid injury.

PLEASE CALL OUR OFFICE IMMEDIATELY if you should experience any of the following after your dilated exam with us: EYE PAIN, HEADACHE, and LOSS OF VISION.

I have been informed, my questions have been answered and I understand the vision and safety problems associated with dilation. I will wear sunglasses following dilation and exercise appropriate caution with regard to driving. If I have any questions or concerns regarding dilation, I will raise them with my provider before leaving the office.

This notice covers the period of time from my first visit to my last visit.

_____ _____

Patient/Guardian Signature Date

EMAIL CONSENT FORM

We are pleased to offer you the opportunity to communicate with us by e-mail upon receiving your informed consent.

Toward that end, please note that the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") established certain privacy and security protections for your personal health information, including the HIPAA Privacy Rule. The HIPAA Privacy Rule allows us to have treatment-related communications by e-mail so long as we take certain precautions to avoid unintentional disclosures of your health information. These precautions include, but are not limited to, checking the e-mail address before sending, and/or sending an e-mail alert to the patient for address confirmation prior to initiating e-mail contact.

It is very important that you understand, however, that our e-mail communications are not encrypted. This means, among other things, that our e-mail communications could be accessed by third parties. As a result, it is critical that we take safeguards to protect your health information. Accordingly, all e-mails should be concise and do **not** use e-mails to communicate sensitive medical information.

It is also important that you follow our internal policies and procedures regarding any e-mail communications. Specifically:

1. E-mail is not appropriate for urgent or emergency situations. Eye Care Hawaii cannot and does not guarantee that any particular e-mail will be read and responded to within any particular period of time.
2. Eye Care Hawaii is not liable for breaches of confidentiality caused by you or any third party.
3. You should schedule a consultation/appointment if the issue is too complex or too sensitive to discuss via e-mail.
4. It is your responsibility to follow up and/or schedule an appointment if warranted.

_____ I acknowledge that I have read and fully understand this consent form. I understand the risks associated with unencrypted e-mail communication and I consent to the conditions and instructions outlined, as well as any other instructions that may be required to communicate with me via e-mail. If I have any questions I will inquire with my practitioner.

OR

_____ I do not consent to unencrypted e-mail communications with Eye Care Hawaii because the risks are unacceptable to me. Please communicate with me only by the ERM portal, mail, or telephone.

Patient Signature: _____ Print Name: _____

Date: _____ Email Address: _____

EFFECTIVE DATE OF NOTICE: March 2020

NOTICE OF PRIVACY PRACTICES

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.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record. You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say “yes” to all reasonable requests.

Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).

Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting us at the number listed above. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: 1) Share information with your family, close friends, or others involved in your care. 2) Share information in a disaster relief situation. 3) Include your information in a hospital directory.

> *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission: 1) Marketing purposes. 2) Sale of your information. 3) Fundraising - We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways. 1) Treat you. We can use your health information and share it with other professionals who are treating you. 2) Run our organization. We can use and share your health information to run our practice, improve your care, and contact you when necessary. 3) Bill for your services. We can use and share your health information to bill and get payment from health plans or other entities.

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues. We can share health information about you for certain situations such as: 1) Preventing

disease. 2) Helping with product recalls. 3) Reporting adverse reactions to medications. 4) Reporting suspected abuse, neglect, or domestic violence. 5) Preventing or reducing a serious threat to anyone's health or safety.

Do research. We can use or share your information for health research.

Comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests. We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests. We can use or share health information about you: 1) For workers' compensation claims. 2) For law enforcement purposes or with a law enforcement official. 3) With health oversight agencies for activities authorized by law. 4) For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

1) We are required by law to maintain the privacy and security of your protected health information. 2) We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 3) We must follow the duties and privacy practices described in this notice and give you a copy of it. 4) We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. 5) For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html. 6) Changes to the Terms of this Notice. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office.

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.

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 one in our office and have copies available in our office.

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.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Eye Care Hawaii Notice of Privacy Practices.

Patient name_____

Signature_____Date_____