Marie Homa-Palladino, O.D.
1776 E. Lancaster Ave #2
Paoli, PA 19301-1550
Main: (610) 647-2502 Fax: (610) 647-2592
CustomerService@Personal-Eyes.net

As a new patient to our practice, we would like to offer a warm welcome and our thanks for choosing us to provide your eye health and vision care. In order for us to establish your file, and provide the most beneficial use of your time with us, the doctor has asked you to complete the following tasks and bring the results to your appointment. The doctor needs this information in order to give you the best care possible.

- ☐ **Completed Intake Form**: This diagnostic information includes personal and family information needed to establish your file, as well as your current eye health and vision status. Your responses will guide our doctors and staff, and remind us to address any significant issues during your visit.

- ☐ **Signed Insurance Submission Form and Notice of Privacy Practices**

- ☐ **Complete Medical and Eye Health History**: Since many general health conditions may be associated with visual symptoms and/or eye health problems, this important record (now required by state health boards and virtually any medical and optical insurance plans) will allow us to care for you as a "whole person" rather than just a pair of eyes. Please bring in a complete list of prescription and non-prescription medication.

- ☐ **Insurance cards or claim forms**: For any optical and/or medical insurance you may be covered by. (Even for "routine" visits, if a medical eye condition is discovered during your examination we can submit a claim to your health insurance for the medical evaluation portion of your examination.)

- ☐ **Eyeglasses**: Please bring ALL pairs of eyeglasses you currently use, including prescription or non- prescription reading glasses, sunglasses, etc. We have instruments to compare the optical power of your old lenses with your new exam findings, thus enabling us to determine and explain how your vision has changed over time. We can also evaluate the condition and fit of your current eyewear.

- ☐ **Contact Lenses**: It is best to wear your current contacts to your appointment if possible. If you wear planned replacement or disposable lenses, it is very helpful if you bring along your cartons or lens packets that indicate the lens series, power, manufacture, etc.

- ☐ **Eye drops, ointments, etc**: Please place any eye drops or ointments that you use in a small bag and bring it along with you. Your doctor will review whether these are appropriate or if a better option is available.

- ☐ **Dilation Explained**: The doctor may need to use drops to dilate your eyes in order to fully evaluate their internal health. This has the effect of temporarily increasing sensitivity to light and causing "fuzzy" vision at a near (reading) distance. Therefore, if you want new eyewear or feel you may need to select new eyewear, please come 15 to 20 minutes before your appointment time in order to look at our frame selection.

Completing the task list for the items that apply to you will assure you of receiving the most thorough and professional care possible and in a very efficient manner. We look forward to your visi

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Welcome to Personal Eyes, LLC

Date_____

Patient's name_____ Gender M / F

Nickname_____

Patient's date of birth_____ Last 4 digits Social Security #_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

E-mail address _____

Occupation_____ Name of employer_____

Who referred you to our office? (Name)_____

Insurance listing Family member Yellow pages Website Physician / Eye Doctor

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Vision insurance_____ Medical insurance_____

Subscriber name _____ Date of birth_____ Last 4 digits of SS # _____

Family physician_____

List any **medical conditions**_____

List all **medications** you currently take_____

Do you have any drug or other **allergies**? No / Yes (List)_____

Please circle if you have ever had any of the following: **Cataracts Glaucoma Lazy Eye Diabetes**

Macular degeneration Eye infections High blood pressure Allergies

Have any blood relatives had diabetes, glaucoma, macular degeneration or other loss of sight? No / Yes

If yes, list relative and condition_____

Previous eye doctor_____ Date of last exam_____

Have you ever had any injury or surgery to your eyes? No / Yes Describe_____

Do you presently wear glasses? No / Yes How old are the glasses?_____

When do you wear them?_____

Do you presently wear contact lenses? No / Yes Gas Permeable Soft Disposable

If yes, how old are the contacts?_____ If no, have you ever worn contacts? No / Yes

Do you currently smoke? Yes / No Did you used to smoke? Yes / No

Do you use alcohol, or other substances? Yes / No

Have you been exposed to any infectious diseases? Yes / No

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Insurance Submission and Responsibility for Payment

The vision and health insurance benefit is a relationship between the patient and the insurance carrier. Personal Eyes, LLC is a provider of health care services and is not the responsible party for payment. We will file all necessary forms to assure timely payment from your insurance carrier. However, the patient is expected to pay the balance of fees ***not*** *covered or reimbursed by their insurance carrier. Please sign the form below authorizing Personal Eyes, LLC to submit services to my insurance company. I agree that any unpaid balance by my insurance carrier is my responsibility.*

Accounts 90 days old are subject to collection fees. There will be a $25.00 service charge on all returned checks. Payment from insurance is to be paid directly to Personal Eyes, LLC.

I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. I further understand that I will be billed for any copays or deductibles.

Patient Name: _____ Date:_____

Patient or Guardian Signature: _____

Personal Eyes
You'll see the difference.

American Optometric Association

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY.

Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice).

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we must carry out in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits: internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death: or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials: for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA;

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for heath care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION

The following are some specific uses and disclosures we may not make of your health information **without** your authorization:

Marketing activities. We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party, your authorization must also include consent to such payment.

Sale of health information. We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.

Psychotherapy notes. Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

- Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization.
- You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.
- We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.
- We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right

- **To request restrictions on the health information we may use and disclose for treatment, payment and health care operations.** We are not required to agree to these requests. To request restrictions, please send a written request to us at the address below.
- **To receive confidential communications of health Information about yon in any manner other than described in our authorization request form.** You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.
- **To inspect or copy your health information.** You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.
- **To amend health information.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:
  - o was not created by us, unless the person that created the information is no longer available to make the amendment
  - o is not part of the health information kept by or for us,
  - o is not part of the information you would be permitted to inspect or copy, or
  - o is accurate and complete.
- **To receive an accounting of disclosures of your health information.** You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).
- **To designate another party to receive your health information.** If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

Contact Person:

Our contact person for all questions, requests or for further information related to the privacy of your health information is:

Personal Eyes, LLC
Marie Homa-Palladino, OD
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610-647-2502

Complaints:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to 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 shown above. If you prefer, you can discuss your complaint in person or by phone.

Changes to This Notice:

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

Notice Revised and Effective: v1.02 Nov 17, 2013

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Personal Eyes, LLC's Notice of Privacy Practices.

Date_____ **Patient name** _____**Signature** _____