

ERDEY SEARCY EYE GROUP PATIENT FORMS & HELP GUIDE

Carefully read and fill out the following forms:

We understand this is a lot of information, but it will help us efficiently, quickly, and safely diagnose your eye care needs. This will also help speed your registration process once you reach our office.

1. **Patient Letter:** Please read.
2. **Patient Information Form:** [All Patients](#)
Please fill in the fields of this form while still on your computer screen (or fill out by hand after first printing it), print the completed form and *bring to your scheduled appointment.*
3. **Assignment of Benefits:** [New Patients ONLY](#)
Please complete, sign, and *bring to your scheduled appointment.*
4. **Health Questionnaire:** [All Patients](#)
Please fill in the fields of this form and sign while still on your computer screen (or fill out by hand after first printing it), then print the completed form and *bring to your scheduled appointment.*
5. **HIPAA Notice of Privacy Practices:** Please read and keep.
6. **Visual Assessment Form:** [Laser Vision Correction / Refractive Surgery Patients ONLY](#)
Please fill in the fields of this form while still on your computer screen (or fill out by hand after first printing it), then print the completed form and *bring to your scheduled appointment.*
7. **Map/Directions:** Your appointment will be scheduled at **ONE** of our several office locations. Please refer to the “locations” section of our website to obtain printable directions to the appropriate office.

If you have any further questions contact our office (614) 863-3937.

Thank You,

ERDEY SEARCY EYE GROUP



RICHARD A. ERDEY, M.D.
Cataract and Corneal Surgery

GREGORY D. SEARCY, M.D.
Comprehensive Ophthalmology

WILBUR C. BLOUNT, M.D. FACS
Consultative Ophthalmology

PATRICK A. JANSON, O.D.
Optometric / Refractive Services

MATTHEW U. NEAL, O.D.
Optometric / Refractive Services

DOUGLAS J. BOSNER, O.D.
Optometric / Refractive Services

JONELLE J. KNAPP, O.D.
Optometric Services

Refractive Surgery

Cosmetic Surgery

Cataract Surgery

Corneal Transplants

Consultative Ophthalmology

Diabetes

Glaucoma

General Eye Exams

Strabismus

Mount Carmel East Hospital
5965 East Broad Street, Suite 490
Columbus, Ohio 43213
Voice: **614.863.EYES (3937)**
Fax: 614.863.5010

50 McNaughten Road, Suite 100
Columbus, Ohio 43213

The Offices at Erinwood
1949 Newark-Granville Road
Granville, Ohio 43023
Voice: **740.587.4841**
Fax: 740.587.3589

e-mail: bestvision@icanseeclearly.com
www.icanseeclearly.com

Affiliated with:
EAST COLUMBUS SURGERY CENTER
www.ecsc.md

Dear Patient,

WELCOME! We appreciate your selection of our office for your eye care needs.

Examination

Your visit will take approximately 1.5 hours. **Dilation** of your eyes will probably be required for the examination. Since dilation can take a few hours to wear off, it is best that you not plan on driving immediately after the appointment. **Sunglasses** will be provided to you before you leave the office, or you may use your own. Depending on the light sensitivity of your eyes, you may be more comfortable having a friend or family member drive you home from your appointment.

Forms

Several forms follow this letter. Fill in the PATIENT INFORMATION FORM & ASSIGNMENT OF BENEFITS form. If you are a NEW patient you also need to complete the HEALTH QUESTIONNAIRE form. If you are new Laser Vision Correction or Refractive Surgery patient, you must also fill out the VISUAL ASSESSMENT FORM. Please thoroughly complete these forms at home, and bring them with you to your appointment. Filling these out in advance will save you significant time at your appointment.

Medications, Eyeglasses, and Contact Lenses

Please also bring with you a **list of your current medications** (including eye drops), and your **eyeglasses**. If you wear **contact lenses**, please bring the foil wrapper (disposable contacts) or the bottle with the printed label containing the prescription.

Insurance Cards

Be sure you have all of your insurance cards with you when you come to the office. Additionally, if your insurance company requires claims to be submitted on its own forms please bring that form with you to your appointment. We will bill your medical insurance for you.

Payment

Applicable co-payments and deductibles will be collected from you for all insurance plans with which we participate. **Payment is required at the time of the office visit for any co-payments or non-covered insurance services – SUCH AS REFRACTIONS** - and may be made in cash, by check or credit card (Visa, MasterCard, Discover, and American Express).

Referrals

Some insurance companies require **referrals** from your primary care physician. Please check with your insurance carrier - **if a referral is needed, it must be obtained by you, the patient, before your appointment.**

If you have any **questions**, please call us at 614.863.EYES (3937) and ask to speak with a Patient Care Coordinator. Feel free to visit our web site at **icanseeclearly.com** or to email us at **bestvision@icanseeclearly.com**.

We look forward to your visit with us!

Sincerely,

ERDEY SEARCY EYE GROUP

ERDEY SEARCY EYE GROUP PATIENT INFORMATION FORM

Answer ALL of the following to assist us in processing your account accurately. Please PRINT. Thank you.

PATIENT INFORMATION

Last Name:		First Name:	
Middle Initial:	<input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms. <input type="checkbox"/> Dr.
Address:			
City, State, Zip:			
Telephone Numbers:	<input type="checkbox"/> Home ()		
Please Place Check (X) Beside Preferred Daytime Number	<input type="checkbox"/> Work ()		
	<input type="checkbox"/> Mobile ()		
E-Mail Address:			
Soc. Sec. #:			
Birth Date:		Age:	
Gender: <input type="checkbox"/> F <input type="checkbox"/> M	Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D		
Employer:		Occupation:	
Emp Address:			
Emp City, State, Zip:			
Spouse's Name:			
Sp's Employer:			
Sp's Work Telephone: ()			
Family Physician:			
Telephone: ()			

PERSON RESPONSIBLE FOR BILL

Complete if someone other than the patient is responsible for the bill.

Last Name:		First Name:	
Middle Initial:	<input type="checkbox"/> Mr.	<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms. <input type="checkbox"/> Dr.
Address:			
City, State, Zip:			
Telephone Numbers:	<input type="checkbox"/> Home ()		
Please Place Check (X) Beside Preferred Daytime Number	<input type="checkbox"/> Work ()		
	<input type="checkbox"/> Mobile ()		
E-Mail Address:			
Soc. Sec. #:			
Birth Date:		Age:	
Gender: <input type="checkbox"/> F <input type="checkbox"/> M	Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D		
Employer:		Occupation:	
Emp Address:			
Emp City, State, Zip:			
Relationship to Patient:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child
	<input type="checkbox"/> Other:		

Has anyone in your family been seen here before: YES NO

Name of family member:

IN CASE OF EMERGENCY NOTIFY (other than spouse):

Name:	
Relationship:	
Telephone Numbers:	<input type="checkbox"/> Home ()
Please Place Check (X) Beside Preferred Daytime Number	<input type="checkbox"/> Work ()
	<input type="checkbox"/> Mobile ()

HOW DID YOU HEAR ABOUT OUR OFFICE?

Physician:	Optometrist:
Relative/Friend:	Church Bulletin:
Yellow Pages:	Other:
Internet [search engine/key word(s) used]:	

PRIMARY INSURANCE INFORMATION

Plan Name:	
Copay? <input type="checkbox"/> YES <input type="checkbox"/> NO	Amount: \$
POLICY HOLDER'S NAME:	
Relationship to Pt: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Policy Holder's SS#:	
Policy Holder's DOB:	
Policy Holder's Address:	
City, State, Zip:	
Home Telephone: ()	
Work Telephone: ()	
Employer:	
Emp Address:	
Emp City, State, Zip:	
Gender: <input type="checkbox"/> F <input type="checkbox"/> M Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D	

SECONDARY INSURANCE INFORMATION

Plan Name:	
Copay? <input type="checkbox"/> YES <input type="checkbox"/> NO	Amount: \$
POLICY HOLDER'S NAME:	
Relationship to Pt: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
Policy Holder's SS#:	
Policy Holder's DOB:	
Policy Holder's Address:	
City, State, Zip:	
Home Telephone: ()	
Work Telephone: ()	
Employer:	
Emp Address:	
Emp City, State, Zip:	
Gender: <input type="checkbox"/> F <input type="checkbox"/> M Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D	

ERDEY SEARCY EYE GROUP
ASSIGNMENT OF BENEFITS / FINANCIAL POLICY / RELEASE OF INFORMATION FORM

<p>All Patients, Read and sign this section →</p>	<p>FINANCIAL POLICY: By signing below I indicate that I understand that all patients must complete the Erdey Eye Group Patient Registration & Medical History forms before seeing the doctor. Payment of my bill is considered a part of my treatment. If I have insurance, I need to bring my insurance card(s) with me to every visit and update us if there are demographic changes. ERDEY SEARCY EYE GROUP will send my claim to my insurance company. A statement will be sent to me for any balance covered and not paid by insurance. Co-pays and deductibles are due at the time of service. Insurance referrals are my responsibility and need to be obtained <i>prior</i> to my visit. If I do not have insurance coverage, payment in full is expected at the time of service. Ultimately, I am responsible for payment of my bill.</p> <p>_____</p> <p style="display: flex; justify-content: space-between;"> Signature of Patient Date of Signature </p> <p>_____</p> <p style="text-align: center;">Printed Name of Patient</p>
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<p>If you have MEDICARE, Read and sign this section →</p>	<p>I request that payment of authorized MEDICARE benefits be made on my behalf to ERDEY SEARCY, M.D., Inc. for any services furnished to me by The ERDEY SEARCY EYE GROUP. I further authorize any holder of medical information about me to release to the HEALTH CARE FINANCING ADMINISTRATION and its agents any information needed to determine these benefits or the benefits payable for related services.</p> <p>_____</p> <p style="display: flex; justify-content: space-between;"> Signature of Patient Date of Signature </p> <p>_____</p> <p style="text-align: center;">Printed Name of Patient</p>
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<p>If you have INSURANCE OTHER THAN MEDICARE (including SUPPLEMENTAL, MEDICAP and SECONDARY INSURANCE) read and sign this section →</p>	<p>I request that payment from _____ Insurance <small style="margin-left: 100px;">Name of Insurance Carrier(s)</small> Company be made on my behalf to ERDEY SEARCY MD., Inc. for any services furnished to me by The ERDEY SEARCY EYE GROUP. I further authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.</p> <p>_____</p> <p style="display: flex; justify-content: space-between;"> Signature of Patient Date of Signature </p> <p>_____</p> <p style="text-align: center;">Printed Name of Patient</p>
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<p>All Patients Read and sign ONE of the two areas to the right</p>	<p>I authorize ERDEY SEARCY, M.D., Inc. to use my photograph and/or written testimonial in ERDEY SEARCY EYE GROUP educational/informational materials, including, but not limited to: video, slides, web page, office/patient presentations, brochures, public seminars and teaching sessions.</p> <p>_____</p> <p style="display: flex; justify-content: space-between;"> Signature of Patient Date of Signature </p> <p>_____</p> <p style="text-align: center;">Printed Name of Patient</p>
	<p>I do not authorize ERDEY SEARCY, M.D., Inc. to use my photograph and/or written testimonial in ERDEY SEARCY EYE GROUP educational/informational materials, including, but not limited to: video, slides, web page, office/patient presentations, brochures, public seminars and teaching sessions.</p> <p>_____</p> <p style="display: flex; justify-content: space-between;"> Signature of Patient Date of Signature </p> <p>_____</p> <p style="text-align: center;">Printed Name of Patient</p>

ERDEY SEARCY EYE GROUP HEALTH QUESTIONNAIRE

Yes	No	General Health Information	Yes	No	Eye Information
		Have you ever been diagnosed with:	Do you have a history of:		
<input type="checkbox"/>	<input type="checkbox"/>	Acne Rosacea	<input type="checkbox"/>	<input type="checkbox"/>	Blurry vision
<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Burning
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (Rheumatoid)	<input type="checkbox"/>	<input type="checkbox"/>	Cataract
<input type="checkbox"/>	<input type="checkbox"/>	Asthma / Chronic Bronchitis / Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Color vision loss
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	Distorted or fluctuating Vision
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Double vision
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Dry eyes
<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Excessive tearing
<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Eye injuries
<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Eyelid swelling
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure (Hypertension)	<input type="checkbox"/>	<input type="checkbox"/>	Eyelid drooping
<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	Flashes of lights
<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Floaters
<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Foreign body sensation
<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease (Herpes, Syphilis)	<input type="checkbox"/>	<input type="checkbox"/>	Glare / Halos around lights at night
<input type="checkbox"/>	<input type="checkbox"/>	Sinus disorders	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Skin disorders	<input type="checkbox"/>	<input type="checkbox"/>	Infection
<input type="checkbox"/>	<input type="checkbox"/>	Stroke / TIA's	<input type="checkbox"/>	<input type="checkbox"/>	Lazy eye / Amblyopia / Eye(s) patched as a child
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>	Light sensitivity
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Loss of central vision
<input type="checkbox"/>	<input type="checkbox"/>	Have you had a blood transfusion ?	<input type="checkbox"/>	<input type="checkbox"/>	Loss of side (peripheral) vision
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant ?	<input type="checkbox"/>	<input type="checkbox"/>	Macular degeneration
<input type="checkbox"/>	<input type="checkbox"/>	Do you drive ?	<input type="checkbox"/>	<input type="checkbox"/>	Mucous discharge
<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke ? # packs/day: # years:	<input type="checkbox"/>	<input type="checkbox"/>	Red eyes
<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol ? # glasses/day:	<input type="checkbox"/>	<input type="checkbox"/>	Other:

Exam	Main reason for today's eye exam:
	Date of your last eye exam : Eye Doctor's name:

Glasses	Eyeglasses: Yes <input type="checkbox"/> No <input type="checkbox"/>	How old are they?
	Where did you buy them?	Percentage of day wearing glasses?
	What activities require their use?	
	Do you wear glasses for reading (near) vision only? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Contacts	History of Contact Lens use? Yes <input type="checkbox"/> No <input type="checkbox"/>	Soft <input type="checkbox"/> Toric <input type="checkbox"/> Hard <input type="checkbox"/> Cleaning solutions:
	Brand: _____ Prescription Rt Eye: _____ Lt Eye: _____	
	Eye Doctor who last fit them: _____ Date of exam: _____	
	How many day(s) per week are they worn? _____ Total years worn: _____ Last time worn: _____	
	Do / did you sleep in them? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, how many nights per week: _____
	Monovision contacts? Yes <input type="checkbox"/> No <input type="checkbox"/>	Distance eye: Right <input type="checkbox"/> Left <input type="checkbox"/> Near eye: Right <input type="checkbox"/> Left <input type="checkbox"/>
	Bifocal contacts? Yes <input type="checkbox"/> No <input type="checkbox"/>	Have you discontinued contacts? Yes <input type="checkbox"/> No <input type="checkbox"/>
	If contacts discontinued, why? _____	

Laser Vision Correction (LVC)	LVC and other Refractive Procedures can reduce or eliminate your dependence on glasses and contacts.
	Would you like to discuss laser vision correction with a member of our staff today? Yes <input type="checkbox"/> No <input type="checkbox"/>

Medication	Eye Medication:
	List (or attach separate page) all Other Medication:

Surgery	Eye Surgery: (list date, type, eye, surgeon):
	List all Other Surgery:

Allergies	Allergic to any Medication? Yes <input type="checkbox"/> No <input type="checkbox"/>
	If so, list medication: _____

Family History	Blindness Yes <input type="checkbox"/> No <input type="checkbox"/>	Macular Degeneration Yes <input type="checkbox"/> No <input type="checkbox"/>
	Cataract Yes <input type="checkbox"/> No <input type="checkbox"/>	Retinal Detachment Yes <input type="checkbox"/> No <input type="checkbox"/>
	Diabetes Yes <input type="checkbox"/> No <input type="checkbox"/>	Eye(s) Turning In or Out Yes <input type="checkbox"/> No <input type="checkbox"/>
	Glaucoma Yes <input type="checkbox"/> No <input type="checkbox"/>	Amblyopia (Lazy Eye) Yes <input type="checkbox"/> No <input type="checkbox"/>
	Eye Tumors Yes <input type="checkbox"/> No <input type="checkbox"/>	Other Medical/Eye Problem(s): _____

Patient Name	Printed: _____	Tech Signature / Date: _____
	Signature: _____	Doctor Signature / Date: _____

ERDEY SEARCY EYE GROUP**Notice of Privacy Practices for Protected Health Information****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 office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information ("PHI") is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services. This notice describes our responsibilities in keeping your PHI private and confidential. This notice also describes your rights in relation to your PHI.

Examples of uses of your health information for treatment purposes are:

- A staff member obtains treatment information about you and records it in a health record.
- During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input. Also, this specialist may need such information so that he/she may directly provide you with treatment.

Example of use of your health information for payment purposes:

- We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the care given and possibly to obtain approval in advance for treatment we would like to provide to you.

Example of use of your information for Health Care Operations:

- We obtain services from our insurers and other third parties, some being business associates with whom we have contracted which may include services such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical/client review, transcription, billing, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the doctor's office. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request on our form to our office – we are not required to grant the request but we will comply with any request granted;
- Obtain a paper copy at any time of this Notice of Privacy Practices for PHI ("Notice") by making a request at our office. This is true even if you have previously received this Notice electronically;
- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request in writing to our office using the form we provide to you upon request. We are not obligated to agree to all requests; if we don't, we will tell you why. You may be charged for such a copy if we agree to your request.
- Appeal a denial of access to your PHI except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office using the form we provide to you upon request. (The physician or other health care provider is not required to make such amendments);
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your PHI;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. An accounting will not include internal uses of information for treatment, payment, or health care operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we give you upon request; and,

If you want to exercise any of the above rights, please contact Pamela J. Andrews in person or in writing, during normal hours. She will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities**The office is required to:**

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the PHI we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information or want to report a problem regarding the handling of your information, you may contact our Practice Administrator at (614) 863-3937.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to ERDEY SEARCY EYE GROUP, 5965 East Broad Street, Columbus, Ohio 43213, Attention: Privacy Officer. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address is 1200 Independence Avenue, S.W., Washington, D.C. 20201.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses

Appointments and Reminders

- We may use and disclose your PHI to contact you to remind you that you have an appointment with us.

Notification

- Unless you object, we may use or disclose your PHI to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death. We may further disclose, using our best judgment to a family member, other relative, close personal friend, or any other person you identify, to whom health information may be relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency situation.

Research

- We may disclose information to researchers other than us when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Disaster Relief

- We may use and disclose your PHI to assist in disaster relief efforts.
- We may disclose your PHI to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.

Organ Procurement Organizations

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

Marketing and Fund Raising

- We may contact you to provide you with appointment reminders, with information about treatment alternatives, information about other health-related benefits and services that may be of interest to you, or as part of a fund raising effort.

Food and Drug Administration (FDA)

- We may disclose to the FDA your PHI relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

- If you are seeking compensation through Workers Compensation, we may disclose your PHI to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

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

Abuse & Neglect

- We may disclose your PHI to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions

- If you are an inmate of a correctional institution, we may disclose to the institution or its agents the PHI necessary for your health and the health and safety of other individuals.

Law Enforcement

- We may disclose your PHI for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight

- Federal law allows us to release your PHI to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

- We may disclose your PHI in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.
- To avert a serious threat to health or safety, we may disclose your PHI consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Government Functions

- We may disclose your PHI for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Other Uses

- All other uses and disclosures must be made pursuant to your written authorization. You may revoke authorizations by delivering a written revocation notice to your office.

Website

- If we maintain a website that provides information about our entity, this Notice will be on the website.

VISUAL ASSESSMENT FORM

(Laser Vision Correction and Refractive Surgery Patients ONLY: Please Complete)

Name _____

Telephone - Home _____

Telephone - Work _____

E-mail Address _____

Does your occupation have minimum requirements for vision correction without corrective lenses? (i.e. Police, Fire, Paramedic, Pilot, Armed Services, etc.) Yes No

Why are you interested in Laser Vision Surgery? _____

How long have you been thinking about having surgery? _____

Why have you not had it done? _____

Have you previously attended any refractive surgery seminars or consultation visits? Yes No

Contact Lenses

Do you currently wear, or have you worn contact lenses? Yes No

Have you experienced any problems wearing contact lenses? Yes No

If yes, explain:

Spectacles

Have you experienced any problems wearing your eyeglasses? Yes No

If yes, explain:

Activity Restrictions

Are there any activities you have not been able to participate in because of your vision? Yes No

If yes, explain:

Your Expectations / Goals Of Refractive Surgery

What are the most important things you expect to gain from refractive eye surgery?

- | | |
|---|--|
| <input type="checkbox"/> Appearance | <input type="checkbox"/> Improved peripheral vision |
| <input type="checkbox"/> Freedom from the hassle | <input type="checkbox"/> Safety |
| <input type="checkbox"/> Meet occupational requirements | <input type="checkbox"/> Sports/Extracurricular Activities |