LARAMIE VISION CLINIC

NAME (Last, First, M.) _____, _____ ____ Birthdate ___/___/_____ Age ___

WHAT IS THE REASON FOR YOUR VISIT TODAY _____

DO YOU WANT NEW GLASSES? ____

Name of Nearest Relative Not Living With You _____ Telephone (____)_____-_____

How were you referred: Another Physician ☐ TV☐ Radio☐ Newspaper☐ Other _____

Have there been any changes to the health of you or your family since your last eye exam (explain)

_____

Language _____ Race _____ Mother's Maiden Name _____

Birth State _____ Birth Country _____ E Mail _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT
(Must be age 18 or older)

Name (Last, First, M) _____, _____ ____

Address _____ City _____ State ___ Zip _____ Years There? ____

Telephone: Home (____)_____-_____ Cell (____)_____-_____

Social Security Number: _____ Driver Lic. No. _____ Patient SS# _____

Previous Address _____ City _____ State _____ Zip _____

Employer _____ Years There ___ Telephone (___)____-_____ Position _____

Employers Address _____ City _____ State ___ Zip _____

Spouse Name _____ Spouse Employment _____

Payment Method (check one of the following) ☐Cash ☐Check ☐Credit Card

I, the undersigned patient/guardian, agree to pay for all services rendered and/or goods sold to me or my ward immediately upon demand by Cheyenne Vision Clinic "clinic". I further agree that in the event of non-payment to the clinic of any amounts due under this agreement, I will pay interest and late fees thereon at the rate of 1.75% per month, and $20.00 late payment fees for each billing cycle (monthly), and all of the Clinic's legal fees and court costs that may be incurred. I agree that in the event that this agreement is assigned to Rocky Mountain Recovery (a collection agency) for collection, I promise to pay a collection fee of 35% of the unpaid balance which is in addition to the unpaid balance due under this agreement.

Signed _____ **Date**_____

Please know that by filling in the form above you are agreeing that you have read the above information and for all intents and purposes, in the court of law especially, you have signed this agreement.

LARAMIE VISION CLINIC

Your Insurance Information

Name of Insurance Company_____

Name of Insured _____

Patient's relationship to the Insured _____ Insured Telephone Number _____

Insured's Social Security Number _____ Group/ Policy Number _____

Insured's Date of Birth _____

CHEYENNE VISION CLINIC, P.C. INSURANCE POLICY

As a courtesy to you, our clinic will submit claims to your insurance company for you. However, we cannot accept liability for collecting your claim because the policy is a contract between you and your insurance company.

I agree to furnish the appropriate insurance information to the Cheyenne Vision Clinic, P.C. so that they may submit charges to my insurance company. If I do not have this information I understand that I am responsible for the charges in full on the date of service.

I hereby authorize benefits, which I am entitled, to be paid to the Cheyenne Vision Clinic, P.C. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges not paid by my insurance. Any portion of the claim not covered within 30 days will be my responsibility. I understand that after 30 days Cheyenne Vision Clinic, P.C. will continue to help collect my benefits from my insurance company.

ALL COPAYMENTS AND OVERAGES ARE DUE AT THE TIME OF SERVICE

I have read and understand the above insurance policy. I hereby authorize Cheyenne Vision Clinic, P.C. to release any information acquired in the course of my care for insurance purposes.

Signed: _____ **Date:** _____

Please know that by filling in the form above you are agreeing that you have read the above information and for all intents and purposes, in the court of law especially, you have signed this agreement.

THANK YOU FOR ALLOWING US TO DELIVER YOUR EYECARE

FROM EYE GLASSES AND CONTACT LENSES TO MEDICINE AND EYE INJURIES

WE HAVE ANSWERS TO YOUR VISION NEEDS FOR A LIFETIME

LARAMIE VISION CLINIC

Name (Last, First, M) _____ **Today's Date** _____

ARE YOU INTERESTED IN ANY OF THE FOLLOWING?

☐ CONTACT LENSES
☐ GLASSES
☐ LASER (LASIK) SURGERY
☐ DRY EYE TREATMENT

Other _____

Do you wear glasses? _____ How old are they? _____

Do you wear contact lenses? _____ How old are they? _____

Brand/ Type of Contact Lenses? _____ Are they comfortable? ___ Type of Solution? _____

Date of Last Eye Exam _____ Previous Eye Doctor _____

Date of Last Medical (Physical) Exam _____ Medical Doctor _____

List all **major injuries**, surgeries (including eye), and/or **hospitalizations** (including general anesthesia) you have experienced:

_____

_____

LIST ANY MEDICATION (S) you take (including oral contraceptives, aspirin, OTC medications and home remedies):

_____ _____

_____ _____

_____ _____

MEDICATION ALLERGIES _____

Are you pregnant or nursing? _____ Have you recently had a baby? _____ Delivery date? _____

Social History (this can be discussed directly and confidentially with your Doctor during the examination)

Do you use tobacco products☐, drink alcohol☐, or use illegal drugs ☐

Explain: _____

Have you ever been exposed to or infected with gonorrhea, hepatitis, HIV, or syphilis _____

Do you drive? _____ Do you have visual difficulty when driving? ____ Difficulty especially at night? ____

Do you have trouble seeing to read ☐, watching television ☐, walking ☐, other: _____?

Do you feel safe at home? ____ Please explain? _____

Family History (parents, grandparents, siblings, children; living or deceased) for the following:

(check those that apply and leave those that do not apply blank)

Disease/Condition		Relationship to you	Disease/Condition		Relationship to you
Blindness	☐	_____	Cancer	☐	_____
Cataract	☐	_____	Diabetes	☐	_____
Crossed Eye /Lazy Eye	☐	_____	Heart Disease	☐	_____
Glaucoma	☐	_____	High Blood Pressure	☐	_____
Macular Degeneration	☐	_____	Kidney Disease	☐	_____
Retinal Detachment	☐	_____	Lupus	☐	_____
Retinal Disease	☐	_____	Thyroid Disease	☐	_____
Arthritis	☐	_____	Other:		_____

Review of Systems

Have you ever had problems with any of the following areas of your body?:

(check those that apply and leave those that do not apply blank)

ALLERGY/IMMUNOLOGIC ☐
CARDIOVASCULAR ☐
Heart Disease/Pain ☐
High Blood Pressure ☐
Stroke ☐
Vascular Disease ☐
CONSTITUTIONAL
Fever, Weight Loss/Gain ☐
EARS, NOSE, MOUTH,THROAT
Allergies/Hayfever ☐
Sinus Congestion ☐
Runny Nose/Post-Nasal Drip ☐
Chronic Cough ☐
Dry Throat/Mouth ☐
Chronic Throat Infections ☐
ENDOCRINE
Thyroid/Other Glands ☐
Hormone Replacement Therapy ☐
Diabetes ☐
EYES
Seeing at night ☐
Loss of Vision/Side Vision ☐
Blurred Vision ☐
Halos/Distorted Vision ☐
Computer Use (how much?) ☐ _____
Double Vision ☐
Flashes/Spots ☐
Lazy Eye ☐
Dryness ☐
Eye Injury ☐
Redness ☐
Sandy/Gritty Feeling ☐
Itching ☐
Burning ☐
Foreign Body Feeling ☐
Glare/Light Sensitive ☐
Eye Pain/Soreness ☐
Chronic Eye/lid Infections ☐
Styes or Chalazion ☐
Tired Eyes ☐
Mucus Discharge ☐

GASTROINTESTIONAL
Diarrhea ☐
Constipation ☐
GENITOURINARY
Genitals/Kidney/Bladder ☐
HEMATOLOGIC/LYMPH ☐
Anemia ☐
Blood Disorders ☐
INTEGUMENTARY (SKIN) ☐
MUSCLE/JOINT/BONES ☐
Rheumatoid Arthritis ☐
Muscle /Joint Pain ☐
NEUROLOGICAL
Headaches ☐
Migraines ☐
Head Trauma ☐
Seizures ☐
PSYCHIATRIC ☐
RESPIRATORY
Asthma ☐
Chronic Bronchitis ☐
Emphysema ☐
OTHER ☐

If you selected any of the above or have a condition not listed, please explain and list any medications related to that condition:

_____

_____

WELCOME TO THE CLINIC AND THANK YOU FOR CHOOSING US FOR YOUR EYECARE
DR. CARROLL DR. LAHIFF DR. WELLS DR. HOWELL DR. ALBERS
LARAMIE VISION CLINIC, P.C.
408 SOUTH 2ND STREET / LARAMIE WY 82070
307-721-3937

Effective date of notice: April 14, 2003
Revised: 08/2011

NOTICE OF PRIVACY PRACTICES

Laramie Vision Clinic

Mark T. Wells, O.D./Martin H. Carroll, O.D./Josh M. Lahiff, O.D./Garrett Howell, O.D/Jessica Albers, O.D.
408 South 2nd Street / Laramie, Wy 82070
307-721- 3937
Contact: Dr. Mark T. Wells

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.

We respect our legal obligation to keep your health information private. We are obligated by law to give to you a notice of our privacy practices. This notice describes how we protect our health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you, testing or examining your eyes, prescribing glasses, contact lenses, or eye medications and faxing them to be filled, showing you low vision aids, referring you to another doctor or clinic for eye care, low vision aids and/or services, or getting copies of your health information from another professional that you may have seen previously. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment, preparing and sending bills or claims, and collecting unpaid amounts (either ourselves or through a collection agency and/or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits, internal quality assurance, personal decisions, participation in managed care plans, defense of legal matters, business planning, and storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose.
- For public health purposes such as: contagious disease reporting, investigation or surveillance, and notices to and from the Federal Food and Drug Administration regarding drugs or medical devices.
- Disclosures to government authorities about victims of suspected abuse, neglect or domestic violence.
- Uses and disclosures for health oversight activities such as for the licensing of doctors, for audits by Medicare or Medicaid, or for investigation of possible violations of health care laws.
- Disclosures of judicial and administrative proceedings such as in response to subpoenas or orders of courts or administrative agencies.
- Disclosures for law enforcement purposes such as to provide information about someone who is suspected to be a victim of a crime, to provide information about a crime at our office, or to report a crime that happened somewhere else.
- Disclosure to a medical examiner to identify a dead person, to determine the cause of death, to funeral directors to aid in burial, or to organizations that handle organ or tissue donations.
- Uses or disclosure for health related research.
- Uses and disclosures to prevent a serious threat to health or safety.
- Uses or disclosures for specialized government functions such as for the prevention of the president or high ranking government officials, for lawful national intelligence activities, for military purposes, or for the evaluation and health of members of the Foreign Service.
- Disclosures of de-identified information.
- Disclosures relating to worker's compensation programs.
- Disclosures of a "limited data set" for research, public health, or health care operations.
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures.
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.
- Any state laws that may affect us.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home or any number(s) that you give us to contact you.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed "authorization form", or you can use one of ours.

If we initiate the process and ask you to sign an "authorization form", you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless you have already have acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

1. Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restriction that you want. To ask for a restriction, send a written request to the office contact person at the address or fax at the beginning of this Notice.
2. Ask to communicate with you in a confidential way, such as by calling you at work rather than at home, by mailing health information to a different address, or by using Email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.
3. Ask to see or to get photo copies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information with in 30 days of asking us (or 60 days if the information is stored off-site). You may have to pay for photo copies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 extension of the time for us to give you access of photo copies if we send you a written notice of the extension. If you want to review or get photo copies of your health information, send a written request to the office contact person at the address of fax shown at the beginning of this notice.
4. Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days form when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment to the office contact person at the address shown at the beginning of this notice.
5. Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you request). By law, the list will not include: disclosures of purposes of treatment, payment or health care operations, disclosures with your authorizations, incidental disclosures, disclosures required by law, and some lists. You will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address or fax shown at the beginning of this notice.
6. Get the additional paper copies of this Notice of Privacy Practices upon request. It does not matter weather you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at he address or fax shown at the beginning of this notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies in our office, and post it on our web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address or fax shown at the beginning of this notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call of visit the office contact person at the address or phone number shown at the beginning of this notice.

PLEASE COMPLETE THE FOLLOWING

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of The Laramie Vision Clinic's Notice of Privacy Practices.

Patient Name:_____

Signature:_____ **Date:**_____

Please know that by filling in the form above you are agreeing that you have read the above information and for all intents and purposes, in the court of law especially, you have signed this agreement.