Panhandle Laser Vision Institute

LASIK Patient Registration Date: _____

Last Name: _____ First: _____ M.I.: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Referred: ☐ Dr. _____ ☐ Insurance ☐ Internet ☐ Phonebook ☐ Other: _____

Sex: ☐ Female ☐ Male Date of Birth: _____ Social Security #: _____

Marital Status: ☐ Single ☐ Married ☐Widowed ☐ Divorced ☐Other: _____

Race: ☐ African American ☐Caucasian ☐ Hispanic ☐Other: _____

Employment Status: _____ Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Insurance: Please provide a photo ID and insurance cards at time of visit.

Primary Medical: _____ ID#: _____

Policyholder: ☐Self ☐Other: Name: _____ DOB: _____

Vision: _____ ID#: _____

Policyholder: ☐Self ☐ Other: Name: _____ DOB: _____

Panhandle Laser Vision Institute

Questionnaire

Patient: _____

Preferred pharmacy: _____ Location: _____ Phone: _____

1. Have you consulted anyone about LASIK? ☐ Yes ☐ No
2. Have any friends or family members had LASIK? ☐ Yes ☐ No
3. What is it about your glasses or contacts that currently prevent you from enjoying everyday living?

_____

4. How long have you been considering LASIK? _____
5. When do you plan on having LASIK? _____
6. My main visual problem is ☐ Distance ☐ Near ☐ Both
7. My current glasses or contact lenses corrects ☐ Distance ☐ Near ☐ Both ☐ N/A
8. My current contact lenses are ☐ Soft ☐ Hard ☐ Removed daily ☐ Removed every _____ days
9. The last date I wore contact lenses was _____
10. My eyes have a history of ☐ No eye diseases
    - ☐ Amblyopia (lazy eye)
    - ☐ Double vision
    - ☐ Dry eyes
    - ☐ Eye trauma
    - ☐ Cataracts
    - ☐ Glaucoma
    - ☐ Retinal disease or tears
    - ☐ Previous eye surgery (list) _____
11. Medical conditions: ☐ No medical problems
    - ☐ Arthritis
    - ☐ Auto-immune disease (E.G. Lupus)
    - ☐ Diabetes
    - ☐ High blood pressure
    - ☐ Thyroid disease
    - ☐ Pregnancy or nursing
12. Current medications: ☐ none ☐ Accutane ☐ Imitrex ☐ Cordarone
    ☐ Other: _____
13. Medication allergies? ☐ No known _____
14. Do you have any LATEX allergies? ☐ Yes ☐ No

HIPAA Notice of Privacy Practices

This notice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) 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, that relates to your past, present, or future physical or mental health or condition and related health services.

1. Uses and Disclosures of Protected Health Information-
Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

a. Treatment-
We will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your information as necessary to a home health agency that cares for you or to a physician to whom you have been referred to ensure the physician has the necessary information to diagnose and treat you.

b. Payment-
Your protected health information will be used, as needed, to obtain payment for your health care services.

c. Healthcare Operations-
We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, appointment reminders, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call your name in the waiting room when your physician is ready to see you.

We may use or disclose your protected health information in the following situations without your authorization: as required by law, Public Health issues as required by law, Communicable diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Worker's Compensation, Inmates. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS:
You have the right to inspect and copy your protected health information. However, you may not inspect or copy the following records: psychotherapy notes, 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.
You have the right to request a restriction of your information. You have the right to request confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.
You have the right to request your physician amend your protected health information. You have the right to receive an accounting of certain disclosure we have made, if any, of your protected health information.

Complaints:
You may complain to us or 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 officer of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask us to explain.
Signature below confirms acknowledgement and receipt of a copy of our Privacy Practices (HIPAA).

Signature: _____ Print Name: _____ Date: _____