HIPAA

By signing below, I authorize the Rosenstein Vision to use any protected health information, or PHI, in any of the following circumstances:

1. We may use and disclose PHI about you to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. In addition, we may use and disclose PHI about you when referring you to another health care provider for additional care.

2. Generally, we may use and give your medical information to others to bill and collect payment for the treatment and services we provided to you. Specifically, sharing information with your health plan (s) allows us to ask for coverage under your plan or policy and for approval of payment before we provide the services. We may also share portions of your medical information with the following:

    - Billing departments
    - Collection departments
    - Insurance companies, health plans and their agents which provide you coverage

3. I am aware that there is a copy of this office's Notice of Privacy Practices as required by HIPAA in each examination room, in the waiting room, and at the front desk. All of these copies are available for my review while I am in the office.

SIGNATURE:___________________________________ DATE:_________________

Welcome to our office!

PLEASE PRESENT PHOTO ID, VISION AND MAJOR MEDICAL INFORMATION AT CHECK IN

If insurance cards are in digital format only, please email to: frontdesk@rosensteinvision.com

IMPORTANT NOTE: Our office requires a 24-hour notice for appointment cancellations. If notice is given less than 24 hours in advance, you may be subject to a cancellation fee.

Demographics		
First Name:	MI:	Last Name:
Date of Birth:	SSN:	Preferred Name/Nickname (if applicable):
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	Daytime/Work Phone:
Email Address:		
Communication Preference: ☐ Email ☐ Postal ☐ Telephone		
Marital Status: ☐ Divorced ☐ Legally Separated ☐ Married ☐ Separated ☐ Single ☐ Widowed		
Student Status: ☐ Full Time ☐ Part Time ☐ Not a Student		
Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Disabled ☐ Active Military ☐ Not Employed ☐ Self-Employed		
Employer:	Occupation:	
Preferred Language: ☐ English ☐ Spanish ☐ Other:___________________________________		
Race: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Decline to Specify ☐ European ☐ Hispanic ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ White		
Ethnicity: ☐ Decline to Specify ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ Not Hispanic or Latino		
Special Accommodations: ☐ Hearing Impaired ☐ Translator ☐ Wheelchair ☐ Other: ____________________		
How did you hear about us?		
Signature of Patient/Representative:	Date:	

EST 1904

ROSENSTEIN VISION

INSURANCE INFORMATION

WE WORK WITH INSURANCE COMPANIES TO FILE CLAIMS DIRECTLY AS A COURTESY

In order to successfully file insurance claims, it is your responsibility to provide any and all insurance cards and information at the time of service and know your current insurance providers. By choosing to provide this information you are allowing Rosenstein Vision Center to bill your insurance. If you do not provide this information on the date of service then you are responsible for filing to your insurance company, and we will provide all necessary documents to do so.

Please keep in mind insurance companies determine all copays, coinsurances and deductibles that may apply to your visit and are not set by Rosenstein Vision Center.

CONTACT LENSES

The FDA (Federal Food and Drug Administration) law requires that all contact lens patients be evaluated annually.

An additional fee will be due at the time of the exam.

The evaluation fees are determined based on *the complexity of the fit*. This fee may be covered, in part, by your insurance - usually with a copay determined by your insurance company. In some situations, your insurance company will determine the type of fit as well as the charge. If you have any questions, please check with your insurance company.

☐ I wear Contact Lenses ☐ I **DO NOT** wear Contact Lenses ☐ I am **interested** Contact Lenses

CONTACT LENS OFFICE POLICIES

If you are a receiving a contact lens exam with our office, it is our policy that you must have back up glasses with a functional prescription.

It is important to have back up glasses for many reasons:

Emergencies such as: allergies, infections, contact lens discomfort, scratched cornea, foreign body or chemical accidents, etc.

Daily Occurrences such as: tired eyes, allergies, dryness, discomfort, air quality issues, etc.

Complications such as: losing or tearing a lens, waiting on your order to be delivered, waiting for an exam appointment due to an outdated prescription, etc.

Keep in mind, with standard contact orders with **no complications** it will take roughly 7-10 business days from the day you place your order for contact lenses to arrive.

Once a prescription is finalized and an order for contact lenses has been placed all sales are final.

☐ I have functioning glasses ☐ I **DO NOT** have functioning glasses ☐ I am **interested** in getting glasses

I understand and agree to these policies: ______________________________ ____________________

Signature Date

REASON FOR VISIT/CURRENT CONCERNS?

CURRENT MEDICATIONS

ALLERGIES

PREFERRED PHARMACY
Pharmacy Name:
Pharmacy Location/Address:

PROVIDERS	
Primary Care Physician/Location:	Approximate date of last visit:
Previous Eye Doctor/Location:	Approximate date of last visit:

MISCELLANEOUS					
Y	N		Y	N	
□	□	Do you wear glasses?	□	□	Do you wear Contact Lenses?
□	□	Are you interested in refractive surgery?	□	□	Do you perform fine or close-up work?
□	□	Are you outdoors all or part of the time?	□	□	Are you sensitive in bright sunlight?
□	□	Are you bothered by glare from overhead lights?	□	□	Are you bothered by glare from a computer screen?
□	□	Are you bothered by glare from oncoming headlights at night?	□	□	Do you have trouble reading signs when driving at night?
□	□	Are you Pregnant?	□	□	Are you Breastfeeding?
□	□	Do you use recreational drugs?	□	□	Do you drink?
□	□	Are you a tobacco smoker?			

How many hours per day do you use a computer?	
What kind of hobbies/recreational activities do you enjoy?	

REVIEW OF SYSTEMS Do you currently have, or have you ever had any of the following? (Please check any/all that apply).			
Allergic/Immunologic	**Cardiovascular**	**Constitutional**	**Ear, Nose, Mouth, Throat**
□ Eczema	□ Heart Disease	□ Fever w/weight loss/gain	□ Allergies
□ Hives	□ High Blood Pressure		□ Sinus Congestion
□ Lupus	□ High Cholesterol		□ Post Nasal Drip
□ Organ Transplant	□ Stroke		□ Chronic Cough
	□ Vascular Disease		□ Dry Mouth/Throat
Endocrine	**Gastrointestinal**	**Genito-Urinary**	**Integumentary (skin)**
□ Diabetes Type I	□ Constipation	□ Bladder/Genital/Kidney	□ Skin Cancer
□ Diabetes Type II	□ Crohn's Disease	□ Herpes Simplex	□ Skin Disease
□ Thyroid/other Glands	□ Hepatitis A	□ Prostate	□ Herpes Zoster/Shingles
□ Chronic Cough	□ Hepatitis B		
	□ Hepatitis C		
	□ Ulcer/Reflux		

Lymphatic – Hematologic	Musculoskeletal	Neurological	Psychiatric	Respiratory
□ Anemia	□ Joint/Muscle Pain	□ Headaches	□ Anxiety	□ Asthma
□ Bleeding Problems	□ Osteo Arthritis	□ Migraines	□ Depression	□ Chronic Bronchitis
	□ Rheumatoid Arthritis	□ Multiple Sclerosis		□ Emphysema
		□ Gout		□ Sleep Apnea
		□ Seizures		

List any previous surgeries (with approximate dates):

Ocular History Do you currently have, or have you ever had any of the following? (please check any/all that apply)			
□ Age-related macular degeneration	□ Amblyopia (Lazy eye)	□ Blindness (one eye)	□ Blindness (both eyes)
□ Cataracts	□ Glaucoma	□ History of refractive surgery	□ Injury to the eye region
□ Keratoconus	□ Retinopathy	□ Strabismus (Crossed eyes)	□ Tear film insufficiency (dry eye)

Patient Past Medical History Do you currently have, or have you ever had any of the following? (Please check any/all that apply)			
□ Acquired Immune Deficiency Syndrome (AIDS)	□ Arthritis	□ Asthma	□ Cancer
□ Chronic obstructive lung disease (COPD)	□ Diabetes Mellitus	□ Emphysema	□ Heart Disease
□ Human immunodeficiency virus infection (HIV)	□ Hypercholesteroleia (high cholesterol)	□ Hypertensive disorder (Hypertension)	□ Seasonal allergies
□ Thyroid dysfunction	□ Mental disorder	□ Rheumatoid arthritis	□

Family Health History **If checked, please specify which family member including maternal/paternal indicators**	
□ Amblyopia (Lazy eye):	□ Blindness and/or vision impairment:
□ Cataracts:	□ Macular Degeneration:
□ Glaucoma:	□ Retinal Disorder:
□ Strabismus (cross eyes):	□ Arthritis:
□ Cancer:	□ Diabetes Mellitus:
□ Hypertension (high blood pressure):	□ Cardiovascular disease:
□ Stroke:	