MEDICAL HISTORY QUESTIONNAIRE

let us get to know you better!

Associate Optometry, P.A
1307 Albion Avenue, Fairmont | 111East 6th Street, Blue Earth

Name_____ Date_____
First M Last

Guardian_____Relationship to patient_____
if applicable

Date of Birth___/___/____ Sex___ Race/Ethnicity_____

Your Medical Doctor_____Last Eye Exam___/___/___

Your Last Eye Examiner_____

In so many words, please tell us why you're here:

check all that apply

☐ My annual eye exam ☐ Emergency Visit ☐ Special Testing ☐ Postop ☐ Not sure
☐ Other (Please explain):_____

Systemic Medical History:

*please exclude any **ocular health** history or medications for **page 2***

Do you have any medical conditions? If so, please explain:_____

Please List and date any Surgeries or Medical Procedures you have had:_____

Are you allergic to any medications? If so, please explain:_____

Please list any Medications you take_____

Please continue on to page 2

Ocular Medical History:

Have you been diagnosed with any of the following?
please mark all that apply

☐ Retinal Diseases ☐ Glaucoma ☐ Macular Degeneration ☐ Cataracts
☐ Eye Infections ☐ Lazy Eye ☐ Crossed Eyes ☐ Drooping Eyelids

Please List and Date any Eye Surgeries, or Procedures Done to Your Eyes:_____
_____
_____

Are you allergic to any ocular medications? If so, please explain:_____
_____

Please list any eye drops or ocular medications you take_____
_____
_____
_____
_____

Eyewear History

Do you currently wear glasses? Y / N
How old is your current pair?_____
Are your current lenses satisfactory? Y / N

Do you currently wear contacts? Y / N
Are they (circle one) *soft* *hard*
What brand of contacts do you wear?_____
How long have you worn this brand?_____

Social History

This information is kept strictly confidential. You may discuss this portion directly with the doctor if you prefer.

If you would like to discuss this privately with your doctor, check here ☐

Do you (please circle yes or no for the following):
Drive: Yes / No. If yes do you have any visual difficulties when driving? Yes / No
If yes, please explain_____
Drink Alcohol: Yes / No. If yes, type/amount/how long?_____
Use Tobacco Products: Yes / No. If yes, type/amount/how long?_____
Do you use illegal drugs? Yes / No If yes, type/amount/how long?_____
Have you been exposed to or infected with: Gonorrhea☐Hepatitis☐ HIV☐Syphilis☐

Family History: Has anyone in your family had any of the following?

***please exclude yourself from this list!*

Disease	Relationship to You	Maternal/Paternal	Disease	Relationship to You	Maternal/Paternal
Blindess	☐ _____	_____	Arthritis	☐ _____	_____
Cataracts	☐ _____	_____	Cancer	☐ _____	_____
Crossed Eyes	☐ _____	_____	Diabetes	☐ _____	_____
Glaucoma	☐ _____	_____	High Blood Pressure	☐ _____	_____
Macular Degeneration	☐ _____	_____	Kidney Disease	☐ _____	_____
Retinal Detachment	☐ _____	_____	Lupus	☐ _____	_____
			Thyroid Disease	☐ _____	_____

Other (Please explain)_____

Patient's Signature_____ Today's Date___/___/_____

ASSOCIATE OPTOMETRY, P.A

CONFIDENTIAL PATIENT INFORMATION RECORD

Name_____ DOB_____ SSN_____
(first MI last)

Addres_____City/State/Zip_____

Phone#1_____ mobile/landline Phone#2_____mobile/landline

Sex_____ Are you: Single Married Widowed Divorced Medicare#_____
circle one

Employer_____ Job Title_____ Work Phone#_____

Employer Address_____City/State/Zip_____

If student, name of school/university_____ City_____

Who can we thank for refering you?_____

Emergency Contact Name_____Phone#_____

May We Contact you via e-mai? Yes ☐ No ☐ E-mail Address_____

BILLING INFORMATION

Name of person responsible for account_____ Relationship_____

Address_____City/State/Zip_____Phone#_____

Parent/Spouse Name_____Parent/Spouse Employer_____

Address_____City/State/Zip_____Phone#_____

HEALTH INSURANCE INFORMATION

Name of Insured_____ Relationship_____ Date of Birth_____

Insured's Employer if group Policy_____Phone#_____

Insured's Company Name_____Insured's SSN_____ID#_____

Company Address_____City/Sate/Zip_____

Do you have routine vision care coverage with this company?_____

****PLEASE READ AND SIGN THE CREDIT AGREEMENT ON THE REVERSE SIDE OF THIS FORM!**

ASSOCIATE OPTOMETRY, P.A

CREDIT AGREEMENT

AGREEMENT

In consideration of treatment by the doctor, the undersigned agrees:

1. To pay the amount charged by the doctor for all professional treatment and services to the undersigned, his/her family, or to the patient indicated above, for vision care including initial and subsequent materials and services required for spectacles and/or contact lenses.
2. To order eyewear or contact lenses, we require one-half of the balance down, with the remaining balance due upon dispense.
3. That after an account is 30 days past the date of service, to pay a finance charge which is computed by a periodic rate of 1 1/2% per month. This is an annual percentage rate of 18% applied to the balance over 30 billing days after deducting current payments and/or credits appearing on your statement. This allows for a minimum of 30 days from date of service to pay for your account without incurring a finance charge.
4. To pay all finance charges in the event agreement is not kept.
5. Responsible party is patient or the parent or guardian requesting examination or treatment of minor.

CREDIT POLICY

To enable you to obtain vision care when you need it, without creating a financial burden, it is the usual policy to extend limited credit to our patients. Credit arrangements must be made at the time of exam and/or order.

1. Several major credit cards are accepted.
2. Financing is available through CareCredit. (Staff can provided applications and details.)
3. All charges are considered "past due" 40 days after the date they are incurred. Any balance over 30 days shall be subject to a finance charge computed at the interest rate of 1 1/2% a month (18% annually), based upon the minimum outstanding balance of the month. A minimum finance charge of 50 cents per month will apply.
4. If, due to the amount of your account balance, full payment creates a financial burden, your account may be paid in three equal payments plus 1 1/2% of the minimum outstanding balance per month, or 50 cents minimum finance charge. These arrangement must be made at the time of exam and/or order.
5. If special circumstances arise, we will be glad to work out an acceptable payment arrangement for your account; however, if no payment or arrangements for payment have been made in a 60-day period, the next billing will show a past-due notice.
6. If payment or arrangements for payment are not made, the account will be transferred to a professional collection agency.
7. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

We recommend and appreciate full cash payment at the time of exam and/or order. Prompt pay discounts *may* apply.
We require full payment for contact lenses upon dispense.

I have read and understand the above agreements and credit policies.

_____ _____

(signature of patient or responsible party) *(date)*

1307 Albion Av. Ste. 102
Fairmont, MN 56031

ASSOCIATE OPTOMETRY, P.A.

notice of privacy practices

111 East 6th Street
Blue Earth, MN 56013

THIS 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 thls notice).

We are required by the Health insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information to provide individuals with this Notice of our legal duties and privacy practices with respect to such 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, contact lenses, 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 or attorney). "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; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

OTHER DISCLOSURES 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 or 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 audits 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 from courts or administrative agencies;
* disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
* disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors 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 service;
* disclosures of de-identified information;
* disclosures relating to worker's 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 or 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].

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for healthcare prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION

The following are some specific uses and disclosures we may not make of your health information without your authorization:

Marketing activities. We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes, unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payments to us from a third party, your authorization must also include consent to such payment.

Sale of health information. We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.

Psychotherapy notes. Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

* Other uses and disclosures of yor health information that are not described in this Notice will be made only with your written authorization.

* You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.

* We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.

* We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for service received by you prior to the date you revoke your authorization.

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right:

* To request restrictions on the health information we may use and disclose for treatment, payment and health care operations. We are not required to agree to these requests. To request restrictions, please send a written request to us at the address below. *(see: Contact Person)*

* To receive confidential communications of health information about you in a manner other than described in our authorization request form. You must make such requests in writing to the address below *(see: Contact Person).* However, we reserve the right to determine if we wil be able to continue your treatment under such restrictive authorizations.

* To inspect or copy your health information you must make such requests in writing to the address below *(see: Contact Person).* If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable 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 to us as the address below *(see: Contact Person).* You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide 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, or
* 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 *(see: Contact Person).* Not all health information is subject to this request. Your request must state a time period for the information you would like to recieve, no longer than 6 years prior to the date of your request and may not include dates before April 13th, 2003. Your request must state how you would like to receive the report (paper, electronically, et cetera).

* To designate another party to receive your health information. If your request for access to 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 *(see: Contact Person)* 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 infomration related to the priacy of your health information is:

James Busche, O.D.
1307 Albion Avenue, Ste. 102
Fairmont, MN 56031

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: October 6th, 2020.

Patient Signautre _____ Date _____