Christa Kim, O.D. and Associates

Welcome to Our Office

So that we can help you best, please fill out <u>both pages</u> legibly and completely. Thank You!

Full Name _____ Today's date _____

Name you go by (if different) _____ Approximate date of last eye exam _____

Home address _____ Date of birth _____ Sex: M F

City _____ State _____ Zip _____ Social security number _____

Home phone ___(_____)_____ Employer (or School) _____

Work phone ___(_____)_____ Occupation (or Grade) _____

Cell phone ___(_____)_____ Emergency contact & phone _____

E-mail address _____ Marital Status (if applicable) _____

Name of Family Members at Home	Relationship	Age	Current Patient of Ours?
			Y N
			Y N
			Y N
			Y N

Primary Care Physician_____ How will you settle your account today?

Physician address & phone number_____ ❑ Debit ❑ Cash ❑ Credit Card

Are you a member of an eye care plan and/or medical plan? Y N (if yes, circle your plan(s) below and sign to authorize benefits)

VSP Eye Med Superior Vision Davis Aetna BCBS Cigna Humana Medicare PHCS UHC Other_____

Primary Insured _____ Birthdate_____ SS#_____ Employer _____

I authorize the payment of any eye care benefits indicated above to my Doctor of Optometry. I understand that I may have co-payments and overages (costs not paid for by the eye care plan), and I am ultimately responsible for all fees incurred.

Patient or Responsible Party's Signature: _____ Date _____

Personal Medical History

Allergies/Asthma	Y	N	Eye Disease/Infection	Y	N
Arthritis	Y	N	Eye Surgery	Y_____	N
Cancer	Y	N	Eye Injury	Y_____	N
Diabetes	Y	N	Heart Disease	Y	N
High Blood Pressure	Y	N	Other	_____	

Do you take any prescription or non-prescription medications regularly? Y N (If yes, please list)

Are you allergic to any medicines? Y N (If yes, please list)

How did you *first* hear about our office?

❑ Family, friend, or co-worker. Who? _____

❑ Doctor referral. Who? _____

❑ Eye care plan directory.

❑ Advertisement? _____

❑ Internet. Which website? _____

❑ Other. Please specify. _____

_____

Do you currently (or in the past), smoke, use alcohol, or narcotics?

Y N

If yes, please explain:

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Family Medical History			
If yes, PLEASE SPECIFY	**(mother, father, etc.)**		
Diabetes	Y	N	Unsure
High Blood Pressure	Y	N	Unsure
Cataracts	Y	N	Unsure
Glaucoma	Y	N	Unsure
Macular Degeneration	Y	N	Unsure
Blindness or Visual Disability	Y	N	Unsure
Other disease (please specify) _____			

Eye Care for Your Lifestyle			
Do you desire glasses that are thinner, lighter, and more comfortable?	Y	N	
Do you spend much time outdoors?	Y	N	
Do you spend much time working on a computer?	Y	N	
Are your eyes very sensitive to bright lights?	Y	N	
Are you bothered by glare and reflections, especially at night?	Y	N	
Are you interested in wearing the most advanced contact lenses?	Y	N	
Current contact lens brand & prescription _____Right_____Left_____	N/A		
Are there times you would rather not wear glasses or contact lenses?	Y	N	
Do you suffer from dry eyes?	Y	N	
If you wear prescription glasses, do you have only one pair?	Y	N	N/A
If you wear bifocal glasses, does the line bother you?	Y	N	N/A
If you wear bifocal or progressive glasses, do you ever wish you could wear contacts?	Y	N	N/A

So that we can get to know you better . . . What hobbies, sports, or other activities do you enjoy?

I acknowledge that I have received a copy of Dr. Kim's *Notice of Privacy Practices*, available from our office receptionist. You can also review it on our website, www.customeyesfrisco.com.

Patient name _____ Today's Date _____

Signature of patient (or parent/guardian for minors) _____

Thank you!

Christa Kim, O.D. and Associates, PC
Custom Eyes Optique and Eyecare
NOTICE OF PRIVACY PRACTICES

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

OUR LEGAL DUTY

We are obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may request a copy of our notice at any time, or print a copy from our website. For more information about our privacy policies, please contact us at 2840 Legacy Drive Suite #430 Frisco, TX 75034.

USES AND DISCLOSURES OF MEDICAL INFORMATION

We use and disclose medical information about you for treatment, payments and referrals to specialists (if necessary). This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, to assist with, aid in, or facilitate the collection for data for purposes of utilization review, quality assurance or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMOs, PPOs, managed care organizations, or other government or third party payer, or any organization contracting with any of the above entities to perform such functions.

Copies of your medical information may be delivered to any optometrist, ophthalmologist or medical physician who is directly or indirectly responsible for your eyecare or the payment thereof.

We may use or disclose your medical information to notify a family member of another person responsible for your care based on professional judgment and the circumstances. We may use your medical information to contact you to provide appointment reminders. We may use your name and your location in our database for purposes of sending out exam reminder cards and promotional materials as well as contacting you by phone or leaving a message for appointment reminders.

We may use or disclose your medical information for the purposes of involving public health and safety issues and activities, death, certain requests from your employer, governmental personnel and programs, judicial and administrative proceedings, law enforcement, abuse, neglect, or domestic violence issues, and workers compensation issues.

INDIVIDUAL RIGHTS

This office will not use or disclose any of your medical and financial information for any purpose not state bout without your specific authorization. You may revoke your authorization at any time. You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy, and amend your protected health information. You may also request and accounting of disclosures of your protected health information from this office. We may charge a cost based fee for copying records and for postage.

QUESTIONS AND COMPLAINTS

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

I acknowledge that I have read and consent to the above policies.

Patient's Signature_____ Date _____

Digital Retinal Imaging

Dear Patient,

A computerized instrument now allows us to provide you with a MORE THOROUGH medical analysis of your eye. The digital retinal imaging camera takes digital pictures of the retina (nerve layer inside the back of your eye). This procedure assists the doctor in the early detection of many disorders, including glaucoma, diabetic retinopathy, macular degeneration, hypertensive retinopathy, and other sight threatening conditions. The pictures are stored in our database and will be used to compare with future images to observe for any future changes in the health inside your eyes.

The doctor strongly recommends that ALL patients have this procedure performed routinely. If you are **40 years and older, the doctor recommends YEARLY photos.** It is especially important for people who have:

1. Headaches
2. Diabetes
3. High blood pressure
4. High cholesterol /triglycerides
5. 40 years of age and older
6. Family history of Glaucoma, Macular Degeneration, and or blindness
7. Family History of Diabetes or High blood pressure
8. NEW PATIENTS

Medical and Vision insurances DO NOT pay for routine photos. **The charge for routine photos is $39.** If there is a medical diagnosis found, your medical insurance may pay for this procedure. This usually requires a written interpretation or report by the doctor and additional fees will be submitted to your insurance company. The doctor will NOT know prior to your exam if there is a medical diagnosis that would allow for insurance submission.

Please check the appropriate line and sign at the bottom.

___ Yes, I would like the imaging procedure performed.

___ No, I decline to have the imaging procedure performed.

_____

Signature of Patient (or parent if under 18 years old)

_____ Date_____

Patient Name (printed)