GRENE VISION GROUP

TOTAL EYE CARE FOR THE ENTIRE FAMILY

Welcome to our office. Please complete this form to the best of your knowledge.

GENERAL INFORMATION: Today's Date ___ / ___ / _____

Patient Name: _____
First Middle Last

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

Social Security Number: ____ - ____ - ____ Date of Birth: ___ / ___ / _____ Gender: ☐ M ☐ F

Home Address: _____
Street City State Zip

Race: _____ Language: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown/Not Reported

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Phone: (___) ____ - _____ Cell Phone: (___) ____ - _____ Work Phone: (___) ____ - _____

Primary Care Physician: _____

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

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

APPOINTMENT REMINDERS

I prefer to get my appointment reminder calls at phone # _____ *(Day Phone)*

In Addition,we can also now send you appointment reminders via text message.
(message rates may apply based on your wireless carrier plan)

❑ Yes, I would like to receive text reminders at phone # _____ *(Cell Phone)*

❑ No, I do not want to receive text message reminders at this time.

ADDITIONAL CONTACT METHODS

How would you like to be contacted: ❑ By Mail ❑ By Phone ❑ By Patient Portal Email

By providing your email address you will be enrolled in our Patient Portal, allowing you to have online access to your medical information: _____
(Please see a Patient Coordinator for more information regarding our Portal)

❑ Already enrolled in the Patient Portal

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

I have 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 _____ _____ _____
Signature of Patient or Patient Representative | Date | Relationship of Patient Representative to Patient

(Please complete other side)

Patient Name: _____ DOB: _____ Today's Date: _____

BILLING INFORMATION (if different from patient):

Name of Person Financially Responsible for Account: _____

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

Home Phone: (___) ____ - _____ Cell Phone: (___) ____ - _____ Work Phone: (___) ____ - _____

Address: _____

Street City State Zip

INSURANCE:

Primary Insurance: _____ Policy Number: _____ ID#: _____

(if policy holder different than billing info, need SS ____ - ____ - _____ & DOB: ___ / ___ / ____)

Secondary Insurance: _____ Policy Number: _____ ID#: _____

(if policy holder different than billing info, need SS ____ - ____ - _____ & DOB: ___ / ___ / ____)

MEDICAL HISTORY QUESTIONNAIRE

Patient Name: _____ DOB: _____ Today's Date: _____

Medical Doctor: _____ Optometrist (Eye Glasses Doctor): _____

MEDICAL HISTORY (Your personal)

SYSTEMIC	Circle	Explanation
Sjogren's disease	yes no	
High blood pressure	yes no	
Heart valve disease	yes no	
Pacemaker	yes no	
Coronary artery disease	yes no	
Emphysema / asthma	yes no	
Crohn's disease	yes no	
Inflammatory bowel disease	yes no	
Rheumatoid arthritis	yes no	
Headaches	yes no	
Sleep Apnea	yes no	
Do you use a c-pap machine	yes no	

SYSTEMIC	Circle	Explanation
Irregular heart beat	yes no	
Heart attack	**yes no**	**When?**
Stroke	**yes no**	**When?**
Multiple sclerosis	yes no	
Leukemia / Lymphoma	yes no	
Hepatitis	**yes no**	
HIV/AIDS	**yes no**	
Lupus	yes no	
Thyroid disease	yes no	
Diabetes	**yes no**	**YRS? ___ Insulin? Y / N**

OCULAR	Circle	Explanation
Corneal disease	yes no	
Crossed / Lazy eyes	yes no	
Double vision	yes no	
Cataracts	yes no	
Glaucoma	yes no	
Retinal detachment / disease	yes no	

OCULAR	Circle	Explanation
Macular degeneration	yes no	
Optic neuritis	yes no	
Eye injury	yes no	
Do you wear glasses?	yes no	
Do you wear contact lenses?	yes no	

LIST OF MEDICAL PROBLEMS

_____ _____

_____ _____

_____ _____

_____ _____

SURGICAL HISTORY - (Excluding EYE surgeries)

Procedure	Date performed	Doctor
1.		
2.		
3.		

EYE SURGICAL HISTORY - (Eye surgeries ONLY)

Procedure	Date performed	Doctor
1.		
2.		
3.		

FAMILY MEDICAL HISTORY (e.g. father, mother, siblings, grandparents, aunts, uncles, etc.)

SYSTEMIC	Circle	Who?
Diabetes	yes no	
Heart disease	yes no	
High blood pressure	yes no	
Stroke	yes no	
Cancer	yes no	
Lupus	yes no	
Rheumatoid arthritis	yes no	
Thyroid disease	yes no	

OCULAR	Circle	Who?
Blindness	yes no	
Corneal disease	yes no	
Corneal transplant	yes no	
Crossed / Lazy eyes	yes no	
Glaucoma	yes no	
Cataracts	yes no	
Retinal detachment	yes no	
Macular degeneration	yes no	

(Please complete other side)

Patient Name: _____

DOB: _____

SOCIAL HISTORY

	Circle
Do you use tobacco?	yes no formerly
Type: _____ Units/day: _____ Years used: _____ Packs Years: _____ Year quit: _____	
Smoker Status:	☐ everyday ☐ some days ☐ former smoker ☐ status unknown ☐ never smoker
Passive smoke exposure?	yes no
Do you use alcohol?	yes no formerly
Do you use illegal drugs?	yes no formerly
Do you drink caffeine?	yes no amount per day: _____

ALLERGIES

	Circle	Explanation
Do you have a latex allergy?	yes no	_____
		If yes, what reaction have you had? _____
Have you been tested for latex allergy?	yes no	_____
Do you have adhesive / tape sensitivity?	yes no	_____
Do you have reactions to Iodine? Skin or Intravenous	yes no	_____
Have you ever been diagnosed with a staph infection, MRSA, VRSA or C-DIF?	yes no	_____

MEDICATION ALLERGIES

Drug	Reaction
1. _____	_____
2. _____	_____
3. _____	_____

MEDICATIONS (name and strength)

Please list all medications you are currently taking.

Prescription Medication Name	Dosage (mg)	How Often
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____

Over the Counter Medication Name	Dosage (mg)	How Often
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

GRENE VISION GROUP
NOTICE OF PRIVACY PRACTICES

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.

WHY WE ARE PROVIDING THIS NOTICE: Grene Vision Group compiles information relating to you and the treatment and services you receive. This information is called protected health information (PHI) and is maintained in a designated record set. We may use and disclose this information in various ways. Sometimes your agreement or authorization is necessary for us to use or disclose your information and sometimes it is not. This Notice describes how we use and disclose your protected health information and your rights. We are required by law to give you this Notice, and we are required to follow it. We may change this Notice at any time if the law changes or when our policies change. If we change the Notice you will have access to a revised Notice. [You may also access this Notice at our website: grenevisiongroup.com]

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION:

- **For your treatment.** We may share your protected health information with other treatment providers. For example, if you have a heart condition we may use your information to contact a specialist and may send your information to that specialist. We may send your information to other treatment providers, as necessary.
- **For payment.** We may share your protected health information with anyone who may pay for your treatment. For example, we may need to obtain a pre-authorization for treatment or send your health information to an insurance company so it may pay for treatment. However, if you pay out of pocket for your treatment and make a specific request that we not send information to your insurance company for that treatment, we will not send that information to your insurer except under certain circumstances.
- **For our healthcare operations.** We may use and disclose your protected health information when it is necessary for us to function as a business. For example, when we contract with other businesses to do specific tasks for us, we may share your protected health information related to those tasks. When we do this, the business agrees in the contract to protect your health information and use and disclose such health information only to the extent Grene Vision Group would be able to do so. These businesses are called Business Associates. Another example is if we want to see how well our staff is doing, we may use your protected health information to review their performance.
- **For appointment reminders.** We may use your protected health information to remind you of appointments, including leaving a voicemail message.
- **For Surveys.** We may use and disclose your protected health information to contact you to assess your satisfaction with our services.
- **For providing your information on treatment alternatives or other services.** We may use and disclose protected health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you. We may also use and disclose protected health information to tell you about health-related benefits or services that may be of interest to you. In some cases the facility may receive payment for these activities. We will give you the opportunity to let us know if you no longer wish to receive this type of information.
- **To discuss your treatment with other people who are involved with your care.** We may disclose your health information to a friend or family member who is involved in your care. We may also disclose your health information to an organization assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.
- **Research.** Under certain circumstances, we may use and disclose your protected health information for medical research. All research projects, however, are subject to a special approval process. Before we use or disclose your health information for research, the project will have been approved.
- **As Required By Law.** We will disclose your protected health information when the law requires us to do so.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety or the health and safety of another person.
- **Organ and Tissue Donation.** We may use or disclose your protected health information to an organ donation bank or to other organizations that handle organ procurement to assist with organ or tissue donation and transplantation.
- **Military and Veterans.** The protected health information of members of the United States Armed Forces members of a foreign military authority may be disclosed as required by military command authorities.
- **Employers.** We may disclose your protected health information to your employer if we provide you with health care services at your employer's request and the services are related to an evaluation for medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. We will tell you when we make this type of disclosure.
- **Workers' Compensation.** We may release your protected health information for workers' compensation or similar programs providing you benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose your protected health information for public health activities which include the prevention or control of disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of recalls of devices or products; to notify a person

who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; or to notify the appropriate government authority if we believe you have been the victim of abuse, neglect or domestic violence. If you agree, we can provide immunization information to schools.

- **Health Oversight Activities.** We may disclose your protected health information to a health oversight agency for activities authorized by law. These activities are necessary for the government to monitor the health care system, government programs, and civil rights laws.
- **Legal Proceedings**. We may disclose your protected health information when we receive a court or administrative order. We may also disclose your protected health information if we get a subpoena, or another type of discovery request. If there is no court order or judicial subpoena, the attorneys must make an effort to tell you about the request for your protected health information.
- **Law Enforcement.** When a law enforcement official requests your protected health information, it may be disclosed in response to a court order, subpoena, warrant, summons, or similar process. It may also be disclosed to help law enforcement identify or locate a suspect, fugitive, material witness, or missing person. We may also disclose protected health information about the victim of a crime; about a death we believe may be the result of criminal conduct; about criminal conduct at Grene Vision Group; or in an emergency to report a crime, the location of the crime, victims of the crime, or to identify the person who committed the crime.
- **Coroners, Medical Examiners, and Funeral Directors.** We may disclose your protected health information to a coroner, medical examiner, or a funeral director.
- **National Security and Intelligence Activities.** When authorized by law, we may disclose your protected health information to federal officials for intelligence, counterintelligence, and other national security activities.
- **Protective Services for the President and Others**. We may disclose your protected health information to certain federal officials so they may provide protection to the President, other persons, or foreign heads of state, or to conduct special investigations.
- **Inmates or Persons in Custody**. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your protected health information to the correctional institution or a law enforcement official when it is necessary for the institution to provide you with health care; when it is necessary to protect your health and safety or the health and safety of others; or when it is necessary for the safety and security of the correctional institution.
- **Fundraising.** We may send you information as part of our fundraising activities. You have the right to opt out of receiving this type of communication.

OTHER USES AND DISCLOSURES:

- Uses and disclosures for marketing purposes, and uses and disclosures that constitute a sale of protected health information, and most uses and disclosures of psychotherapy notes require your authorization.
- There are some circumstances when we directly or indirectly receive a financial (e.g., monetary payment) or non-financial (e.g., in-kind item or service) benefit from a use or disclosure of your protected health information. Your authorization is necessary for us to sell your protected health information. Your authorization is also necessary for some marketing uses of your protected health information.
- Other uses and disclosures of your protected health information not covered by this Notice or the laws that apply to us will be made only with your written authorization. You may revoke your authorization in writing at any time, provided you notify us. If you revoke your authorization, it will not take back any disclosures we have already made.

YOUR HEALTH INFORMATION RIGHTS:

- **Right to Access.** You have the right to access, or to inspect and obtain a copy of your protected health information. To exercise this right, you must complete a specific form so we have the information we need to process your request. You may request that your records be provided in an electronic format and we can work together to agree on an appropriate electronic format. Or you can receive your records in a paper copy. You may also direct that your protected health information be sent in electronic format to another individual. You may be charged a reasonable fee for access. We can refuse access under certain circumstances. If we refuse access, we will tell you in writing and in some circumstances you may ask that a neutral person review the refusal.
- **Right to Amend Your Records**. If you feel that your protected health information is incorrect or incomplete, you may ask that we amend your health records. To exercise this right, you must contact the Chief Compliance Officer to complete a specific form stating your reason for the request and other information that we need to process your request. We can refuse your request if we did not create the information, if the information is not part of the information we maintain, if the information is part of information that you were denied access to, or if the information is accurate and complete as written. You will be notified in writing if your request is refused and you will be provided an opportunity to have your request included in your protected health information.
- **Right to a Restriction.** You have the right to ask us to restrict disclosures of your protected health information. To exercise this right, you must complete a specific form to provide us with the information that we need to process your request.

If you self-pay for a service and do not want your health information to go to a third party payor, we will not send the information, unless it has already been sent, you do not complete payment, or there is another specific reason we cannot accept your request. For example, if your treatment is a bundled service and cannot be unbundled and you do not wish to pay for the entire bundle, or the law requires us to bill the third party payor (e.g., a governmental payor), we cannot accept your request. We do not have to agree to any other restriction. If we have previously agreed to another type of restriction, we may end that restriction. If we end a restriction, we will inform you in writing.

- **Right to Communication Accommodation.** You have the right to request that we communicate with you in a certain way or at a specific location. To exercise this right, you must complete a specific form to provide us the information that we need to process your request.
- **Breach Notification.** You have the right to be notified if we determine that there has been a breach of your protected health information.
- **Right to Obtain the Notice of Privacy Practices**. You have the right to have a paper copy of this Notice. You may request a copy from the Chief Compliance Officer or you may go to our website at www.grenevisiongroup.com. This Notice is also available in each of our locations.
- **Right to File a Complaint**. If you believe your privacy rights as described in this Notice have been violated, you may file a written complaint with our Chief Compliance Officer or with the U.S. Department of Health and Human Services – Office for Civil Rights (Regional Office at Kansas City), 601 East 12th Street Room 248, Kansas City MO 64106, 816.426.7277, or through www.hhs.gov/ocr/privacy/hipaa/complaints/index.html. You will not be penalized for filing a complaint.

YOUR RIGHTS REGARDING ELECTRONIC HEALTH INFORMATION TECHNOLOGY

Grene Vision Group participates in electronic health information technology or HIT. This technology allows provider or a health plan to make a single request through a health information organization or HIO to obtain electronic records for a specific patient from other HIT participants for purposes of treatment, payment, or health care operations. HIOs are required to use appropriate safeguards to prevent unauthorized uses and disclosures.

You have two options with respect to HIT. First, you may permit authorized individuals to access your electronic health information through an HIO. If you chose this option, you do not have to do anything.

Second, you may restrict access to **all** of your information through an HIO (except as required by law). If you wish to restrict access, you must submit the required information either online at http://www.KanHIT.org or by completing and mailing a form. The form is available at http://www.KanHIT.org. You cannot restrict access to certain information only, your choice is to permit or restrict access to all of your information.

If you have questions regarding HIT or HIOs, please visit http://KanHIT.org for additional information.

If you receive health care services in a state other than Kansas, different rules may apply regarding restrictions on access to your electronic health information. Please communicate directly with your out-of-state health care provider regarding those rules.

CHANGES TO THIS NOTICE:

We reserve the right to change this Notice at any time. We reserve the right to make the revised Notice effective for protected health information that we currently maintain in our possession, as well as for any protected health information we receive, use, or disclose in the future. A current copy of the Notice will be posted in our facility.

Effective Date: September 23, 2013