BAILEY, WAKIL & AURINGER EYE PHYSICIANS & SURGEONS, PLLC

Thomas A. Bailey, M.D., F.A.C.S. Aida S. Wakil, M.D., F.A.C.S. David E. Auringer, MD

Welcome to our practice, and thank you for choosing to schedule an appointment with us. Please take a few moments to read this welcome letter and instructions.

Enclosed are several "new patient" forms that we ask you to complete prior to your visit. If you have any questions regarding the forms, or are unsure how to answer a question, please mark the section in question and we will be happy to assist you when you arrive for your appointment.

1. The two-sided white "Patient Demographics" sheet is primarily general information about you (the patient).

2. The two-sided blue "Medical & Social History" form asks you to list any medications (both prescription and over-the-counter) that you take in Section 1 - **if your medication list is lengthy~ please feel free to attach a separate list rather than rewriting your list.**

3. The "HIPAA Notice of Privacy Practices" is a copy for your records; you do not need to return this to the office.

Please bring the completed forms to your appointment with you- **it is not necessary to mail the forms back to the office prior to your appointment.**

We also ask that you bring All current health insurance cards to your appointment. If your health insurance plan requires you to obtain referrals from your primary care physician, remember that it is YOUR responsibility to contact your family doctor for the referral.

If you are a contact lens wearer, soft contact lenses must be out for a minimum of 48 hours prior to your appointment. Hard or gas-permeable lenses must be out for a minimum of 7 days.

At your appointment, you will have drops put in your eyes to dilate your pupils. These drops make you very light sensitive, and will make your close/near vision blurry. Although they do not blur your far/distance vision, you may find that your depth perception is "off", especially as the drops wear off which can take several hours. If you have had your pupils dilated previously and know that it bothers you to drive afterwards, or if you are unsure whether or not the drops will bother you~ you may want to arrange to have a driver with you.

Also, please be aware that a new patient appointment can easily take 2 hours, and up to 3 hours if any additional testing is needed.

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HIPAA NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices describes how we may use and disclose your **protected health information** (*"PHI"*) to carry out **treatment, payment, or healthcare operations** (*"TPO"*) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI.

PHI is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical and/or mental health and/or condition and related health care services.

Uses and Disclosure of Protected Health Information: Your PHI may be used and disclosed by your physician(s), 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 physicians' practice, and for any other use required by law.

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

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a surgical procedure may require that your relevant PHI be disclosed to the health plan to obtain approval for payment of the fee for the procedure.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of the physicians. These activities include, but are not limited to, quality assessment activities, employee training and review activities, licensing, and conducting or arranging for other business activities. For example, we may call you by name in the waiting room with other patients when your physician is ready to see you, or we may use or disclose your PHI as necessary to contact you to remind you of your upcoming appointment(s).

We may use or disclose your PHI in some situations without your authorization, as required by law. These situations may include public health issues, communicable disease information, health oversight, abuse or neglect cases, Food and Drug Administration (*"FDA"*) requirements, legal proceedings, law enforcement or investigation of criminal activity, organ donation and transplantation, research, military or national security activity, and Workers' Compensation cases.
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 and/or determine our compliance with the requirements of §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.

YOUR RIGHTS

The following is a statement of your rights with respect to your protected health information ("*PHI*").

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 any PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means that you may ask us not to use or disclose any part of your PHI for the purposes of **treatment, payment, or healthcare operations** ("*TPO*"). You may also request that any part of your PHI NOT be disclosed to family members or friends who may be involved in your care, or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing, and must state the specific restriction requested and to whom you want it to apply.

Your physician is NOT required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will NOT be restricted. You then have the right to use another healthcare provider.

You have the right to 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.

You MAY have the right to have your physician amend your PHI. 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 PHI.

Complaints

You may complain to us, or to the Secretary of Health and Human Services, if you believe that 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 our patients, and to provide individuals with copies of our legal duties and privacy practices with respect to protected health information ("PHI"). If you have any objections to this form, please as to speak with our HIPAA Compliance/Privacy Officer in person, or by telephone at our main office number.

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.

This notice was published and becomes effective on or before April 14, 2003.

1. **PATIENT DEMOGRAPHICS (information about YOU)**

Miss Mr. Mrs. Ms. Dr. Rev. Sr. Other _____ None — PREFERRED PREFIX (PLEASE CIRCLE ONE)

D D/P M SEP SINGLE WID — MARITAL STATUS (PLEASE CIRCLE)

M F — GENDER

_____ — NAME (FIRST, MIDDLE INITIAL, LAST, SUFFIX)

_____/_____/_____ — DATE OF BIRTH (mm/dd/yyyy)

_____ — STREET ADDRESS

_____ — CITY

_____ — STATE

_____ — ZIP

(_____)_____ — HOME PHONE #

(_____)_____ — WORK PHONE #

(_____)_____ — CELL PHONE

2. **EMERGENCY CONTACT (SOMEONE WITH A DIFFERENT PHONE NUMBER THAN YOU, PLEASE)**

_____ — EMERGENCY CONTACT NAME

_____ — RELATIONSHIP

(_____)_____ — PHONE #

3. **RESPONSIBLE PARTY/GUARANTOR (ONLY COMPLETE IF SOMEONE OTHER THAN PATIENT)**

Miss Mr. Mrs. Ms. Dr. Rev. Sr. Other _____ None — PREFERRED PREFIX (PLEASE CIRCLE ONE)

D D/P M SEP SINGLE WID — MARITAL STATUS (PLEASE CIRCLE)

M F — GENDER

_____ — NAME (FIRST, MIDDLE INITIAL, LAST, SUFFIX)

_____/_____/_____ — DATE OF BIRTH (mm/dd/yyyy)

_____ — STREET ADDRESS

_____ — CITY

_____ — STATE

_____ — ZIP

(_____)_____ — HOME PHONE #

(_____)_____ — WORK PHONE #

(_____)_____ — CELL PHONE

4. **MEDICAL PROVIDERS (PLEASE PROVIDE AS MUCH INFORMATION AS POSSIBLE)**

_____ — PHARMACY NAME/ADDRESS/PHONE (please provide as much information as you can)

Do we have your permission to obtain your medication history from your pharmacy? ___ Yes ___ No

_____ — REFERRING PHYSICIAN (IF ANY) – NAME, ADDRESS, PHONE

_____ — PRIMARY CARE PHYSICIAN – NAME, ADDRESS, PHONE

_____ — OTHER PHYSICIAN (Endocrinologist, Rheumatologist, etc.) – NAME, ADDRESS, PHONE

_____ — OTHER PHYSICIAN (Endocrinologist, Rheumatologist, etc.) – NAME, ADDRESS, PHONE

PLEASE COMPLETE BOTH SIDES

TODAYS' DATE ___/___/_____

5. LANGUAGE/ETHNICITY/RACE

PRIMARY LANGUAGE IF NOT ENGLISH: _____

ETHNICITY: ___ HISPANIC/LATINO ___ NOT HISPANIC/LATINO ___ PATIENT DECLINED/UNKNOWN

RACE: ___WHITE ___ BLACK/AFRICAN-AMERICAN ___ ASIAN ___ NATIVE AMERICAN/ALASKA NATIVE

___ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ___ OTHER ___ PATIENT DECLINED/UNKNOWN

6. *OCCUPATION/EMPLOYMENT*

_____ _____

EMPLOYER NAME OCCUPATION

_____

EMPLOYER ADDRESS

7. RELEASE OF INFORMATION (in order to comply with HIPAA privacy regulations, please answer the following questions)

Is it alright for us to leave detailed messages/information for you:	ABOUT APPOINTMENTS	MEDICAL INFORMATION
On your home phone answering machine?	___ YES ___NO	___ YES ___NO
On your cell phone voice mail?	___ YES ___NO	___ YES ___NO
On your office voice mail?	___ YES ___NO	___ YES ___NO
With another person?	___ YES* ___NO	___ YES* ___NO
Via regular mail?	___ YES ___NO	___ YES ___NO

If you answered "Yes" to allowing us to discuss your appointment and/or medical information with another person, please list their name(s), phone number(s) and relationships(s) below:

_____ (___)_____ _____

NAME PHONE RELATIONSHIP

_____ (___)_____ _____

NAME PHONE RELATIONSHIP

_____ (___)_____ _____

NAME PHONE RELATIONSHIP

_____

OTHER PRIVACY INFORMATION

8. INSURANCE

IS THIS VISIT RELATED TO A WORKERS' COMPENSATION OR NO-FAULT CASE? ___ YES ___ NO (if yes, complete additional forms)

ARE YOU COVERED BY HEALTH INSURANCE? ___ YES ___ NO

_____ _____ ____/____/_____

PRIMARY INSURANCE COMPANY NAME NAME OF INSURED PERSON IF NOT YOU INSURED DATE OF BIRTH

_____ _____ ____/____/_____

SECONDARY INSURANCE COMPANY NAME NAME OF INSURED PERSON IF NOT YOU INSURED DATE OF BIRTH

_____ _____ ____/____/_____

THIRD INSURANCE COMPANY NAME NAME OF INSURED PERSON IF NOT YOU INSURED DATE OF BIRTH

PLEASE COMPLETE BOTH SIDES

MEDICAL & SOCIAL HISTORY – PLEASE COMPLETE *BOTH* SIDES

NAME _____ TODAY'S DATE ____/____/_____

1. **Chief Complaint:** What brings you to the office today?

PHARMACY (NAME/ADDRESS/PHONE)

PLEASE LIST **ALL MEDICATIONS** THAT YOU TAKE (FOR YOUR EYES OR ANY OTHER CONDITIONS) BOTH PRESCRIPTION AND OVER-THE-COUNTER (if you have a lengthy list, feel free to attach the list and note "see attached")

PLEASE LIST ANY MEDICATION **ALLERGIES** THAT YOU HAVE:

2. **EYE HEALTH/HISTORY**

Do you wear: ___ eyeglasses (___ distance ___ near ___ both) ___ contact lenses ___ both ___ none

Have you had any eye surgery/procedures: ___ no ___ yes (specify) _____

Please check any of the following **EYE** conditions that **YOU or ANOTHER FAMILY MEMBER/BLOOD RELATIVE** have currently or have had in the past:

CONDITION	YOU	FATHER	MOTHER	SIBLING	GRANDPARENT	OTHER
DRY EYES						
GLAUCOMA						
CATARACTS						
MACULAR DEGENERATION						
RETINAL DETACHMENT						
OTHER (SPECIFY _____)						

3. **GENERAL HEALTH/HISTORY**

Please check any of the following **MEDICAL** conditions that **YOU or ANOTHER FAMILY MEMBER/BLOOD RELATIVE** have currently or have had in the past:

CONDITION	YOU	FATHER	MOTHER	SIBLING	GRANDPARENT	OTHER
Hypertension (high blood pressure)						
Heart problem(s)						
Arthritis						
Lung problem(s)						
Stroke						
Thyroid problems						
Diabetes						
Cholesterol problem(s)						
Ulcer(s)						
Cancer (specify _____)						
Other (specify _____)						

Do you have annual colorectal screenings? ___ yes ___ no

Do you have an annual mammogram? ___ yes ___ no

Have you had any previous surgeries? ___ yes ___ no

Do you have an annual flu vaccine? ___ yes ___ no

If yes, please specify _____

MD INITIAL WHEN REVIEWED _____

4. **REVIEW OF SYSTEMS** - Please indicate if YOU currently have or previously had any of the following conditions:

Allergic/Immunologic & Blood/Lymphatic

___ seasonal allergies ___ hay fever

___ other (specify) _____

Cardiovascular

___ chest pain ___ congestive heart failure

___ irregular rhythm

___ other (specify) _____

Constitutional & Integumentary

___ fever ___ weight loss

___ skin disease ___ rash

___ other (specify) _____

Gastrointestinal

___ vomiting ___ ulcers

___ diarrhea ___ bloody stools

___ other (specify) _____

Genitourinary

___ genital ulcers ___ discharge

___ kidney stones ___ blood in urine

___ other (specify) _____

Head/Neck

___ sinus problems ___ post-nasal drip

___ runny nose ___ dry mouth

___ hearing loss

___ other (specify) _____

Neurological/Psychological/Musculoskeletal

___ headaches ___ migraine

___ paralysis/fever ___ joint ache

___ other (specify) _____

Respiratory

___ cough ___ bronchitis

___ shortness of breath ___ asthma

___ emphysema ___ COPD

___ other (specify) _____

5. **SOCIAL HISTORY**

SMOKING ___ never smoked ___ former smoker ___ current smoker

How long did you smoke? _____ How long have you smoked? _____

How much did you smoke? _____ How much do you smoke? _____

How long since you stopped? _____

FAMILY HISTORY OF SMOKING ___ no family members smoked/currently smoke

___ family members smoked/currently smoke (how much/how long) _____

ALCOHOL ___ no alcohol consumption

___ consume alcohol beer spirits wine ___ drinks per day week

"RECREATIONAL" DRUGS (please list any drugs used/consumed currently or in the past):

_____