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GRENE VISION GROUP

TOTAL EYE CARE FOR THE ENTIRE FAMILY

Welcome to our office. Please complete this form to the best of your knowledge.
The information you give will enable us to provide you with total eye care for you and your family.

GENERAL INFORMATION:

Today's Date ___/___/___

Mr. Mrs. Miss Ms. Dr. Marital Status: S M D W Gender: M F

Patient Name _____ Social Security Number _____ - _____ - _____
First Middle Last

How do you wish to be addressed? (e.g. – Mr., 1st Name, Nickname) _____

Home Address _____
Street City State Zip

Date of Birth ___/___/___ Home Phone # (____) _____ - _____ Cell Phone # (____) _____ - _____

Your Occupation _____ Employer _____ Work # (____) _____ - _____

Spouse's Name _____ Employer _____ Work # (____) _____ - _____

Date of Last Eye Exam _____ Previous Eye Doctor Seen _____

Date of Last Medical Exam _____ Name of Medical Doctor _____

Emergency Contact _____ Relationship _____ Phone (____) _____ - _____

BILLING INFORMATION (if different from patient):

Name of Person Financially Responsible for Account _____

Relationship to Patient _____ SSN _____ - _____ - _____ DOB ___/___/___

Home Phone # (____) _____ - _____ Work Phone # (____) _____ - _____

Address _____
Street City State Zip

INSURANCE:

Primary Insurance Company _____ Policy Holder _____ ID# _____

(If policy holder different than billing info, need SSN _____ - _____ - _____ & DOB ___/___/___)

Secondary Insurance Company _____ Policy Holder _____ ID# _____

(If policy holder different than billing info, need SSN _____ - _____ - _____ & DOB ___/___/___)

I do hereby authorize the release of any medical information necessary to process all claims, and request payment of any medical benefit be paid to Grene Vision Group.

I have reviewed the consent form, received the brochure entitled "Notice of Privacy Policies and Practices" and give my permission to GRENE VISION GROUP to use and disclose my health information in accordance with the consent and the notice provided.

X _____ Date _____ Relationship of Patient Representative to Patient _____
Signature of Patient or Patient Representative

ADDITIONAL INFORMATION (optional):

Hobbies _____ Email Address _____

Family Members:

Name	Age	Relationship	Date of last eye exam
_____	_____	_____	_____
_____	_____	_____	_____

How did you decide to come to Grene Vision Group?

Referral Location AT&T Yellow Book Feist Other _____

If referred, who may we thank? _____

REVIEW OF SYSTEMS

Do you have any problems in the following areas:

CONSTITUTIONAL	No	Yes	?	CARDIOVASCULAR	No	Yes	?	GASTROINTESTINAL	No	Yes	?
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MUSCULOSKELETAL			
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart valve disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EYES				Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic low back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coronary artery disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Droopy eyelids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leg pain with walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NEUROLOGICAL			
Eyelid matting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sudden loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY				Dizziness/vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of central vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEMATOLOGIC/LYMPHATIC			
Blurry vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness/burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GENITOURINARY				Leukemia/lymphoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Corneal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crossed/lazy eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIC/IMMUNOLOGIC			
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Discharge from genitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sjogren's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ENDOCRINE				HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Optic neuritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC			
EARS, NOSE, MOUTH, THROAT				Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	INTEGUMENTARY				Alcohol addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin growths/lesions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Dry throat or mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

MEDICAL HISTORY

List all medications you take and dosage (including prescription, over the counter, and eye medications) or attach list:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any allergies to medications? no yes If yes, which medications? _____

List all surgeries, hospitalizations and/or eye injuries you have had:

_____	_____
_____	_____
_____	_____

Are you pregnant and/or nursing? no yes

Do you wear glasses? no yes

Do you wear contact lenses? no yes

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following conditions:

SYSTEMIC	No	Yes	?	Relationship	OCULAR	No	Yes	?	Relationship
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Corneal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Corneal transplant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Crossed/lazy eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

SOCIAL HISTORY

Do you live alone? no yes Do you use alcohol? no yes

Do you use illegal or "street" drugs? no yes Do you use tobacco products? no yes

Do you drive? no yes If yes, how much? _____

THANK YOU FOR CHOOSING GRENE VISION GROUP!

GRENE VISION GROUP

Consent to Use and Disclose Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by GRENE VISION GROUP or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

GRENE VISION GROUP is required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the “Notice of Privacy Policies and Practices” brochure provided to you. **PLEASE REVIEW IT CAREFULLY.**

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information. GRENE VISION GROUP may or may not agree to restrict the use or disclosure of your protected health information (see authorization).

If GRENE VISION GROUP agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

GRENE VISION GROUP reserves the right to modify the privacy practices outlined in the notice. GRENE VISION GROUP will notify you of these changes via the method you have authorized or upon your next appointment.

NOTICE OF PRIVACY POLICIES AND PRACTICES FOR GRENE VISION GROUP

DEAR PATIENT:

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

At Grene Vision Group, we are committed to treating and using protected health information about you responsibly. This Notice describes the personal information we collect, and how and when we use or disclose that information. This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION

Each time you visit Grene Vision Group a record of your visit is made. Typically, this record contains information about your visit including your examination, diagnosis, test results, treatment as well as other pertinent healthcare data. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication with other health professionals involved in your care
- Legal document outlining and describing the care you received
- A tool that you, or another payer (your insurance company) will use to verify that services billed were actually provided
- An education tool for medical health providers
- A source for medical research
- Basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards
- A source of data for planning and/or marketing
- A tool that we can reference to ensure the highest quality of care and patient satisfaction

Understanding what is in your record and how your health information is used helps you to ensure it's accuracy, determine what entities have access to your health information, and make an informed decision with authorizing the disclosure of this information to other individuals.

YOUR RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

OUR RESPONSIBILITIES

Grene Vision Group is required to:

- Maintain the privacy of your health information
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have regarding communication of health information via alternative means and / locations

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain. We will not use or disclose your health information without authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according procedures included in the authorization.

HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

We will use your health information for treatment. Staff may use your health information or disclose to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example: results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

We will use your information for payment. Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for the services rendered to you.

We will use your information for regular health operations. Your health information may be used as necessary to support the day-to-day activities and management of Grene Vision Group. For example: information on the services you receive may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Business Associates. In some instances, we have contracted separate entities to provide services for us. These “associates” require your health information in order to accomplish the tasks that we ask them to provide. Some examples of these “business associates” might be a billing service, collection agency, answering services and computer software/hardware provider.

Communication with family. Due to the nature of our field, we will use our best judgement when disclosing health information to a family member, other relatives, or any other person that is involved in your care or that you have authorized to receive this information. Please inform the practice when you do not wish a family member or other individual to have authorization to receive your information.

Research / Teaching / Training. We may use your Information for the purpose of research, teaching, and training.

Healthcare Oversight. Federal law requires us to release your information to an appropriate health oversight agency, public health authority or attorney, or other federal/state appointee if there are circumstances that require us to do so.

Public health reporting. Your health information may be disclosed to public health agencies as required by law.

Law Enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Appointment Reminders. The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are sent by mail on a postcard, or a brief, non-specific message may be left on your answering machine. If you don't approve of these methods, or if you prefer alternative methods (i.e., e-mail) please inform the practice.

Other uses and disclosures. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have complaints, questions or would like additional information regarding this notice or the privacy practices of Grene Vision Group, please contact:

Susan Wade
GRENE VISION GROUP
6100 EAST CENTRAL, SUITE 215
WICHITA, KS 67208

PHONE (316) 691-4400

EMAIL SWade@grenevisiongroup.com

If you believe that your privacy rights have been violated, please contact the aforementioned Practice Privacy Official, or you may file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Practice Privacy Official or with the Office for Civil Rights. The address for the Office of Civil Rights is listed below:

OFFICE FOR CIVIL RIGHTS
U.S. Department of
Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C., 20201