



Please print and complete this patient information form prior to your appointment.

Patient Information

Name:

Sex:

Age:..

Address:

Birthdate:

City, State, Zip:

SSN:

Home Phone:

Work Phone:

ext.

*Cell Phone:

*Home Email:

*Work Email:

**Please read next page for explanation of use.*

Occupation:

Employer:

Work Address:

City, ST:

ZIP:

Please List Other Family Members Living at Home

- | | | |
|----|------|----------------|
| 1. | DOB: | Last Eye Exam: |
| 2. | DOB: | Last Eye Exam: |
| 3. | DOB: | Last Eye Exam: |
| 4. | DOB: | Last Eye Exam: |
| 5. | DOB: | Last Eye Exam: |

Medical & Insurance Information

Family Doctor:

Medical Insurance:

Vision Insurance:

Account Responsible

Name:

Address:

City, State, Zip:

Home Phone:

Work Phone:

ext.

Cell Phone:

Emergency Information

Friend or Relative Not Living at Home:

Daytime Phone Number:

Other Emergency Phone Number:

Referred By

Employer Friend Doctor TV Radio

Insurance Billboard Family Member

Yellow Pages Location

Other (please specify on line below)

Name of person who referred you:

Check this box if this individual is an Ossip Patient

Ossip Optometry E-mail Services



Instant notification when your glasses or contact lenses arrive!

Access to our "Web Scheduler" system found at ossip.com

You can now make your Appointments on-line 24/7

You can give your feedback — compliments or advice — with our two quick surveys!

Features in the Making

E-mail appointment reminders — no more postcards or automated phone calls

Registration via e-mail to make your visits faster

Go Green — Reduce Paper

Sign up for Ossip Optometry E-mail Services today!

Name: _____

E-mail address home: _____

(Please print clearly)

E-mail address work: _____

(Please print clearly)

Cell phone: _____ Do you receive text messages? _____

Signature: _____ Date: _____

*Ossip Optometry, as a health care provider and in compliance with HIPAA,
will NOT share your e-mail information with any third party.*

We do NOT spam.

Ossip Optometry Patient Medical Questionnaire

Name: _____ Date of Birth: __/__/__ Today's Date: __/__/__

Name of Medical Doctor: _____ Last Eye Exam: __/__/__

Name of Medical Insurance Carrier: _____ Last Medical Exam: __/__/__

Review of Systems (Please "x" the appropriate column and CIRCLE conditions that apply)

Do you currently, or have you ever had any problems in the following areas:

	YES	NO
Constitution (Chronic fever, weight loss/gain, fatigue)	_____	_____
Cardiovascular (Chest pain, irregular heart beat, <i>high blood pressure</i>)	_____	_____
Ears, Nose, Mouth, Throat (Hearing loss, sinus, sore throat)	_____	_____
Respiratory (Shortness of breath, asthma, emphysema)	_____	_____
Gastrointestinal (Heartburn, vomiting, abdominal pain)	_____	_____
Genitourinary (Kidney, bladder/urinary, genitals)	_____	_____
Musculoskeletal (Arthritis, muscle pain, joint pain)	_____	_____
Integumentary (Skin problems, rashes, excessive dryness)	_____	_____
Neurological (Headaches, migraines, seizures, numbness)	_____	_____
Psychiatric (Depression, anxiety)	_____	_____
Endocrine (<i>DIABETES</i> , thyroid, problems with other glands)	_____	_____
Hematologic/Lymphatic (Anemia, bleeding problems)	_____	_____
Allergic/Immunologic (Allergies)	_____	_____
Other conditions _____	_____	_____

If you answered YES to any of the above, please EXPLAIN treatments and/or medications used.

Past/Present Ocular History

	YES	NO		YES	NO
Glaucoma	_____	_____	Loss of vision	_____	_____
Cataracts	_____	_____	Tired eyes	_____	_____
Macular Degeneration	_____	_____	Eye pain or soreness	_____	_____
Eye injuries	_____	_____	Double vision	_____	_____
Retinal Disease	_____	_____	Excessive tearing	_____	_____
Blindness	_____	_____	Itchy eyes	_____	_____
Strabismus (Lazy eye)	_____	_____	Burning, red eyes	_____	_____
Amblyopia	_____	_____	Flashes	_____	_____
Dry Eyes	_____	_____	Floaters	_____	_____
Refractive (Blur)	_____	_____	Glare/Light Sensitivity	_____	_____
Other conditions/concerns _____					

***** IMPORTANT: PLEASE FILL OUT OTHER SIDE *****

Ossip Optometry Patient Medical Questionnaire

Family History/Relationship

Please identify any parents, grandparents, siblings and/or children for the following conditions

	YES	NO	If YES, please explain relationship to you
Glaucoma	_____	_____	_____
Cataracts	_____	_____	_____
Macular Degeneration	_____	_____	_____
Eye Injuries	_____	_____	_____
Retinal Disease	_____	_____	_____
Blindness	_____	_____	_____
Strabismus (Lazy eye)	_____	_____	_____
Amblyopia	_____	_____	_____
Diabetes	_____	_____	_____
Cancer	_____	_____	_____
Heart Disease	_____	_____	_____
Arthritis	_____	_____	_____
High Blood Pressure	_____	_____	_____
Kidney Disease	_____	_____	_____
Thyroid Disease	_____	_____	_____
Other conditions/relationship	_____	_____	_____

Patient Medical History

1. Have you ever had any surgery, major injuries and/or been hospitalized? YES NO
If YES, please explain: _____
2. PLEASE list all MEDICATIONS you take including supplements, vitamins and over the counter eye drops: _____

3. Do you have any DRUG or food allergies? YES NO If YES, please list: _____
4. If you are a female, are you currently pregnant and/or nursing? YES NO

Social History

Do you smoke? If yes, how much? _____	If employed, how many hours per week do you work? _____
Do you drink alcohol? If yes, how much? _____	Do you use a computer at work? YES NO
Do you drive? YES NO If YES, do you have difficulty seeing when driving? YES NO	On average, how many hours daily? _____
If YES, please explain _____	Is computer use continuous? YES NO
Please circle the following items you would like to update today. Glasses - Contacts . Are you interested in refractive surgery? YES NO	Please list sports/hobbies that you participate in regularly. _____

_____ **Patient/Guardian Signature** _____ **Date** _____ **Doctor Signature** _____ **Date**

I have reviewed the above information and it remains the same as my last exam. Any new information has been noted above, initialed and dated. _____ Initials

Ossip Optometry
Financial Agreement and Release of Medical Information

Insurance Benefits:

_____ I authorize Ossip Optometry to furnish information concerning my visit to my insurance carrier and assign to the provider all insurance payments for medical/vision services rendered on my behalf.

_____ I understand that verification of insurance eligibility and benefits is not a guarantee of payment, and that payment of insurance benefits is determined only when the claim is processed by the insurance carrier. I agree to assume financial responsibility for all co-payments, coinsurance, deductibles, denied, or non-covered services.

Financial Responsibility:

_____ I understand all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. In case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection to this account or future outstanding accounts.

Patient's Signature: _____

Date: _____

Parent/Guardian: _____
(036)

Date: _____

NOTICE OF PRIVACY PRACTICES

Ossip Optometry and Ophthalmology

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

By law, we must abide by the terms of this Notice of Privacy Practices. We reserve the right to change this notice at any time in compliance with and 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 information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our website (www.ossip.com).

Uses and Disclosures of Protected Health Information

Treatment: We use information for treatment purposes, when, for example, we set up an appointment for you, when our technician or doctor tests your eyes, when the doctor prescribes glasses or contact lenses, when the doctor prescribes medication, when our staff helps you select and order glasses or contact lenses, and when we show you low vision aids. We may disclose your health information outside of our office for treatment purposes if, for example, we refer you to another doctor or clinic for eye care or low vision aids or services, if we send a prescription for glasses or contacts to another to be filled, when we provide a prescription for medication to a pharmacist, or when we phone to let you know that your glasses or contact lenses are ready to be picked up. Sometimes we may ask for copies of your health information from another professional that you may have seen before us.

Payment: We use your protected health information to obtain payment for your health care services. For example, our staff asks you about health or vision care plans that you may belong to, or about other sources of payment for our services, when we prepare bills to send to you or your health or vision care plan, when we process payment by credit card, and when we try to collect unpaid amounts due. We may disclose your health information outside of our office for payment purposes when, for example, bills or claims for payment are mailed, faxed, or sent by computer to you or your health or vision plan, or when we occasionally have to ask a collection agency or attorney to help us with unpaid amounts due. Our staff also discloses your protected health information to third party payors/insurance company to obtain information regarding eligibility or coverage for insurance benefits.

Health Care Operations: We use and disclose your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, financial and billing audits, quality assurance activities, employee review and training activities, training of health care students, and to develop business plans.

Outside Business Associates: We may share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Marketing: We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also contact you by mail, telephone, text or e-mail regarding information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

Appointment Reminders: We may use or disclose your demographic information to send you a postcard notifying you of a future appointment. We may also telephone, leave a message, text or email you to remind you of a future appointment.

Uses and Disclosures Without Consent or Authorization

The law allows or requires us in some situations to use or disclose your health information without your permission. 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 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 relating to worker's compensation programs;
- Disclosures to business associates who perform health care operations for us and who agree to keep your health information private.

Your Rights to Privacy of Health Information

Inspection/Copy of Your Record: You have the right to inspect and copy your protected health information. Under federal law, you may not view or copy the following records: information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

Requests to Further Restrict Disclosure: You have the right to ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want.

Request Communication by Alternate Methods or Location: You have the right to ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using an email address. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact.

Amending Your Records: You have the right to ask us to amend your protected health information if you think that it is incorrect or incomplete. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may

prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If we agree to amend your information, we will do so within 60 days of the date of your request.

Right to Record of Information Disclosures: You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information, except for disclosures for purposes of treatment, payment, or health care operations as described in this Notice of Privacy Practices. It will exclude disclosures we have made to you, to personal care givers, family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that have occurred after April 14, 2003, but not more retroactive than six years.

Right to Privacy Statement: You have the right to obtain a paper copy of this notice from us upon request. You may also obtain this notice electronically at www.ossip.com.

Requests for the above must be sent in writing to the address, fax or email shown at the end of this notice. Requests may also be obtained at www.ossip.com.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact of your complaint. We will not retaliate against you for filing a complaint.

ALL WRITTEN REQUESTS AND COMPLAINTS MUST BE SUBMITTED IN WRITING TO:

Lillian Roberts, HIPAA Privacy Officer
5455 Harrison Park Lane
Indianapolis, IN 46216
HIPAA@ossip.com
Fax: 317-259-8609

Ossip Optometry

**Notice of Privacy Practices
Patient Acknowledgment**

Patient Name: _____

Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, and the practice's legal duties with respect to my protected health information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____

Date: _____

Relationship to patient (if signed by a personal representative of patient):
