PATIENT INFORMATION

□ Dr. □ Mr. □ Mrs. □ Ms. Name____Date____________________

Address____City_____________________State_______Zip___________

Email____Occupation_________________________________

Home Phone____________________Cell Phone_______________________Text Messaging OK? □ Yes □ No

Date of birth____________________Age__________ Last 4 digits of Social Security #____________

Parent or Guardian Name_______________________________ Relationship to Patient_________________________

PATIENT'S REFERRAL SOURCE Who may we thank for referring you? Check all that applies.

□ Family/Friend/Professional, who?_______________ □ Yelp □ Facebook □ Instagram □ Google □ Other ___________

PATIENT MEDICAL AND OCULAR HISTORY

Primary Reason for your visit today____

Any problems with your glasses and/or contact lenses?____

Any activities you enjoy doing but avoid because of your vision?____

List your hobbies ____

Name of Last Eye Doctor______________________________ Date of Last Eye Exam______________________

Name of Family Physician_____________________________ Date of Last Physical Exam__________________

Primary Medical Insurance_____________________________ □ HMO □ PPO □ Medicare Supplemental___________

Please bring Medical Insurance Card to Appointment

Check Box for ALL conditions you currently have.

□ EYES
- □ Loss of Vision
- □ Blurred Vision
- □ Double Vision
- □ Dryness
- □ Redness
- □ Itching
- □ Mucous Discharge
- □ Excess Tearing/Watering
- □ Glare/Light Sensitivity
- □ Eye Pain or Soreness
- □ Chronic Infection
- □ Flashes/Floaters in Vision
- □ Tired Eyes/Eyestrain

□ ALLERGIC/IMMUNOLOGIC

□ CARDIOVASCULAR
- □ Hypertension

□ CONSTITUTIONAL
- □ Fever, Weight Loss/Gain

□ ENDOCRINE
- □ Diabetes
- □ Cholesterol
- □ Thyroid

□ GASTROINTESTINAL
- □ Diarrhea
- □ Constipation

□ GENITOURINARY
- □ Genitals/Kidney/Bladder

□ EAR/NOSE/THROAT
- □ Allergies
- □ Sinus Congestion
- □ Dry Throat/Mouth

□ HEMATOLOGIC/LYMPHATIC
- □ Anemia
- □ Bleeding Problems

□ INTEGUMENTARY (Skin)

□ BONES/JOINTS/MUSCLES
- □ Rheumatoid Arthritis
- □ Muscle/Joint Pain

□ NEUROLOGICAL
- □ Migraines
- □ Seizures

□ PSYCHIATRIC

□ RESPIRATORY
- □ Asthma
- □ Chronic Bronchitis
- □ Emphysema

□ OTHER ____________________

Are you in good health? □ Yes □No Are you pregnant and/or nursing? □ Yes □ No

Do you smoke? □ Yes □ No List type/amount/how much ____

Do you drink alcohol? □ Yes □ No List type/amount/how much ____

Do you and/or a family member have any of the following? Check ALL that apply and WHO has it.

□ Cataract ______________________ □ Glaucoma ______________________ □Macular Degeneration ____________________

□ Diabetes ____________________ □ Cholesterol ____________________ □ Hypertension ___________________________

What **medications** are you currently taking (include eyedrops)? □ See List

____

What **medications** are you allergic to? ____

List any major surgeries (What type & When?) ____

VISION AND MEDICAL INSURANCE ASSIGNMENT OF BENEFITS AGREEMENT

I certify that the information I provided is true and correct. I authorize *Aloha Family Optometry, Inc*. to act as my agent to obtain payment from all my insurances and give authorization for payment of any insurance benefits to be made directly to *Aloha Family Optometry* for services and/or procedures rendered and/or materials purchased. I understand that all patient charges for services rendered and/or products purchased will be due at the time of service, and I am financially responsible for any unpaid balances from my insurance after claim has been processed. Unpaid balances can include copays/coinsurance, deductibles, non-covered services or products, ineligibility, or termination of coverage. I authorize *Aloha Family Optometry* to release any information about me that is necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

PRODUCT RETURN/EXCHANGE AGREEMENT

All clinical procedures and/or services are non-refundable, including comprehensive eye examination, refraction, contact lens fitting, and medical office visits. Frames (except discontinued styles), frame accessories and unopened boxes of contact lenses may be exchanged within thirty (30) days of receiving the product, provided the product is returned without damage at the time the exchange is issued, and restocking fees may apply. Opened boxes of contact lenses are non-refundable or exchangeable. Prescription lenses are custom made; therefore, they are non-refundable, and once ordered cannot be canceled. Prescription lenses are guaranteed for sixty (60) days and any concerns must be reported within this time. Any orders not picked up within ninety (90) days are returned and deposits are forfeited unless other arrangements have been made.

CONSENT FOR TREATMENT

I hereby authorize the doctors at *Aloha Family Optometry, Inc*. to administer diagnostic and medical procedures and treatments necessary to ensure the proper health care of my eyes.

I have read and understood the *Vision and Medical Insurance Agreement*, *Product Return/Exchange Agreement*, and I accept the *Consent for Treatment* and have received a copy of the Notice of Privacy Policies or *Aloha Family Optometry, Inc.*

____
Print Patient Name

____ ________________________
Signature of Patient or Guardian Date

Privacy Notice

FORM OF NOTICE OF PRIVACY 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.
THIS NOTICE IS EFFECTIVE SEPTEMBER 10, 2011 UNTIL FURTHER NOTICE.
Please review this entire notice for details about the uses and disclosures Aloha Family Optometry may make of your medical information, about your rights and how to exercise them and about complaints regarding or additional information about our privacy practices.

OUR LEGAL DUTY

We use many methods to protect your oral, written and electronic medical information from illegal use or disclosure. We are required by law to: (a) keep your medical information private (b) provide you with this notice and follow the policies listed here (c) inform you if we cannot agree to limit how we share your medical information (d) agree to reasonable requests to contact you by alternative means or at alternative locations and (e) get your written approval to share your medical information for reasons other than those listed above and permitted by law.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. If we make a significant change in our privacy practices, we will change this notice and make available a copy of the notice at our office. You may request a paper copy of our notice at any time by contacting us using the information at the end of this notice.

USES AND DISCLOSURES OF MEDICAL INFORMATION

We will use and disclose medical information about you for treatment, payment and health care operations. For example:
Treatment: We may disclose your medical information, without your permission, to a physician or other health care provider to treat you, or to coordinate or manage your health care and any related services.
Payment: We may use and disclose your medical information, without your permission, to determine eligibility, process claims or make payment for covered services you receive under your benefit plan. We may also disclose your medical information to a health care provider or another health plan for that provider or plan to obtain payment or engage in other payment activities.
Health Care Operations: We may use and disclose your medical information, without your permission, for health care operations. Health care operations include, for example, health care quality assessment and improvement activities and general administrative activities.

You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice.

Unless you object, we may disclose your medical information to a family member, friend or any other person you involve in your health care or payment for your health care. We will disclose only the medical information that is relevant to the person's involvement, and at all times, we will only disclose the minimum necessary information. We may use or disclose your name, location and general condition to notify, or to assist an appropriate public or private agency to locate and notify, a person responsible for your health care in appropriate situations, such as a medical emergency or during disaster relief efforts.

We may contact you to remind you of appointments. We may use your medical information to communicate with you about health-related products, benefits and services, payment for those products, benefits and services, and treatment alternatives that may be of interest to you.

We may use and disclose your medical information, without your permission, when required by law, and when authorized by law for the following kinds of public health and interest activities, judicial and administrative proceedings, law enforcement, research and other public benefit functions: for public health, including to report disease and vital statistics, child and adult abuse, neglect or domestic violence to avert a serious and imminent threat to health or safety for health care oversight, such as activities of state insurance commissioners, licensing and peer review authorities and fraud prevention enforcement agencies for research in response to court and administrative orders and other lawful process to law enforcement officials with regard to crime victims, crimes on our premises, crime reporting in emergencies and identifying or locating suspects or other persons to coroners, medical examiners, funeral directors, and organ procurement organizations to the military, federal officials for lawful intelligence, counterintelligence and national security activities, and correctional institutions and law enforcement regarding persons in lawful custody and as authorized by state worker's compensation laws.

INDIVIDUAL RIGHTS

Access

You have the right to examine and to receive a copy of your medical information, with limited exceptions. You must make a written request to the contact at the end of this notice to obtain access to your medical information.

Disclosure Accounting

You have the right to a list of instances after April 13, 2003, in which we disclose your medical information for purposes other than treatment, payment and health care operations, as authorized by you, and for certain other activities. You must make your request to the contact at the end of this notice. We will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than six years before the date of your request and never for a disclosure that occurred before April 14, 2003.

Amendment

You have the right to request that we amend your medical information. You must make a written request to the contact at the end of this notice and the written request must explain why the information should be amended. We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction

You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. You must make a written request to the contact at the end of this notice.

Confidential Communication

You have the right to request that we communicate with you about your medical information in confidence by alternative means or to alternative locations that you specify. You must make a written request to the contact at the end of this notice and your request must represent that the information could endanger you if it is not communicated in confidence as you request. We will accommodate your request if it is reasonable and specifies the alternative means or location for confidential communication.

Right to Obtain a Paper Copy

If you receive this notice on our web site or by e-mail, you are entitled to receive this notice in written form. Please contact us using the information at the end of this notice to obtain this notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information at the end of this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information in response to a request you made to amend, restrict the use or disclosure of, or communicate in confidence about your medical information, you may complain to us using the contact information at the end of this notice. You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, Washington, D.C. 20201. You may contact the Office of Civil Rights' Hotline at 1-800-368-1019. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

CONTACT

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(714) 996-3937(EYES)