

**Vision Salon Eye Care Associates**  
**Adult & Pediatric Comprehensive Eye Care**

**FORMA DE REGISTRACION**

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

<input type="checkbox"/> Sr. <input type="checkbox"/> Dr.	Nombre:	Apellido:	<input type="checkbox"/> Jr	<input type="checkbox"/> H	
<input type="checkbox"/> Sra. <input type="checkbox"/> Srita.			<input type="checkbox"/> Sr	<input type="checkbox"/> M	
Dirección:		Apt #	Ciudad:	Estado:	Código Postal:
Teléfono de Casa: ( ) -	Celular: ( ) -	Teléfono de Trabajo: ( ) -	Fecha de Nacimiento: / /	Edad:	S.S. # - -
Ocupación:	Empleador:	Correo Electrónico:		<input type="checkbox"/> Soltero	<input type="checkbox"/> Divorciado
Responsable de la cuenta: (Por favor complete si el paciente es menor de edad )			Como fue referido a nuestra oficina? <input type="checkbox"/> Familia/Amigo <input type="checkbox"/> Otro		<b>Médico Primario</b> Dr. _____ Dirección: _____ _____ Teléfono de Oficina: ( ) -
Relación con el Paciente:	Fecha de Nacimiento: / /	S.S.N. # Del Padre - -	<input type="checkbox"/> Nombre del Médico que lo refirió		
Ocupación:	Empleador:	<input type="checkbox"/> Periódico <input type="checkbox"/> Radio			
Nombre de la Escuela:	Grado Escolar:	<input type="checkbox"/> Aseguranza <input type="checkbox"/> Localidad			

**Forma de Autorización para Pago**

*(Porfavor provea la información de todas las aseguranzas)*

<input type="checkbox"/> Aseguranza Médica Primaria:	<input type="checkbox"/> Aseguranza Médica Secundaria:	<input type="checkbox"/> Plan de Visión:
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- ✓ Yo autorizo a mi aseguranza a pagar directamente a **VISION SALON EYE CARE ASSOCIATES**.
- ✓ Yo autorizo el uso de esta forma para propositos de reclamos médicos y para obtener información relacionada con pagos hechos directamente a ésta oficina. Yo permito el uso de ésta copia en lugar de la forma original.
- ✓ Yo entiendo que cualquier deductible y/o copagos seran colectados el día de servicio.
- ✓ Yo entiendo que yo soy responsable de liquidar los servicios proveidos por los médicos y ésta oficina. Yo autorizo el uso de mis aseguranzas con el propósito de obtener pagos.
- ✓ En el dado caso que la aseguranza deniege los servicios, yo me comprometo a pagar la totalidad del costo de los servicios con dichos intereses, costos de colección y/o cuotas de abogados.
- ✓ **Al firmar éste documento entiendo todas las polizas anteriormente mencionadas.**

- 1.) Entiendo que soy responsable por el pago complete a **Vision Salon Eye Care Associates** al momento que los sevicios son rendidos, al menos que un acuerdo anterior se halla hecho.
- 2.) En el evento en que mi cheque se regrese con insuficiente fondos, pagare **\$25.00 por cargos de servicio**.
- 3.) En el evento en que mi cuenta este mandado a colección, estoy de acuerdo en pagar de cargo de colección 25% de la cantidad que fue mandada a colección, costos de abogados y corte. Una vez su cuenta esta transferida a colección, pago y/o preguntas deberían ser dirigidas a la agencia de colección.
- 4.) Al firmar yo reconozco que he recibido una copia de **"La Privacidad de Prácticas Privadas"**, de Vision Salon Eye Care Associates, la cual describe el uso de mi informacion médica personal en detalle de acuerdo a la ley federal (HIPAA Privacy Policy).

**Con mi firma, yo entiendo y concuerdo con las pólizas, y accedo con todo lo previamente escrito.**

Paciente \_\_\_\_\_  
 POR FAVOR ESCRIBIR CON LETRA DE MOLDE

Fecha \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Paciente/ Guardian \_\_\_\_\_  
 FIRMA

Relación al paciente \_\_\_\_\_

## 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.visionsalon.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.

**ESTA INFORMACIÓN ES CONFIDENCIAL SI USTED DESEA PUEDE DEJAR ESTO EN BLANCO Y DISCUTIRLO CON EL MEDICO.**

INFORMACION SOCIAL	SÍ	NO	
¿Maneja?	<input type="checkbox"/>	<input type="checkbox"/>	Si existen dificultades, por favor explicar:
¿Tiene dificultades cuando conduce?	<input type="checkbox"/>	<input type="checkbox"/>	
¿Usa productos de tabaco?	<input type="checkbox"/>	<input type="checkbox"/>	¿Si usa que tipo, cantidad, y por cuanto tiempo?
¿Toma alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	¿Si consume que tipo, cantidad, y por cuanto tiempo?
¿Usa drogas ilegales?	<input type="checkbox"/>	<input type="checkbox"/>	¿Si consume que tipo, cantidad, y por cuanto tiempo?
¿A sido infectado o expuesto a enfermedades como Gonorrea, Hepatitis, Herpes, VIH, o Sífilis?	<input type="checkbox"/>	<input type="checkbox"/>	Si ha sido infectado ¿Está siendo tratado?

REFERENTE A OJOS		-¿Usted presenta problemas o a tenido sintomas relacionadas en ésta area?							
		SI	NO	INSEGURO			SI	NO	INSEGURO
Pérdida de Visión		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Picazón		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visión Borrosa		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ojos Cansados		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visión Distorcionada/ Aureolas		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensaciones de Cuerpo Extraño		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perdida de Vista periférica		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lagrimo Excesivo		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doble Visión		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensitividad a la luces o resplandor		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resequedad		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dolor de Ojo/ Ardor		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lagañas		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Infección Crónica de Ojos/ Párpados		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rojez		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pocilgas (comunmente perrillas)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensación Arenosa		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Destellos/ Flotantes en la Visión		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REFERENTE A SU CUERPO		- ¿Usted presenta problemas o a tenido sintomas relacionadas en ésta area?							
		SI	NO	INSEGURO			SI	NO	INSEGURO
<b>Alérgias</b>	Estacional/ Ambiental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Endocrino</b>	Diabetes Tipo I	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Medicinas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes Tipo II	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Comidas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Tiroide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Cardiovascular</b>	Hipertensión	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Gastrointestinal</b>	Problemas del Riñón	<input type="checkbox"/>	<input type="checkbox"/>
Anfermedad del Corazón		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acides		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problemas Circulatorios		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vesicular Biliar		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colesterol		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Genitourinary</b>	Problemas de la Vejiga	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Peso</b>	Pérdida/Aumento	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Endometriosis / Problemas de Ovarios	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Debilidad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Desorden de la Prostata	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Hematológico</b>	Seno / Linfático	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Cabeza</b>	Problemas del Oido	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Migranas/ Dolores de Cabeza	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Inmunológico</b>	Enfermedad de la célula Animica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Musculoesqueletal</b>	Dolor De Articulaciones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	VIH / SIDA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Hérpes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Debilidad Muscular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sarcoid / Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Artritis / Reumatismo		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Problemas De la Piel</b>	Acné	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Psiquiátrico</b>	Desorden De Atención	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Piel Reseca/	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Demensia/ Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neurológico</b>	Bell's Palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Depresión	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<b>Respiratorio</b>	Asma/Bronquitis	<input type="checkbox"/>	<input type="checkbox"/>
	Ataques Epilepticos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enfisema		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Parkinsons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Problema Pulmonar		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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<b>HISTORIAL FAMILIAR</b> -¿Usted a algún miembro de su familia padece de lo siguiente?						
	YO	FAMILIAR	(Quién?)	YO	FAMILIAR	(Quién?)
Hipertensión	<input type="checkbox"/>	<input type="checkbox"/>		Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Colesterol	<input type="checkbox"/>	<input type="checkbox"/>		Asma	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (Tipo 1/ Tipo 2)	<input type="checkbox"/>	<input type="checkbox"/>		Alergias Estacionales	<input type="checkbox"/>	<input type="checkbox"/>
Artritis	<input type="checkbox"/>	<input type="checkbox"/>		Cáncer (Por favor listo el tipo)	<input type="checkbox"/>	<input type="checkbox"/>
Enfermedad Cardíaca	<input type="checkbox"/>	<input type="checkbox"/>		Ceguera / Degeneración Macular	<input type="checkbox"/>	<input type="checkbox"/>

Últimos exámenes	FECHA	DOCTOR / FACILIDAD	ACERCA DE SUS LENTES	SI	NO
¿Cuando fue su último examen físico?			¿Actualmente usa lentes resetados?	<input type="checkbox"/>	<input type="checkbox"/>
¿Cuando fue su último examen de los ojos?			¿Actualmente usa lentes de contacto?	<input type="checkbox"/>	<input type="checkbox"/>
¿A sufrido una herida en sus ojos? <input type="checkbox"/> SI <input type="checkbox"/> NO			¿Previamente a usado lentes de contacto?	<input type="checkbox"/>	<input type="checkbox"/>
¿A tenido cirugía en los ojos? <input type="checkbox"/> SI <input type="checkbox"/> NO			¿Presenta problemas de Keratoconus y/o transplante de cornea?	<input type="checkbox"/>	<input type="checkbox"/>

Liste sus Medicamentos	Mencione Alergias

**Al firmar testifico que lo escrito es correcto y válido**

Paciente \_\_\_\_\_  
*POR FAVOR ESCRIBIR CON LETRA DE MOLDE*

Fecha \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Paciente/ Guardian \_\_\_\_\_  
*FIRMA*

Relación al paciente \_\_\_\_\_



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