



**LASERVUE**  
EYE CENTER

**PATIENT INFORMATION**

Please Print

Name \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Sex *M F*

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell # (\_\_\_\_) \_\_\_\_\_ Work # (\_\_\_\_) \_\_\_\_\_

E-mail \_\_\_\_\_ Family Doctor \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact (Name & Phone) \_\_\_\_\_

Eye Doctor \_\_\_\_\_ did he/she refer you to LaserVue?  yes  no

Did someone else refer you to LaserVue?  yes  no Who? \_\_\_\_\_

If not, how did you hear about us? \_\_\_\_\_

How long have you been considering LASIK? \_\_\_\_\_

When do you plan on having LASIK? \_\_\_\_\_

Are you interested in learning about our affordable payment plans?  yes  no

Have you visited any other LASIK centers/doctors?  yes  no Who? \_\_\_\_\_

**Medical History:**

Do you have any current health conditions? (please circle) (diabetes, high blood pressure, heart disease, thyroid disease, cold sores/herpes on face or eyes, autoimmune diseases [Rheumatoid Arthritis, HIV, Sjogren's, etc]; Hepatitis, keloid scars, pregnancy, nursing, other)	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you have any past or current eye conditions or diseases? (please circle) (eye surgery, eye infections, ocular herpes, glaucoma, cataracts, retinal detachment, other)	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you take any medications? _____	<input type="checkbox"/> yes <input type="checkbox"/> no
Are you allergic to any medications? _____	<input type="checkbox"/> yes <input type="checkbox"/> no
Is there anything in your medical history that we should know about?	<input type="checkbox"/> yes <input type="checkbox"/> no
If "yes" to any of the above, please specify: _____	

**Contact Lens Wear History:**

None  Soft, years worn \_\_\_\_\_  Rigid, years worn \_\_\_\_\_ Last date worn \_\_\_\_/\_\_\_\_/\_\_\_\_

----- **FOR OFFICE USE ONLY** -----

Dom.	UCVA	Glasses	AutoRefraction #	Pupil	Pachy C/IC
OD	20/	20/	20/		/
OS	20/	20/	20/		/

Tech: \_\_\_\_\_

# HIPAA NOTICE OF PRIVACY PRACTICES

## LASERVUE EYE CENTER, A MEDICAL CORPORATION

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operation (TPO) and for other purposes that are permitted 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.

### **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our 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.

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

**Payment:** Your protected health information will be used as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These include, but are not limited to quality assessment activities, employee review activities, training of medical students, licensing, marketing medical school students that see patients at our office. In addition, we may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues a required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; Organ Donation; Research; Criminal Activity; Military Activity; National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; 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 that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Your Rights:** Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information:** Under federal law, 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 laws that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information:** This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends whom may be involved in your care or for notification purpose as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request and receive 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 have your physician amend your protected health information.** 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.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**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.**

This notice was published or becomes effective on/or before April 1, 2003.

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 to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_