Name:_____ Birthday:_____ [ ] Male [ ] Female

Address:_____ City:_____ State:_____ Zip:_____

Cell Phone:_____ Home:_____ Work:_____

Spouses Name:_____ Parents (if child)_____

Social Security or insurance ID#_____ Employer_____

Marital status_____ Name of insurance member_____

Current Medications:_____

_____

Medical Allergies [ ] None [ ] Yes_____

Do you smoke? [ ] Yes [ ] No Use illicit or recreational drugs? [ ] Yes [ ] No

Do you, or anyone in your family have medical problems in the following areas? (check if yes)

	Self	Family	Explain
Allergies (Hayfever, Seasonal, Pets)	[ ]	[ ]	_____
Cardiovascular (Heart, Stroke, Circulation)	[ ]	[ ]	_____
Endocrine (Diabetes, Thyroid, Pancreas)	[ ]	[ ]	_____
Gastrointestinal(Ulcers,acid reflux, digestion)	[ ]	[ ]	_____
Ear, Nose, Throat(sore throat, sinus, hearing)	[ ]	[ ]	_____
Cancer (list what type of cancer)	[ ]	[ ]	_____
Skin (Rashes, Bumps, Roseacea)	[ ]	[ ]	_____
Musculoskeletal (Arthritis, Osteoperosis)	[ ]	[ ]	_____
Nervous System(MultipleSclerosis,Depression)	[ ]	[ ]	_____
Respiratory (Cough, asthma, wheezing)	[ ]	[ ]	_____

Do you have Diabetes? [ ] Yes [ ] No

Do you have High Blood Pressure? [ ] Yes [ ] No

Do you have frequent Headaches? [ ] Yes [ ] No If yes, how often?_____

Eye History

Do you wear glasses? [ ] Yes [ ] No If yes, how often? [] Full time [] Part time [] Reading only

Do you wear contact lenses? [ ] Yes [ ] No If yes, when did you start?_____

Date of last exam:_____ Where?_____

Do you have blurred vision? [ ] Yes [ ] No If yes, how often?_____

Distance blur? [ ] Yes [ ] No Near blur? [ ] Yes [ ] NO

Have you ever had eye surgery or injury? [ ] Yes [ ] No Explain:_____

Do you, or anyone related to you have any eye disease, such as glaucoma, macular degeneration, retinitis pigmentosa, ect.? [ ] Yes [ ] No Explain:_____

If child, is he/she having any problems at school (seeing whiteboard, reading)? [ ] Yes [ ] No

Explain:_____

If new patient, how did you hear about our office?_____

Drs. Cripe, Stephens & Stickel LLP
1722 Bashor Road Goshen IN 46526 574-533-4141
212 West Warren St. Middlebury IN 46540 574-825-7434

Authorization to Discuss Your Information with persons listed below

To comply with the new HIPAA Federal Privacy Regulations, we must receive your written approval to discuss your case with anyone else **INCLUDING** your family, spouse, children, caregivers, ect.. By authorizing this, we will be able to, without requiring your presence, discuss your case, answer questions, leave detailed messages, and contact in the event of an emergency, the person(s) listed below. If you would like us to answer questions of discuss your case with anyone other than yourself, you must include them below. This authorization is optional and can be withdrawn at any time by you.

Name_____ Name_____

Relationship_____ Relationship_____

Phone_____ Phone_____

Do you give our office permission to leave a message stating that your glasses/contacts are in?
YES or NO

List the phone number we can leave a message/voicemail_____

Due to new government regulations

Please provide your email address_____ (we will not release your email address to any marketing entity) you will receive an email from a secure website **gosheneyecare.eyefinitydirect.com** with your personal health information please take a moment to review this email to make sure the information is correct.

Signature_____ Date_____

NOTICE OF PRIVACY PRACTICES

THE NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY. Your "health information," for purposes of this notice is generally any information that identifies you and is created, received, maintained, or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this notice). We are required by the health insurance portability and accountability act of 1996 ("HIPPA") and other applicable laws to maintain the privacy of your health information, and to abide by the terms of this notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contacts lens, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency). "Health care operations" mean those administrative and managerial functions that we must carry out in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personal decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

OTHER DISCLOUSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are

- When a state Federal law mandates that certain health information be reported for a specific purpose
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the Federal Food and Drug Administration regarding drugs or medical devices.
- Disclosures to Governmental authorities about victims of suspected abuse, neglect or domestic violence.
- Uses and disclosures for health oversight activities, such as for the licensing of doctors; for adults by Medicare or Medicaid; or for investigation of possible violations of health care laws.
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of court or administrative agencies.
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victims of a crime; provide information about a crime at our office; or to report a crimes that happened somewhere else.
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directions to aid in burial; or to organizations that handle organ or tissue donations.
- Uses or disclosures for health related research.
- Uses and disclosures to prevent a serious threat to health or safety.
- Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign services.
- Disclosures of de-identified information.
- Disclosures relating to workers compensation programs.
- Disclosures of a "limited data set" for research, public health, or health care operations.
- Incidental disclosures that are an unavoidable by product of permitted uses and disclosures.
- Disclosures to "business associates" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA.
- [Specify other uses and disclosures affected by state law].

- **To amend health information.** If you feel that the health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write us at the address below. You must also give us a reason to support your request. We may also deny your request if the health information:
    - Was not created by us, unless the person that created the information is no longer available to make the amendment.
    - Is not part of the health information kept by or for us
    - Is not part of the information you would be permitted to inspect or copy
    - Is accurate and complete.
- **To receive an accounting of disclosures of your health information.** You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).
- **To designate another party to receive your health information.** If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

Contact person:

Our contact person for all questions, requests or for further information related to the privacy of your health information is:

James S. Stickel OD

Complaints:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for civil rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E-mail shown above. If you prefer, you can discuss your complaint in person or by phone.

Changes to this notice:

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised notice that will be posted prominently in our facility. Copies of this notice are also available upon request at our reception area.

Notice Revised and Effective: September 23rd, 2013

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Drs Cripe, Stephens & Stickel LLP O.D., Notice Privacy Practices.

Date_____Patient Name_____ Signature_____