SANTA CLARITA VISION CENTER

# Digital Retinal Photography and Laser Scan

Evidence shows that retinal photography and laser scans are vital for the detection and treatment of conditions not detected by routine examination. Recent advancements in eye care now aid doctors in detecting and preventing many conditions that lead to permanent vision loss or blindness. These conditions include glaucoma, macular degeneration and diabetic retinopathy. The two-part screening consists of a high-resolution digital photo and laser scan of the back of the eye. This imaging is now recommended for all patients once a year. Our doctors agree these tests are an essential part of a comprehensive and detailed exam. The test is safe, painless, and only takes a few minutes to complete. This screening is elective and only covered by insurance if you have certain medical eye conditions. We offer this scan for $35.

___ Yes, I would like the screening today.

___ Unsure, I would like more information.

___ No, I decline these tests today.

_____ _____

Signature Date

26506 Bouquet Canyon Road, Saugus, CA 91350
Ph: 661.297.2020 Fx: 661.297.3380
www.santaclaritavisioncenter.com

# PATIENT INFORMATION and VISION / HEALTH HISTORY

***It is now a state law that we receive a medical and visual history from all patients as a part of your eye examination. Thank you for your co-operation.*** **(Please print or place a ✓ in the boxes or blanks.)**

E-mail Address:_____ Birth Date:_____ Today's Date: _____

Patient Last Name: Mr. Mrs. Ms._____ First Name:_____ M.I.:____ Age:____

Home Address:_____

City:_____ State:____ Zip:_____ Home Phone: Cell#

If patient is a minor... Responsible party:_____

Address if different from above:_____

Drivers License Number:_____ Social Security Number:_____

Patient Employed By:_____ Located In City Of:_____

Occupation:_____ Work Phone:_____

Patient Referred By:_____

Do you have Optical Insurance? Yes_____ No_____ Optical Insurance Carrier Name _____

Do You have Medi-Cal? Yes_____ No _____ Medical Insurance Carrier Name_____

**********

**Medical and Visual History:** General Health: _____Excellent _____Good _____Fair _____Poor

**Any personal or family history of:**

| Visual | You ✓ | Family Menber (who?) |
|---|---|---|
| Glaucoma | | |
| Cataracts | | |
| Crossed Eye(s) | | |
| Retina Problems | | |
| High Eyeglass Prescriptions | | |

| General | You ✓ | Family Member (who?) |
|---|---|---|
| Allergies | | |
| Diabetes | | |
| Arthritis | | |
| Thyroid Problems | | |
| High Blood Pressure | | |

Do you personally have: _____Pain in or around eyes _____Nervous tension _____Hormonal problems ____Asthma

Last complete eye exam?_____ Do you wear eyeglasses? Yes_____ No_____ How old are the glasses?_____ years.

Do you now or have you ever worn contact lenses? Yes_____ No_____ Hard? _____ Soft? _____

Do you have an interest in trying contact lenses? Yes_____ No_____ Are you active in any sport? Yes_____ No_____

| Do you ever experience: ✓ | With Glasses | Without Glasses |
|---|---|---|
| Blur at near | | |
| Blur at far | | |
| Print running together | | |
| Headaches | | |
| Night driving problems | | |
| Eyestrain (Tired Eyes) | | |

| Do Your Eyes: ✓ | With Glasses | Without Glasses |
|---|---|---|
| Itch | | |
| Burn | | |
| Tear | | |
| Ache | | |
| Blur in & out | | |
| Get red | | |

**IF YOU USE A COMPUTER....**
please provide the following information

How Often? _____ Hours per day
Type of work? _____Word processing
_____Numbers _____ Drawing
_____Data Entry _____Other
Monitor screen color? _____
Does it bother your eyes? _____

Does bright light bother your eyes? Yes_____ No_____ Do you wear sunglasses? Yes_____ No_____

If you get headaches: Location? Front___ Back___ Sides___ Top___ How often? ___ time(s) each day week month (circle one)

Ever had eye surgery? Yes_____ No_____ For _____ When_____

Ever had an eye injury? Yes_____ No_____ Nature _____ When_____

Do you have a job or a hobby that involves a need for clear vision at a definite distance? Yes_____ No_____

Have you had any surgery involving a general anesthesia in the past year? Yes_____ No_____

| List of medication now taken | How often? | How long? | For what? |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

# NOTICE OF PRIVACY PRACTICE

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 12/12/02 UNTIL FURTHER NOTICE.

**Right to Notice**

As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPAA). The Santa Clarita Vision Center can use your protected health information for treatment, payment and health care operations.

a) Treatment - We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

b) Payment - We may use and disclose your health information to obtain payment for services we provide you.

c) Health care operations - We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization**

Most uses and disclosures that do not fall under treatment, payment, health care operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

**Emergency Situations**

In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your healthcare.

**Marketing**

We will not use your health information for marketing communications without your written authorization.

**Required by Law**

We may also use or disclose your health information when we are required to do so by law.

**Abuse or Neglect**

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health or safety.

**National Security**

We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

**Appointment Reminders**

We may use or disclose your health information to provide you with appointment reminders via phone, e-mail or letter.

**Your Rights as a Patient**

You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or health care operations.

-You have the right to receive confidential communications regarding your protected health information.

-You have the right to inspect and copy your protected health information.

-You have the right to amend your protected health information.

-You have the right to receive an account of disclosures of your protected health information.

-You have the right to a paper copy of this notice of privacy practices.

**Legal Requirements**

The Santa Clarita Vision Center is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are posted or are available within our office.

**Complaints**

If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint.

**Contact Information**

For further information about Santa Clarita Vision Center's privacy policies, please contact

Santa Clarita Vision Center 26506 Bouquet Canyon Road Saugus, CA 91350 (661) 297-2020

Dr. Leonard Forbes, Optometrist

I understand that the above refers to my rights under the Health Insurance Portability and Accessibility Act (HIPAA). I may ask for a copy of this.

Patient Signature _____ Date _____

# INSURANCE ASSIGNMENT AND RELEASE

**THE VISION CENTER**
26506 Bouquet Canyon Road
Saugus, CA 91350
(661) 297-2020

I certify that I, and/or my dependent (s), have insurance coverage with _____ and assign
Name of Insurance company (ies)
directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Guardian or Personal Representative Relationship to Patient