

Refractive Patient Information Form

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ Age: _____ Sex: M F Marital Status: _____

Social Security #: _____ E-mail : _____

Preferred Contact Method: Home Phone Other _____

Preferred Language: English Other _____ Ethnicity*: Hispanic/Latino Other

Race*: _____

Pharmacy: _____ Phone number : _____

Pharmacy Address: _____

Mailing Address: _____

City State Zip

Home #: _____ Cell #: _____ Work #: _____

Employers Name: _____ Position: _____

Address: _____ City: _____ St: _____ ZIP: _____

Emergency Contact: _____ Relationship: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Referred By: _____

Primary Eye Doctor: _____ Last Seen: _____

PLEASE READ AND SIGN BELOW

I hereby authorize the physicians and staff of **Cornea Associates of Texas** to perform or procedures necessary to assess and diagnose my condition properly and such treatments as may be prescribed by my attending physician during any and all visits to **Cornea Associates of Texas**. I understand that I am financially responsible for all charges from services rendered to me by **Cornea Associates of Texas**.

Signature: _____ Date: _____

*For more information regarding Race and Ethnicity, see Supplemental Handout.

Cornea Associates of Texas
MEDICAL HISTORY QUESTIONNAIRE

Date _____ Name _____ Age _____ DOB _____
 Height _____ Weight _____

Drug Allergies/Reactions: No known drug allergies Yes (please list) _____

Have you ever had an adverse reaction to latex or been diagnosed with a latex allergy? Yes No

Please list all medications you take (prescription, over-the-counter, and vitamins)

Past/Present Medical History (Check all that apply)

- No known health problems**
- Ears, Nose, Throat** Hearing Loss Other _____
- Cardiovascular** High Blood Pressure Atrial Fibrillation Congestive Heart Failure Heart Attack
 Stroke Heart Disease Other _____
- Respiratory** Asthma Emphysema Other _____
- Gastrointestinal** Acid Reflux Ulcer Hiatal Hernia Other _____
- Genital/Kidney/Bladder** Prostate Disorder Incontinence Other _____
- Muscles/Bones/Joints** Arthritis Rheumatoid Arthritis Osteoporosis Other _____
- Skin** Rosacea Eczema Acne Other _____
- Neurological** Migraines Multiple Sclerosis Parkinson's Alzheimer's Other _____
- Psychiatric** Anxiety Depression Insomnia Other _____
- Endocrine** Diabetes Thyroid Other _____
- Blood/Lymph** High Cholesterol Anemia Cancer _____ Other _____
- Allergic/Immunologic** HIV + Lupus Sjogren's Allergies Other _____

Eye Surgeries No prior eye surgeries

Type of eye surgery	Eye	Doctor	Date

Past Surgical History (Other than eye)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History Glaucoma Diabetes Heart Disease Heart Attack Cancer _____
 Hypertension Other _____

Social History

Current Occupation _____

Marital Status Married Single Widowed Divorced

Living Arrangements Alone With Family Nursing Home Assisted Living Other

Do you drink alcohol? Yes No If Yes: Occasional 1/Day 2-3/Day 4+/Day

Tobacco Use: Current Former Never Type of tobacco used: _____

Amount: Occasional 1/2 pack/Day 1 pack/Day 1+ Pack/Day Years: _____

Do you use drugs? Yes No Type: _____ How Often? _____

Do you use caffeine? Yes No If Yes: Occasional 1/Day 2-3/Day 4+/Day

Have you ever had a blood transfusion? Yes No

Person Filling out this form:

Patient Technician _____ Doctor Parent/Guardian _____

Other _____ relationship to patient: _____

Patient's Signature

Date

Doctor's Signature

Date

Office Use Only
ROS/Medical History Reviewed and Updated

Date	Initials	Date	Initials	Date	Initials	Date	Initials
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____

Cornea Associates of Texas is currently implementing processes to comply with the new federal Electronic Medical Records, meaningful use requirements. The purpose of collecting this information is to ensure that all patients receive high-quality healthcare. We would like for you to provide us with your race and ethnic background. We will only use this information to ensure all patients receive the best care available and to comply with current and future federal requirements.

Ethnicity: There are two ethnic groups as define by the US. Census, list the option that best describes your Ethnicity.

- Hispanic/Latino
- Not Hispanic/Latino

Race: Following are the standard choices, list the choice that best describes your Race.

- American Indian or Alaska Native
- Black or African American
- White
- Multiracial
- Asian (Includes Pakistan or Indian origins)
- Native Hawaiian or Other Pacific Islander
- Decline

Language: What language do you feel most comfortable speaking with your doctor or nurse?

- English
- Spanish
- Vietnamese
- Chinese
- German
- French
- Hindi
- Korean
- Tagalog
- Sign Language or other Auxillary Aid/Service
- Do Not Know
- Decline
- Other

CORNEA ASSOCIATES OF TEXAS
NOTICE OF PROTECTED HEALTH INFORMATION PRACTICES

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.

Understanding Your Health Record/ Information

This notice describes the practices of Cornea Associates of Texas (hereinafter “Cornea Associates”) and that of its physicians with respect to your protected health information created while you are a patient at Cornea Associates. Physicians and personnel of Cornea Associates authorized to have access to your medical chart are subject to this notice. In addition, physicians of Cornea Associates may share medical information with each other for treatment, payment or health care operations described in this notice.

We create a record of the care and services you receive at Cornea Associates. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the records of your care at Cornea Associates.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

Your Health Information Rights

Although your health record is the physical property of Cornea Associates, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information for treatment, payment, health care operations and as to disclosures permitted to persons, including family members involved with your

care and as provided by law. However, we are not required by law to agree to a requested restriction;

- Obtain a paper copy of this notice of protected health information practices;
- Inspect and request a copy of your health record as provided by law;
- Request that we amend your health record as provided by law. We will notify you if we are unable to grant your request to amend your health record;
- Obtain an accounting of disclosures of your health information as provided by law;
- Request communication of your health information by alternative means or at alternative locations. We will accommodate reasonable requests; and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken in reliance on your authorization.

You may exercise your rights set forth in this notice by providing a written request, except for requests to obtain a paper copy of the notice, to the Cornea Associates’ Privacy Officer at 900 W. Magnolia, Suite 203; Fort Worth, Texas 76104.

Our Responsibilities

In addition to the responsibilities set forth above, we are also required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you;

- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on certain uses and disclosures;
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change. Should our information practices change we are not required to notify you, but we will have the revised notice available for you to request at any Cornea Associates’ location. The revised notice will also be posted at our offices and on the Cornea Associates’ web page at www.CorneaTexas.com; and
- We will not use or disclose your health information without your written authorization, except as described in this notice.

Examples of Disclosures for Treatment, Payment, Health Care Operations and As Otherwise Allowed By Law.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information should fall within one of the categories.

We will use your health information for treatment.

For example: We may disclose medical information about you to doctors, nurses, technicians, medical

students, or other personnel who are involved in taking care of you at Cornea Associates. We may share medical information about you in order to coordinate different treatments, such as prescriptions, lab work and x-rays. We may also provide your physician or a subsequent health-care provider with copies of various reports to assist in treating you once you are discharged from care at Cornea Associates.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health care operations.

For example: We may use the information in your health record to assess the care and outcome in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

We will use your health information as otherwise allowed by law. The following are some examples of how we may use or disclose medical information about you.

Business associates: There are some services provided in our organization through agreements with business associates. Examples include answering services and copy services. To protect your health information, however, we require business associates to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in

notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to protect the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Communications for treatment and health care operations: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, medications, devices, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Worker's compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse, neglect or domestic violence: As required by law, we may disclose health information to a governmental authority authorized by law to receive reports of abuse, neglect, or domestic violence.

Judicial, administrative and law enforcement purposes: Consistent with applicable law, we may disclose health information about you for judicial, administrative and law enforcement purposes.

Required or allowed by law: We will disclose medical information about you when required or allowed to do so by federal, state or local law.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact Cornea Associates' Privacy Officer at Metro (817) 261-9282.

If you believe your privacy rights have been violated, you can file a complaint with Cornea Associates' Privacy Officer or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

EFFECTIVE DATE: 04/01/03
VERSION: 1

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CONSENT

TO THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, AND AS OTHERWISE ALLOWED BY LAW

Cornea Associates of Texas (hereinafter referred to as “Cornea Associates”) will maintain a record of the care and services you receive at Cornea Associates. This consent only covers your protected health information created while you are a patient of Cornea Associates. Your protected health information pertains to your diagnosis and/or treatment at Cornea Associates, including but not limited to information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus (“HIV”), and Acquired Immune Deficiency Syndrome (“AIDS”), laboratory test results, medical history, treatment progress or any other such related information.

By signing this form, you consent to Cornea Associates’ use and/or disclosure of protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. Our *Notice of Protected Health Information Practices* provides information about how Cornea Associates and its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. **By signing this form, you also acknowledge that you have received a copy of Cornea Associates’ Notice of Protected Health Information Practices and an opportunity to review it before signing this consent.**

Signature of Patient or Legal Representative

Witness

Date

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Patient Authorization To Release Protected Health Information

I authorize Cornea Associates of Texas to release protected health information to the individual (s) listed below for the purpose of assisting with my care and/or payment.

Name Relation

Name Relation

Name Relation

Description of the information to be used or disclosed:

- Patient's demographic information
- Patient's medical information
- Patient's billing information

I understand that this authorization will be in effect during the time period I am a patient at Cornea Associates of Texas.

I further understand that this authorization is voluntary and that my health care and the payment of my health care will not be affected if I do not sign this form.

I further understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

I further understand that I may revoke this authorization at any time by notifying *Cornea Associates of Texas* in writing at *800 5th Avenue, Suite 140 Fort Worth, Texas 76104*. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

Signature of Patient or Patient's Representative Date

Printed name of Patient or Patient's Representative

Relationship to patient or Legal Authority