

HEALTH HISTORY

NAME: _____

DATE: _____

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Head or spinal injuries
<input type="checkbox"/>	<input type="checkbox"/>	COPD /Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Seizures, Convulsions, or Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I or Type II # of yrs _____	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure # of yrs _____	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged steroid use
<input type="checkbox"/>	<input type="checkbox"/>	Carotid Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other diagnosed health problems _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you drink?	<input type="checkbox"/>	<input type="checkbox"/>	(Women) Are you pregnant?
<input type="checkbox"/>	<input type="checkbox"/>	Within the last 12 months have you taken any illegal substances?			

Please list all medications you are CURRENTLY taking:

Please list allergies including medication, food, tape, etc.

Your OCULAR HISTORY (Have you been diagnosed with any of the following in the past?)

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Injury _____
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Iritis
<input type="checkbox"/>	<input type="checkbox"/>	Retina Disease	<input type="checkbox"/>	<input type="checkbox"/>	Crossed / Lazy eye
<input type="checkbox"/>	<input type="checkbox"/>	Cornea Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Cataract surgery (date of surgery) Right eye _____ Left eye _____ Do you have a lens implant? Yes No

Retina Surgery _____

Eye Lasers _____

FAMILY HISTORY: Has anyone in your family (blood relatives) had any of the following?

Please note the relationship to patient: F-father M-mother P-paternal M-maternal S-sister B-brother
GF-grandfather GM-grandmother U-uncle A-aunt

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I or Type II
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems
<input type="checkbox"/>	<input type="checkbox"/>	Cornea Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Retinitis Pigmentosa	<input type="checkbox"/>	<input type="checkbox"/>	Asthma / COPD / Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Other Eye problems _____	<input type="checkbox"/>	<input type="checkbox"/>	Other general health problems _____

SURGICAL HISTORY (Please include date and type)

Agreement of Responsibility

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductibles and co-insurance may be collected at the time of service. I understand that I am financially responsible for charges not covered by my insurance company.

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her judgment.

Release of Information/Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize release of information needed to process a claim to all of my insurance companies. I permit a copy of this to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me.

I hereby authorize Silverstein Eye Centers, P.C., its agents, employees and affiliates to have access to my complete medical records for the purpose of performing its management functions and as they deem necessary.

Medicare Authorization

I request payment of authorized Medicare benefits be made on my behalf to Silverstein Eye Centers, P.C., for any services furnished to me by that physician/supplier. I authorize the holder of medical information, about me, to release to Medicare and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of the information to the insurer to the agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Medigap Authorization

The following is to be filled out if you have a Medigap insurance policy for which you wish to assign benefits. A Medigap or Medicare Supplemental policy is a health insurance policy or other health plan, offered by a private company, to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered by an employer to employees or former employees, as well as a policy or plan offered by a labor organization to members or former members.

This agreement is in effect until revoked in writing by the patient.

SIGNATURE: _____ **DATE:** _____

NAME: (PRINT) _____

Summary of Our Notice of Privacy Practices

Silverstein Eye Centers, PC

Effective Date: April 14, 2003

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

Please review the full Notice of Privacy Practice (NPP) which is attached. If you have any questions about this notice, please contact Todd Laytham, Administrator at (816) 358-3600.

WHO WILL FOLLOW THIS NOTICE:

- Silverstein Eye Centers, PC

This notice describes our privacy practices. All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites, and locations may share health information with each other for treatment, payment, or healthcare operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your healthcare is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization.

There are also various other ways in which we may use or disclose your information:

- Appointment Reminders
- Health-Related Services and Treatment Alternatives
- To provide information about Organ and Tissue Donation
- To allow oversight of the quality of the healthcare we provide
- To allow Workers' Compensation Claims
- As required by Subpoena in Lawsuits and Disputes
- Various uses as required by law or to avert a serious threat to Health or safety

The full details for all these uses are contained in the full NPP.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:

You have the following rights regarding health information we maintain about you:

- Right to Inspect and Copy
- Right to Amend
- Right to an Accounting of Disclosures
- Right to Request Restrictions
- Right to Request Confidential Communications
- Right to a Paper Copy of This Notice

Information on how to exercise these rights can be seen in the NPP or can be obtained from Todd Laytham, Administrator at (816) 358-3600.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Lew Mcbee, Administrator. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice of the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Acknowledgement of Receipt of
Notice of Privacy Practices

I, _____, have received the
Notice of Privacy Practices from Silverstein Eye Centers, PC.

X _____ Date: _____

Silverstein Eye Centers Staff Only:

<p>In lieu of patient signature, I, _____, A staff member of Silverstein Eye Centers, PC, state that the patient, _____ Has been given our Notice of Privacy Practices.</p>

SILVERSTEIN EYE CENTERS, PC
RELEASE OF INFORMATION

PATIENT'S NAME: _____

ADDRESS: _____

BIRTHDATE: _____

I AUTHORIZE SILVERSTEIN EYE CENTERS, PC TO SHARE INFORMATION
(EXCLUDING EXCEPTIONS) FROM MY RECORD WITH:

NAME (RELATIONSHIP) _____

NAME (RELATIONSHIP) _____

NAME (RELATIONSHIP) _____

NAME (RELATIONSHIP) _____

I UNDERSTAND THAT ONCE THIS INFORMATION IS RELEASED, IT IS
SUBJECT TO REDISCLOSURE BY THE RECEIVING PARTY.

EXCEPTIONS;

PLEASE DO NOT RELEASE THE FOLLOWING INFORMATION:

SUBSTANCE ABUSE _____

HIV _____

PREGNANCY/ABORTION _____

SEXUALLY TRANSMITTED DISEASES _____

MENTAL HEALTH _____

THIS LIFETIME AUTHORIZATION MAY BE REVOKED AT ANY TIME,

DATE: _____

SIGNED: _____

(Must be signed by patient except where there is a POA on file, legal guardianship, or the patient is a minor)