Patient History Questionnaire

Today's Date _____

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 _____
Date of Birth _____ Occupation _____ Employer _____
Emergency Contact Name _____ Phone Number _____
Date of Last Eye Exam _____ Dilated? Yes/No Referred By _____
Primary Vision Coverage _____ Secondary Coverage _____

Medical Information

How is your general health? _____
Do you take medications for 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? _____
Name of family doctor and/or primary care physician _____
Date of last visit _____ Date your blood pressure was last checked _____

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 _____

PUPILLARY DILATION

A pupillary dilation is the most thorough comprehensive eye examination, and should be assessed annually in order to maintain proper health of the structure 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 bring a driver to their exam or return to our office with a designated driver at a later visit.

___ **Yes**, I want my eyes dilated at this time. ____ **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. **Please Initial ____**

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 TO SEE YOUR EYE CARE PROFESSIONAL BEFORE WEARING YOUR CONTACT LENSES AGAIN. Contact lenses should never be worn during sleeping hours due to increased risk 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.

Signature: _____ Date: _____

(patient, or legal guardian if minor)

HIPAA Notice of Privacy Practices

Revised 2013

Effective as of April/14/2003
Revised March/26/2013

Dr. Heloi Stark, O.D., P.C., Visual Image Eyecare Associates
3900 Jermantown Rd., 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 is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, 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 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 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, 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, employee review, training of medical students, licensing, fundraising, 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, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

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, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent**, **authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the 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

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request**,** you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

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 your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication 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 an amendment to 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 – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

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 Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Dr. Heloi Stark, O.D., P.C.	703-385-6134	703-447-4925
HIPAA COMPLIANCE OFFICER	Work Phone	Cell Phone

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. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.