IDENTIFICATION FORM

PATIENT INFORMATION:

Patient Name:_____ Male___Female____

Date of Birth:_____ Social Security #_____

Single__Married__Other__Child__ Preferred Language:_____

Current
Address_____

Street City State Zip Code

Cell Phone #_____ Home Phone #_____

Email Address:_____

Primary Care Physician, Pediatrician:

Name_____ Phone #_____

INSURANCE INFORMATION:

Current Insurance Company Please Check All That Apply:

Medicare ____
Public Aid ____
HMO Plan ____
PPO Plan ____
Self-Pay ____
Workmen's Comp___

Insurance Policy Holder's Name:_____ D.O.B._____

Relationship to Patient:_____

Medications:

Please list all Medications Currently Taken (Including Non Prescribed Medications)

_____

_____

_____

_____

_____

Please List Any Known Drug Allergies:

_____

Signature:_____ Relationship to Patient:_____

Continued -->

IDENTIFICATION FORM

Medical History Form

Patient Name:_____

Please list the reason for your visit today:

_____

When was your last eye exam preformed?_____

Patient Visual History:

Please check Yes or No to the following questions:

Have you ever been diagnosed with Glaucoma? Yes_____ No_____
Have you ever had prior eye surgery? Yes_____No_____
Have you ever been told you have Cataracts? Yes_____No_____
Do you have any Retinal Disorders? Yes_____No_____
Have you ever had any Eye Injuries? Yes_____No_____
Have you ever had any "Laser" Treatments? Yes_____No_____
Have you ever had any Eye Infections? Yes_____No_____
Do you wear Eye Glasses? Yes_____No_____
Do you wear Contact Lenses? Yes_____No_____
Have you ever had Double vision? Yes_____No_____
Do you suffer from Dry Eyes? Yes_____No_____
Have you had Lasik Eye Surgery? Yes_____No_____

Patient Medical History:

Yes	No		Yes	No	
__	__	High Blood Pressure	__	__	Diabetes
__	__	Thyroid Disease	__	__	Arthritis
__	__	Heart Disease	__	__	Asthma
__	__	Cancer (Type_____)	__	__	Stroke
__	__	High Cholesterol	__	__	Neurological Disease
__	__	Autoimmune Disease	__	__	Bleeding Disorder
__	__	Keloid Healer (Scar Easily)	__	__	Are you Pregnant
__	__	Are you currently nursing?	__	__	Have you ever had Surgery?

Continued -->

IDENTIFICATION FORM

PATIENT NAME:_____

Patient Social History:

Do you Currently Smoke? Yes__No__(If Yes How Much_____)
Have you ever Smoked? Yes__No__(If Yes when did you quit_____)
Do You Drink? Yes__No__(If Yes How Much_____)
Do You Use Recreational Drugs? Yes__No__

Family Vision and Health History:

Has anyone in your family ever been diagnosed with the following?

Glaucoma Yes__No__(if yes who_____)
Blindness Yes__No__(if yes who_____)
High blood pressure Yes__No__(if yes who_____)
Autoimmune Disease Yes__No__(if yes who_____)
Thyroid Yes__No__(if yes who_____)
Heart Disease Yes__No__(if yes who_____)
Stroke Yes__No__(if yes who_____)
Diabetes Yes__No__(if yes who_____)

FEE POLICIES FOR MCCARTHY EYE CENTER:

All Fees pertaining to your office visit will be billed to your insurance company. Any annual Deductibles and or co-payments are your responsibility and should be paid at the time of your visit. I understand that I will be held responsible for any deductibles or co-payments or non-covered services by my insurance. If my account goes without payment for 90-120 days, I understand that my account will be sent to a collection agency and I will be responsible for paying an additional 30% of the fee.

By Signing below I have read and understand the Fee policies

Signature:_____
Relationship to Patient: _____

Continued -->

IDENTIFICATION FORM

PATIENT NAME:_____

CONSENT FOR MEDICAL CARE AND RELEASE OF MEDICAL RECORDS

I give my permission for medical care, including the recording of my medical history, physical examination, laboratory tests, and x-ray films; any of which may help evaluate my condition, plan treatment, or evaluate its' results. I have been informed that written and computerized records regarding my illness, treatment and follow-up will be kept by my doctors and their staff. I also understand that computer access to and/or copies of these records which may include pathology slides, x-rays and associated reports may be provided to authorize personnel at affiliated institutions where I may continue my treatment. If I wish to get a copy of my medical records I am aware of a fee. I am aware of the fact that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me in terms of treatment of examination.

I am aware of the fact that my pupils may need to be dilated as part of my eye examination and that I may or may not be able to drive immediately following my exam. My Medical records may be used by McCarthy Eye Center, S.C. and/or my insurance carrier for auditing as well as billing purposes to improve the efficiency and quality of healthcare.

By signing here I have read the above statement and understand

Signature_____

Relationship to patient_____

ACKNOWLEDGEMENT OF RECEIPT

McCarthy Eye Center, S.C.

NOTICE OF PRIVACY PRACTICES

By signing this page you acknowledge that you have received a copy of our Notice of privacy practices.

Name of patient_____

Signature_____

Relationship to Patient _____

Date Signed_____

Witnessed By_____

Continued -->

Temperature: _____

1.Do you or have you recently had a fever, cough, shortness of breath or any other related Covid-19 symptoms?

☐ **Yes**

☐ **No**

2. Have you been in close contact to someone known to have novel coronavirus infection (2019-nCoV or COVID-19 or ill with respiratory symptoms?

☐ **Yes**

☐ **No**

3. Within the past 14 days have you or a family member traveled to countries such as China, Iran, Europe, South Korea, and domestic travel to states with high numbers of infected patients (e.g., Washington, California, New York)?

☐ **Yes**

☐ **No**

Name:_____ **Date:**_____

D.O.B:_____ **Signature:** _____

Pharmacy Information

***During your visit today, the doctor may have to send drops or medications for you. Please let us know which pharmacy you prefer to use. We will be sending it electronically:**

Pharmacy Name:

_____

Pharmacy Address:

_____

(Cross streets)

_____

(zip code)

Pharmacy Phone #

_____

Height (inches)

_____

Weight (pounds)

_____

McCarthy Eye Center, S.C.

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Pledge Regarding Your Health Information

We understand that information about you and your health is personal. We are required by law and committed to maintaining the privacy of this information. Each time we provide services, we create a record of the care and services you receive. We need this record to provide quality care and to comply with certain legal requirements. This notice applies to all of your information and the records of your health care generated by us or received by us from you or others.

Along with safeguarding your personal health information, we must also make available this notice of our legal duties and privacy practices, and we must follow the terms of the notice currently in effect. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights of access, amendment, control, and other rights concerning the use and disclosure of your health information. McCarthy Eye Center is also required to notify you if your health information is breached.

If you are the parent, legal guardian, or personal representative of the patient, the references herein such as"..your person health information.." shall be understood to refer to that patient.

Complaits: If you believe your privacy rights have been violated, you may file a complaint with us, directly to our Privacy Officer:

Timothy McCarthy, 7055 W. North Avenue, Oak Park, IL 60302, 708-848-2030. You can also file a complaint with the Secretary of Department of Health and Human Services at www.hhs.gov or in writing to any regional HHS office. There will be no retaliation for filing a complaint.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

The following categories describe different ways that we may USE your health information within the McCarthy Eye Center, and DISCLOSE your health information to persons and entities outside of the McCarthy Eye Center. We have nor listed every use or disclosure within the categories, but give some examples for understanding.

COMMON USES AND DISCLOSURES ALLOWED BY LAW

Treatment: We may use your health information to provide you treatment and services. We may disclose health information about you to others who are involved in your care.

Payment: We may use and disclose your health information so the treatment and services you receive at the McCarthy Eye Center may be billed to and payment collected from you, an

insurance company or a third party. We may also disclose health information to your insurance plan to obtain prior authorization for treatment and procedures.

Health Care Operations: We may use and disclose your health information for health care activities such as: quality assurance; administration; the McCarthy Eye Center financial and business planning and development; and customer service (including investigation of complaints). These uses and disclosures are necessary to operate our health care facility and make sure patients receive quality care.

Business Associates: Some services may be provided to our organization through contracts with business associates, such as: accountants; consultants; quality assurance reviewers; billing and transcription services. We may disclose your health information to our business associates so that they can perform the job we've asked them to do. Business associates are required to sign a contract that states they will appropriately safeguard your information.

Contact you about your health: We may use and disclose health information to contact you, such as a reminder about an appointment or other treatment options at the McCarthy Eye Center.

Fundraising: If we are going to contact you as part of a fundraising effort, you will have a simple way to opt out of these contacts.

Individuals Involved in you care: We may disclose health information about you to a friend or family member who is involved in your care, unless you tell us in advance not to do so.

Other Laws: At times there may be federal, state or local laws that require us to use or disclose health information in other ways, or give you additional privacy protections. We will obey those laws.

Special Situations Which Do Not Require Your Authorization

The following disclosures of your health information are permitted by law without any oral or written permission from you:

Public Health Activities: We may disclose health information about you for public health activities, including:

- To prevent or control disease, injury or disability.
- To report birth and deaths.
- To report child abuse or neglect
- To report reactions to medication, problems with products or other adverse events.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- To avert a serious threat to you or others. These disclosures would be made only to someone able to intervene.
- To notify the appropriate government authority if we believe a patient has been a victim of abuse (including Child Abuse), neglect or domestic violence.
- Immunization records to a school requiring such for entry, provided informal approval is given by parent, guardian, or the patient if the patient is an adult or emancipated minor.
- To disaster relief agencies (such as the Red Cross) for notification as to your location and condition.
- If you are an organ donor, we may release health information to the organizations that handle the process, as necessary to facilitate the donation.

Military and Veterans: If you are a member of the armed forces, we may release health information about you as required by military command authorities.
Worker's Compensation: We may release health information about you for worker's compensation or similar programs if you have a work related injury.
Health Oversight Activities: McCarthy Eye Center may disclose health information to a health oversight agency for activities authorized by law. These include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with the civil rights law.
Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may be required to disclose your health information in response to a court order, administrative order, subpoena, discovery request or other lawful process by someone involved in the dispute.
Law Enforcement: We may disclose health information t the law enforcement officials for the reasons such as:

- In response to a court order, subpoena, warrant, summons or similar process.
- To identify or locate a suspect, fugitive, material witness or missing person.
- About a victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement.
- About a death we believe may be the result of criminal conduct.
- About criminal conduct at our facility.
- In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Health Records of Deceased Patients: We may disclose health information to a coroner or medical examiner, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral home directors as necessary to carry out their duties. We may disclose to relatives or close personal friends who were involved with the patient's care prior to death, health information

relevant to their involvement. HIPAA privacy protections continue until 50 years after the patient's death.

National Security and Intelligence Activities: We may disclose health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Legal Requirements: We will disclose health information about you without your permission when required to do so by federal, state or local law.

Other Uses and Disclosures Required Your Authorization

Other uses and disclosures of health information not covered by this notice or applicable laws will be made only with your written permission (called "authorization"). If you do give authorization in some instance, you may revoke that authorization in writing at any time. Uses and disclosures of your personal information that require your authorization include marketing functions, and most disclosures that involve sale of health information.

Your Health Information Rights

You have the following rights concerning your health information:

1. **Request a restriction on certain uses and disclosures** of you information. We may agree to your request but are not required by law to do so, with the one following exception...
2. **Restricting disclosures to health plan or insurance** for treatment you pay for in full. If you pay in full at the time of service and request we do not disclose the information to your health plan or insurer, we must and will comply.
3. **Obtain a Copy of this Notice of Privacy Practices** upon request.
4. Inspect and/or request a copy of your health record. You must make the request in writing, and we have 30 days to comply.
5. **Request and amendment to your health** record if you feel the information is incorrect or incomplete. McCarthy Eye Center may deny your request if, for instance, we believe it is accurate and complete as it stands.
6. **Obtain an accounting of disclosures of your health information.** This will include the times when someone used or disclosed your health information other than the allowed common uses and disclosures, or uses and disclosures that you authorized.
7. **Request communication of your health information** by alternative means or locations. For instance: an address or phone number other than your home.
8. **Revoke a previously agreed upon authorization** except to the extent that action has already been taken.

For more information contact our privacy officer: Timothy McCarthy, 7055 W. North avenue, Oak Park, IL 60302 708-848-2030.

We reserve the right to change this notice and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. A copy of the current notice in effect will be available at the McCarthy Eye Center.

Effective Date: 02-01-2014