

Vision Salon Eye Care Associates
Adult & Pediatric Comprehensive Eye Care

PATIENT REGISTRATION

12812 S. Western Avenue • Blue Island, IL 60406 • Office: (708) 385-0013 • Fax: (708) 385-1175

<input type="checkbox"/> Mr. <input type="checkbox"/> Dr.		Patient's First Name:		Patient's Last Name:		<input type="checkbox"/> Jr	<input type="checkbox"/> M
<input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.						<input type="checkbox"/> Sr	<input type="checkbox"/> F
Street Address:			Apt #	City:		State:	ZIP Code:
Home Phone: () -		Cell Phone: () -		Work Phone: () -		DOB: / /	
Age:		S.S. # - -		Occupation:		Employer:	
Email Address:		<input type="checkbox"/> Single <input type="checkbox"/> Divorced		<input type="checkbox"/> Married <input type="checkbox"/> Widowed			
Parent/Guardian:		<i>(Please complete if patient is child/student)</i>		How were you referred to us? <i>(Please name so we can thank them)</i>		Primary Care Physician <i>(PCP) Info</i>	
Relationship to Patient:		DOB: / /		Parent S.S. # - -		Dr. _____	
Occupation:		Employer:		<input type="checkbox"/> Family/Friend <input type="checkbox"/> Other		Address: _____	
School Name:		School Grade:		<input type="checkbox"/> Referring doctor		_____	
				<input type="checkbox"/> Newspaper <input type="checkbox"/> Radio		Office Phone: () -	
				<input type="checkbox"/> Insurance <input type="checkbox"/> Walk-in		_____	

Insurance Payment Authorization and Billing Policies

(Please list any/all medical and/or vision insurance plans, if applicable)

<input type="checkbox"/> Primary Medical Insurance:	<input type="checkbox"/> Secondary Medical Insurance:	<input type="checkbox"/> Vision Plan:
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- ✓ I authorize my insurance benefits to be paid directly to **VISION SALON EYE CARE ASSOCIATES**.
- ✓ I authorize the use of this form for medical insurance submissions, and release of information with payment made directly to the doctor. Payment, in whole or part, shall be considered the same as if paid, by insurance company, directly to me (the insured). I permit a copy of this to be used in place of the original.
- ✓ I understand that any deductibles and/or co-payments are due at the time of service or immediately upon notification.
- ✓ I understand that I am ultimately responsible for payment in full for services provided by the doctor and the Vision Salon, Ltd. Use of insurance within the guidelines of my medical/ vision policy is permitted.
- ✓ In the event of default, declines, and/or rejections of claims by me or my insurance carrier, I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this debt.
- ✓ **By providing my signature at the bottom of this form, I agree to the aforementioned billing policies and authorization.**

- 1.) I understand that I (we) are responsible for payment in full to **Vision Salon Eye Care Associates** at the time services are rendered, unless prior arrangements are made for any services beyond the Vision Service Plan Voucher.
- 2.) In the event of default, I (we) understand that checks declared with non-sufficient funds will be charged a **\$25.00 service fee**.
- 3.) In the event of default, I (we) understand and agree to pay a collection fee of **25% of the total owed** when sent to collection, all attorney fees, and court costs incurred by the creditor. Once transferred to collection, payment and/or questions are to be paid directed to the collection agency.
- 4.) I acknowledge that I have reviewed the Vision Salon Eye Care Associates **"Notice of Privacy Practices"**, which describes the use and disclosure of my personal medical information in detail as per federal law (HIPAA Privacy Policy).

By my signature, I understand the above, and agree to its guidelines, policies, and to comply with them.

Patient _____
PLEASE PRINT NAME OF PATIENT

Today's Date ____/____/____

Patient /Guardian _____
SIGNATURE

Relationship to Patient _____

NOTICE OF PRIVACY PRACTICES

Effective Date of Notice: 09.10.2010

Vision Salon Eye Care Associates

12812 S. Western Avenue | Blue Island, IL 60406 | (708) 385-0013 | www.visionсалon.com

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 health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your 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 or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. 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 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; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside 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 we will obtain written permission, as needed, in accordance with HIPAA and State Law.

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 governmental 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 for 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 or 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 or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures 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 protection 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 other uses and disclosures affected by state law.

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.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you 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 we have already 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:

- 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 restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E-mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E-mail to your personal E-Mail 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, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies 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 within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies 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 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- 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 from 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, fax or E mail shown at the beginning of this Notice.
- 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 want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent 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, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether 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 the address, fax or E mail 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 available 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, fax or E mail 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 or visit the office contact person at the address or phone number shown at the beginning of this Notice.

THIS INFORMATION IS KEPT STRICTLY CONFIDENTIAL. HOWEVER YOU MAY DISCUSS THIS PORTION DIRECTLY WITH YOUR DOCTOR.

SOCIAL HISTORY

	YES	NO	
Do you drive?	<input type="checkbox"/>	<input type="checkbox"/>	If yes to vision difficulty, please describe:
Do you have visual difficulty when driving?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you use tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, type/amount/how long?
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, type/amount/how long?
Do you use illegal drugs?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, type/amount/how long?
Have you ever been exposed to/ infected with Gonorrhea, Hepatitis, HIV, or Syphilis?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, when? Are you currently being treated for this condition?

REVIEW OF SYSTEMS: EYES -Do you currently, or have you ever had any symptoms/problems in the following areas?

	YES	NO	UNSURE		YES	NO	UNSURE
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/ Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foreign Body Sensations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excess Tearing/ Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glare/ Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain/ Soreness/ Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Infection of Eye/ Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy/ Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Flashes/ Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REVIEW OF SYSTEMS: BODY -Do you currently, or have you ever had any symptoms/problems in the following areas?

	YES	NO	UNSURE		YES	NO	UNSURE		
Allergy	Seasonal / Environmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine	Diabetes Type I	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes Type II	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid Gland Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Cardiovascular	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease / Stroke		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Burn/ Acid Reflux		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Circulation Problems		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Problems		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary	Bladder / Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constitutional	Weight Loss / Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Endometriosis / Ovarian Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Prostate Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hematological	Breast / Lymphatic Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Head	Hearing Impairment / Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>
	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches / Migraines		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sickle Cell Disease / Trait	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunologic	HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal		Joint Pain / Gout	<input type="checkbox"/>	<input type="checkbox"/>
	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Sarcoid / Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin Problems)	Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Arthritis / Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Dry Skin / Rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Psychiatric	Attention Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	Bell's Palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dementia/ Alzheimer's		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory		Asthma / Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
	Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				COPD		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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FAMILY HISTORY -Do you or any family members suffer from any of the following ailments?

	ME	FAMILY	(Who?)		ME	FAMILY	(Who?)
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>		Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes (Type 1/ Type 2)	<input type="checkbox"/>	<input type="checkbox"/>		Hay Fever/ Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>		Cancer (please list type)	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		Blindness/ Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	

LAST EXAMINATIONS	DATE	DOCTOR / FACILITY	ABOUT YOUR EYEWEAR	YES	NO
When was your last physical exam?			Do you currently wear prescription eyewear?	<input type="checkbox"/>	<input type="checkbox"/>
When was your last eye exam?			Do you currently wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had any injury to your eyes? <input type="checkbox"/> YES <input type="checkbox"/> NO			Have you previously worn contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had eye surgery? <input type="checkbox"/> YES <input type="checkbox"/> NO			Do you have a history of Keratoconus or Corneal Transplant?	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE LIST ANY / ALL MEDICATIONS YOU ARE CURRENTLY TAKING	PLEASE LIST ANY FOOD/ MEDICATION ALLERGIES YOU HAVE

By my signature, I attest that the information provided is accurate and true to best of my knowledge.

Patient _____
PLEASE PRINT NAME OF PATIENT

Today's Date ____ / ____ / ____

Patient /Guardian _____
SIGNATURE

Relationship to Patient _____



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