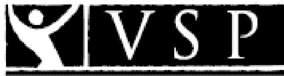

PATIENT HISTORY QUESTIONNAIRE

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last name ______________________ First name ____________________________ MI _____

Address __________________________________ City ___________________ State _____ Zip _____

Work phone (____)______________ Home phone (____)______________ Member ID # _________________

DOB ___________________ Occupation ___________________________ Employer ____________________

Emergency contact name _____________________ Phone number (____)____________________

Date of last eye exam ___________________ Dilated? Yes/No

Today's date ___________________ Referred by _________________________________

Medical Information

What 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) ____ Check if none ☐

Have you had any operations? Yes/No Kind?___________________________ When?___________

Name of family doctor__________________________

Date of last visit _________________ Date of last tetanus shot ___________________

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 ____

Doctor Use Only

Reviewed by ______________________________________ ☐ No changes Date ____________________

Reviewed by ______________________________________ ☐ No changes Date ____________________

Reviewed by ______________________________________ ☐ No changes Date ____________________

11935 1/04

PUPILLARY DILATION

A pupillary **dilation** is the most thorough comprehensive eye examination, and should be assessed **annually** in order to maintain the proper health of the structures inside the eye including the optic nerve, retina and macula. Dilation enables the optometrist to more easily identify cataracts, macular degeneration, tumors, bleeding, and many other vision threatening problems. Dilation is indicated in **trauma, diabetes, hypertension, headaches, high spectacle prescriptions, and for patients who are seeing flashing lights or floating spots. Dilation is like a full physical for your eyes, and is recommended for all of our patients, especially new patients and children.**

The process involves the use of **eye drops** to dilate the pupils and the patient is instructed to wait approximately twenty to thirty minutes for adequate dilation to occur. Distance vision may be blurred and near vision will be blurred for about 4-6 hours as the dilation gradually wears off. There will also be some light sensitivity for which the front desk will supply you with a pair of complimentary disposable sunglasses. Some patients feel uncomfortable with driving after being dilated, and wish to return to our office with a designated driver at a later visit. There is an **additional fee of $20.00 to cover the extra time spent for this procedure.** **Fee may vary based on insurance.**

___**Yes**, I want my eyes dilated at this time. **($20.00)** ___ **Yes**, I want my eyes dilated at a later time. **($35.00)**

___**No**, I do not want my eyes dilated at this time despite the **annual** recommendation by the optometrist.

Signature____ Date ______________

VISUAL FIELD SCREENING

In an effort to provide total vision care to our patients, we are now offering our new automated visual field screening in combination with your annual comprehensive vision examination. This is a state of the art test performed to rule out the early signs of ocular disease. This test involves the use of a special **computer to evaluate both your central and peripheral vision, and is used to detect eye diseases such as glaucoma, macular degeneration, tumors of the eye and brain, and visual changes secondary to diabetes and hypertension. We strongly recommend that all of our patients over the age of six receive the screening version of this exam**. It is especially important for patients who have frequent headaches, circulatory problems, and borderline eye pressures. There is an **additional charge of $15.00 for the visual field screening.**

___ **Yes**, I do want the visual field screening at this time.

___ **No**, I do not want the visual field screening at this time.

Signature____ Date ______________

__**Please note: Polycarbonate lenses for eyeglasses are ten times more impact resistant than standard plastic lenses (CR-39). Dress wear frames are not for safety use or sports, injury or loss of vision could occur.**__ ____**Initials**

Please read and complete below ONLY if this is an exam for CONTACT LENSES

As with any drug or device, the use of contact lenses is not without risk. A small, but significant, percentage of individuals wearing contact lenses could develop potentially serious complications that can lead to permanent eye damage. **If you have any unexplained eye pain or redness, watering of the eye or discharge, cloudy or foggy vision, recent onset decrease in vision, or increased sensitivity to light, immediately REMOVE YOUR CONTACT LENSES AND MAKE ARRANGEMENTS T0 SEE YOUR EYE CARE PROFESSIONAL BEFORE WEARING YOUR CONTACT LENSES AGAIN. Contact lenses should never be worn during sleeping hours due to the increased risks for infections and ulcers with overnight wear. Also, contact lenses should never be worn when you are in or around __any fresh or salt water__, including showers, hot tubs, swimming pools or the beach (serious eye infections and or loss of vision could occur).**

It is of utmost importance that you return to your prescribing doctor for ALL FOLLOW-UP CARE. A one-week follow-up is __required__ to finalize the contact lens prescription, and a contact lens prescription once finalized is valid for one year after the exam date. The contact lens examination fee includes up to three __routine__ follow-ups at no charge during the first six weeks after the examination. Contact lenses should be evaluated on your eyes every six months, and a comprehensive contact lens examination should be completed every year.

By my signature, I acknowledge that I will comply with the recommended care and follow-up instructions.

____ _________________________________

(patient, or legal guardian if minor) Date

HIPAA Notice of Privacy Practices

Dr. Heloi Stark, O.D., P.C., Visual Image Eyecare Associates
3900 Jermantown Road, Suite 170
Fairfax, VA 22030
Ph: 703.385.6134 Fax: 703.273.0938

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 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 and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

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 .

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 relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

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, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. 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 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 as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and 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 to the extent 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 law 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 purposes 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 who may be involved in your care or for notification purposes 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 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, even if you have agreed to accept this notice alternatively i.e. electronically.

You may 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 and becomes effective on/or before **April 14, 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 703.385.6134.

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

Print Name:___________________________ Signature_______________________Date________

PATIENT CONSENT FORM

Patient Name: ___________________________ Date of Birth: ____________

I, _____________________________, (self, parent or guardian) consent Dr. ___________________
to the release of medical records for the above specified individual to:

VSP
P.O. Box 997100
Sacramento, CA 95899-7100

PLEASE READ CAREFULLY: I understand that my medical records are confidential. I understand that by signing this consent form I am allowing my medical information to be released upon VSP's request, to VSP for the purpose of Health Care Operations (including, but not limited to, provider review functions, claims payment and quality assessment). I also understand that I may revoke this consent by written request, at any time, with this doctor. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

For additional information on VSP's Patient Confidentiality Policy, please refer to www.vsp.com. VSP updates the Patient Confidentiality Policy periodically and reserves the rights to make changes as required.

I understand that I have the right to restrict the disclosure of specific information in my medical records if I request such restriction in writing. I also understand that my request for restriction may be denied if the information restricted is required for Health Care Operations.

I have read the above and foregoing consent for release of information. I do hereby acknowledge that I am familiar with and fully understand the terms and condition of the consent.

Signature: ____________________________________ Date: _____________