

Patient History Questionnaire

Last Name _____ First Name _____ MI _____
Address _____
City _____ State _____ Zip _____
Work Phone _____ Home/Cell Phone _____
Date of Birth _____ SSN: _____
Occupation _____ Employer _____
Emergency Contact Name _____ Phone Number _____
Date of Last Eye Exam _____ Dilated? Yes/No _____
Medical Coverage _____ Vision Coverage _____
Primary Member's Name _____ Primary's Date of Birth: _____

Medical Information

How is your general health?

Do you have problems with any of these systems? (Please circle yes or no.)

Gastrointestinal Yes/No	Nervous Yes/No	Endocrine (glands) Yes/No
Ears/Nose/Throat Yes/No	Urinary Yes/No	Blood/Lymph Yes/No
Cardiovascular Yes/No	Muscles/Bones Yes/No	Allergic/Immunologic Yes/No
Respiratory Yes/No	Integumentary (skin) Yes/No	Headaches Yes/No
High blood pressure Yes/No	Eyes Yes/No	Mental Yes/No

Please explain _____

Diabetes Yes/No _____ Type _____ Date of diagnosis _____

Allergies to medication Yes/No Which? _____
Reactions? _____

Other health problems

Current medication(s) _____

Have you had any operations? Yes/No Kind? _____

When? _____

Do you use cigarettes/tobacco? _____ Alcohol? _____ Other substances? _____

Name of family doctor and/or primary care physician: _____

Date of last visit _____

Pharmacy/Location: _____

Phone Number: _____

Family History

High blood pressure Yes/No Relation _____

Macular degeneration Yes/No Relation _____

Diabetes Yes/No Relation _____

Retinal detachment Yes/No Relation _____

Glaucoma Yes/No Relation _____

Cataracts Yes/No Relation _____

Personal Eye Information

Do you have any eye conditions or problems? Yes/No

What kind? _____

Have you had any eye operations? Yes/No Type _____

Date _____

Have you had an eye injury? Yes/No Kind _____

Date _____

Do you have glaucoma? Yes/No

Cataracts? Yes/No

Dry eyes? Yes/No

Macular degeneration? Yes/No

Retinal detachment? Yes/No

Blurred vision? Yes/No

Do you wear glasses? Yes/No

Contact lenses? Yes/No Type _____

Additional information:

Whom may we thank for referring you? _____

Acknowledgement of Receipt of Notice of Privacy Practices

Dr. Joseph S. Hargrave
Box 1146
Lewiston, NY 14092
(716) 754-8816

Signing this document signifies that you have received a copy of our Notice of Privacy Practices.

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The Notice of Privacy Practices you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the Notice of Privacy Practices from Dr. Joseph S. Hargrave.

Signature: X _____

Date: _____

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to Patient: _____ Print Name: _____

Source of Authority: _____

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Dr. Joseph S. Hargrave on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

X

Lifetime Patient Signature

Date

Notice of Privacy Practices

Effective date of notice: April 14, 2003
Dr. Joseph S. Hargrave
Box 1146
Lewiston, NY 14092
716 754 8816

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

General Rule

We respect our legal obligation to keep health information, that identifies you, private. The law obligates us to give you notice of our privacy practices.

Generally, we can only use your health information in our office or disclose it outside of our office, without your written permission, for purposes of treatment, payment or healthcare operations. In most other situations, we will not use or disclose your health information unless you sign a written authorization form. In some limited situations, the law allows or requires us to disclose your health information without written authorization.

Uses or Disclosures of Health Information

Examples of how we use information for treatment purposes:

- When 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.
- When we show you low vision aids.

We may disclose your health information outside of our office for treatment purposes, for example:

- If 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 professional to be filled.
- When we provide a prescription for medication to a pharmacist.
- 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.

We may use your health information within our office or disclose your health information outside of our office for payment purposes. Some examples are:

- When 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.
- When bills or claims for payment are mailed, faxed, or sent by computer to you or your health or vision plan.
- When we occasionally have to ask a collection agency or attorney to help us with unpaid amounts due.

We use and disclose your health information for healthcare operations in a number of ways. Health care operations means those administrative and managerial functions that we have to do in order to run our office. We may use or disclose your health information, for example, for financial or billing audits, for internal quality assurance, for personnel decisions, to enable our doctors to participate in managed care plans, for the defense of legal matters, to develop business plans, and for outside storage of our records.

Appointment Reminders

We may call to remind you of scheduled appointments. We may also call to notify you of other treatments or services available at our office that might help you.

Uses & Disclosures without an Authorization

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

- A state or federal law that mandates certain health information be reported for a specific purpose.
- Public health purposes, such as contagious disease reporting, investigation or surveillance, and notices to end 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, audits by Medicare or Medicaid, or investigation of possible violations of healthcare 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 workers' compensation programs.
- Disclosures to business associates who perform healthcare operations for us and who agree to keep your health information private.

Other Disclosures

We will not make any other uses or disclosures of your health information unless you sign a written authorization form. You do not have to sign such a form. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it.

Your Rights Regarding Your Health Information

The law gives you many rights regarding your health information.

You can ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or healthcare operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to Dr. Joseph S. Hargrave at the address shown at the beginning of this notice.

You can 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 e-mail to your personal e-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to Dr. Joseph S. Hargrave at the address shown at the beginning of this notice.

You can ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. Primarily, however, you will be able to review or have a copy of your health information within 30 days of asking us. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally required. By law, we can have one 30-day extension of this time for us to give you access or photocopies if we sent you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to Dr. Joseph S. Hargrave at the address shown at the beginning of this notice.

You can ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to Dr. Joseph S. Hargrave at the address shown at the beginning of this notice.

You can get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want), except disclosures for purposes of treatment, payment or health care operations, disclosures made in accordance with an authorization signed by you, and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to Dr. Joseph S. Hargrave at the address shown at the beginning of this notice.

Our Notice of Privacy Practices

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. 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 such 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 and have copies available in our office.

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 Dr. Joseph S. Hargrave at the address shown at the beginning of this notice. If you prefer, you can discuss your complaint in person or by phone.

For More Information

If you want more information about our privacy practices, call or visit Dr. Joseph S. Hargrave at the address or phone number shown at the beginning of this notice.