Welcome to InFocus Vision Optometric Center

Please take a few minutes to fill out this form as completely as possible.
If you have any questions, we will be glad to assist you.

PATIENT INFORMATION Today's Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____ Apt # _____ City: _____ Zip:_____

Home #:( ) _____ - _____ Work #:( ) _____ - _____x_____ Cell #:( ) _____ - _____

Patient's Social Security Number: _____ - _____ - _____ E-Mail: _____

Patient Status: ☐ Single ☐ Married ☐ Male ☐ Female

☐ Employed (occupation): _____

☐ Retired ☐ Full-Time Student ☐ Part-Time Student

Hobbies: _____

I'm interested in… ☐ Glasses ☐ Sunglasses ☐ Computer Glasses ☐ Contact Lenses ☐ Laser Consultation

Date of last eye exam: _____ at _____

How did you hear about our practice? ☐Walk-in ☐Insurance ☐Yellow Page ☐Referred by _____

Whom may we contact in case of emergency?_____ _____ ( ) _____ - _____

Name Relationship

INSURANCE INFORMATION

Subscriber Name: _____ Name of Insurance: _____

Subscriber SS # : _____ - _____ - _____ Plan / Group # : _____

Subscriber DOB: _____ Relationship to Patient: _____

Occupation: _____ Employer : _____

Employer Address: _____

Business Phone # : ( ) _____ - _____ Is the patient covered by additional insurance? Y / N

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Emily Kuo Wang 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use to this signature on all insurance submissions.

For Saturday appointments only: We will be charging a no show $25.00 fee per person, per missed appointment, without a 24hr. notice. Please be advised that we will call, as a courtesy to you but it is your responsibility to call to reschedule any appointments.

_____ _____ _____

Responsible Party Signature Relationship Date

Name: _____ **Today's Date:** _____

I experience this on a REGULAR basis:	Yourself YES	Yourself NO
Blurry Vision (D or N) w/o glasses	☐	☐
Burning Eyes	☐	☐
Color Vision (Poor)	☐	☐
Crossed eyes	☐	☐
Discharge from Eyes	☐	☐
Dizzy Spells	☐	☐
Double Vision	☐	☐
Dry Eyes	☐	☐
Eye Infection	☐	☐
Eye Injury	☐	☐
Eye Itch	☐	☐
Eye Strain	☐	☐
Eye Surgery	☐	☐
Eye Turn or Lazy Eye	☐	☐
Flashes	☐	☐
Floaters or Spots	☐	☐
Halos	☐	☐
Headaches / Migraines	☐	☐
Light Sensitive	☐	☐
Red Eyes	☐	☐
Temporary Loss of Vision	☐	☐
Water Eyes	☐	☐
I have been diagnosed with the following:		
Blindness / Permanent Loss of Vision	☐	☐
Cataract	☐	☐
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Retinitis Pigmentosa	☐	☐
Retinal Detachment	☐	☐
Other:		

	Yourself YES	Yourself NO	Your Family YES	Your Family NO
AIDS / HIV	☐	☐	☐	☐
Arthritis / Artificial Joints	☐	☐	☐	☐
Asthma / Emphysema	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐
Cancer (_____)	☐	☐	☐	☐
Cholesterol	☐	☐	☐	☐
Diabetes (Type ____)	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
-Artificial Heart Valve	☐	☐	☐	☐
-Pacemaker	☐	☐	☐	☐
Hepatitis (Type ____)	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Lupus	☐	☐	☐	☐
Seasonal Allergies	☐	☐	☐	☐
Shingles	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Thyroid Condition	☐	☐	☐	☐

Other medical problems:

Current medications including eye drops:

_____

_____

_____

_____

Drug allergies? ☐ No ☐ Yes _____

_____

Chemical dependency? ☐ Yes ☐ No ☐ N/A

Frequent alcohol use? ☐ Yes ☐ No ☐ N/A

Frequent tobacco use? ☐ Yes ☐ No ☐ N/A

Pregnant? ☐ Yes ☐ No ☐ N/A

InFocus Vision Optometric Center

Acknowledgement of Receipt of Notice of Privacy Practices

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Privacy Notice on the date indicated below.

_____
Today's Date

_____ or _____
Patient's Signature Parent or Legal Guardian's Signature

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because of the following:

___ The patient refused to sign.

___ Due to an emergency situation, it was impossible to obtain a signature.

___ We were not able to communicate with the patient.

___ Other Reason: _____

_____

_____ _____
Employee's Signature Date

InFocus Vision Optometric Center's Notice of Privacy Practices

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Overview
The law requires us to keep your protected health information ("PHI") private in accordance with this Notice of Privacy Practices ("Notice"), as long as this Notice remains in effect. We are also required to provide you with a paper copy of this Notice, which contains our privacy practices, our legal duties, and your rights concerning your PHI. From time to time, we may revise our privacy practices and the terms of our Notice at any time, as permitted or required by applicable law. Such revisions to our privacy practices and our Notice may be retroactive. Our Notice will be updated and made available to our patients prior to any significant revisions of our privacy practices and policies.

Organizations Covered by this Notice: This Notice contains the privacy practices for types of organizations listed below affiliated with InFocus Vision Optometric Center for delivery of health care services. Each of these organizations participates in an organized health care arrangement and may use and disclose your PHI among themselves as they shall deem appropriate for your treatment, payment or health care operations.

Our Privacy Practices
Use and Disclosure. We may use or disclose your PHI for treatment, payment, or health care operations. For your convenience, we have provided the following examples of such potential uses or disclosures:

Treatment. Your PHI may be used by or disclosed to any physicians or other health care providers involved with the medical services provided to you.

Payment. Your PHI may be used or disclosed in order to collect payment for the medical services provided to you.

Health Care Operations. Your PHI may be used or disclosed as part of our internal health care operations. Such health care operations may include, among other things, quality of care audits of our staff and affiliates, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Authorizations. We will not use or disclose your medical information for any reason except those described in this Notice, unless you provide us with a written authorization to do so. We may request such an authorization to use or disclose your PHI for any purpose, but you are not required to give us such authorization as a condition of your treatment. Any written authorization from you may be revoked by you in writing at any time, but such revocation will not affect any prior authorized uses or disclosures.

Patient Access. We will provide you with access to your PHI, as described below in the Individual Rights section of this Notice. With your permission, or in some emergencies, we may disclose your PHI to your family members, friends, or other people to aid in your treatment or the collection of payment. A disclosure of your PHI may also be made if we determine it is reasonably necessary or in your best interests for such purposes as allowing a person acting on your behalf to receive filled prescriptions, medical supplies, etc.

Facility Directories. Our facility directory may list the following information about you: (1) your name, (2) your location in our facility, (3) your general condition without reference to specific medical information, *e.g.*, stable, serious, fair, etc. You may restrict or prohibit the release of the above information.

Locating Responsible Parties. Your PHI may be disclosed in order to locate, identify or notify a family member, your personal representative, or other person responsible for your care. If we determine in our reasonable professional judgment that you are capable of doing so, you will be given the opportunity to consent to or to prohibit or restrict the extent or recipients of such disclosure. If we determine that you are unable to provide such consent, we will limit the PHI disclosed to the minimum necessary.

Continuing Care. Based upon your PHI, we may provide you with appointment reminders or information concerning health issues, benefits and services, or treatment alternatives that we believe may be of interest to you.

Disasters. We may use or disclose your PHI to any public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Required by Law. We may use or disclose your medical information when we are required to do so by law. For example, your PHI may be released when required by privacy laws, workers' compensation or similar laws, public health laws, court or administrative orders, subpoenas, certain discovery requests, or other laws, regulations or legal processes. Under certain circumstances, we may make limited disclosures of PHI directly to law enforcement officials or correctional institutions regarding an inmate, lawful detainee, suspect, fugitive, material witness, missing person, or a victim or suspected victim of abuse, neglect, domestic violence or other crimes. We may disclose your PHI to the extent reasonably necessary to avert a serious threat to your health or safety or the health or safety of others. We may disclose your PHI when necessary to assist law enforcement officials to capture a third party who has admitted to a crime against you or who has escaped from lawful custody.

Deceased Persons. We may disclose your PHI to a coroner, medical examiner, funeral director, or organ procurement organization in limited circumstances.

Research. Your PHI may also be used or disclosed for research purposes only in those limited circumstances not requiring your written authorization, such as those which have been approved by an institutional review board that has established procedures for ensuring the privacy of your PHI.

Military and National Security. We may disclose to military authorities the medical information of Armed Forces personnel under certain circumstances. When required by law, we may disclose your PHI for intelligence, counterintelligence, and other national security activities.

Your Individual Rights
Access and Copies. In most cases, you have the right to review or to purchase copies of your PHI by requesting access or copies in writing to our Privacy Officer. Please contact our Privacy Officer regarding our copying fees.

Disclosure Accounting. You have the right to receive an accounting of the instances, if any, in which your PHI was disclosed for purposes other than those described in the following sections above: Use and Disclosures, Facility Directories, Patient Access, and Locating Responsible Parties. For each 12-month period, you have the right to receive one free copy of an accounting certain details surrounding such disclosures that occurred after April 13, 2003. If you request a disclosure accounting more than once in a 12-month period, we will charge you a reasonable, cost-based fee for each additional request. Please contact our Privacy Officer regarding these fees.

Additional Restrictions. You have the right to request that we place additional restrictions on our use or disclosure of your PHI, but we are not required to honor such a request. We will be bound by such restrictions only if we agree to do so in writing signed by our Privacy Officer.

Alternate Communications. You have the right to request that we communicate with you about your PHI by alternative means or in alternative locations. We will accommodate any reasonable request if it specifies in writing the alternative means or location, and provides a satisfactory explanation of how future payments will be handled.

Amendments to PHI. You have the right to request that we amend your PHI. Any such request must be in writing and contain a detailed explanation for the requested amendment. Under certain circumstances, we may deny your request but will provide you a written explanation of the denial. You have the right to send us a statement of disagreement to which we may prepare a rebuttal, a copy of which will be provided to you at no cost. Please contact our Privacy Officer with any further questions about amending your medical record.

Complaints
If you believe we have violated your privacy rights, you may complain to us or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with us by notifying our Privacy Officer. We support your right to protect the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Us: InFocus Vision Optometric Center, Inc.
Rosie, Privacy Officer
29 E. Huntington Dr., Ste. B, Arcadia, CA 91006
Tel: (626) 303-1888