Daniel B. Pope, M.D., P.A. (The Eye Depot)

PLEASE PRINT

Chart# **Date**

PATIENT INFORMATION

Last Name **First Name** **M.I.** **Nickname/AKA**

Date of Birth **Social Security Number** **Gender** ❑ Male ❑ Female

Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Life Partner ❑ Separated ❑ Widowed ❑ Other **Language** other than English

Race (Optional) ❑ Black – Non Hispanic ❑ American Indian/ Alaskan Native ❑ Hispanic ❑ Asian/Pacific Islander ❑ White – Non Hispanic ❑ Other

Home Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Cell Phone**

Email Address **Employment Status** ❑ Active Duty Military ❑ Child ❑ Disabled ❑ Employed Full-Time ❑ Employed Part-Time ❑ Homemaker ❑ Not Employed ❑ Retired ❑ Self Employed ❑ Student Full-Time ❑ Student Part-Time ❑ Other

Employer **Employer Phone**

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician **Referring Physician**

How did you hear about us? ❑ Billboard ❑ Employer ❑ Family Member ❑ Friend ❑ Health Fair Event ❑ Insurance ❑ Magazine ❑ Mail ❑ News ❑ Physician ❑ Radio ❑ Television ❑ Website ❑ Yellow Pages ❑ Other

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ❑ Self (If self, skip to Emergency / Next of Kin) ❑ Spouse ❑ Parent ❑ Other

Last Name **First Name** **M.I.**

Date of Birth **Social Security Number**

Home Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Cell Phone**

Employer **Employment Status** ❑ Active Duty Military ❑ Child ❑ Disabled ❑ Employed Full-Time ❑ Employed Part-Time ❑ Homemaker ❑ Not Employed ❑ Retired ❑ Self Employed ❑ Student Full-Time ❑ Student Part-Time ❑ Other

Employer Phone

EMERGENCY / NEXT OF KIN CONTACT INFORMATION

Last Name **First Name** **Relationship to Patient**

Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Cell Phone**

OTHER CONTACT INFORMATION – NOT LIVING WITH PATIENT

Last Name **First Name** **Relationship to Patient**

Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Cell Phone**

- **Fax completed form and insurance cards to our office at 941-746-7365 or print completed form and bring to your appointment.**

The Eye Depot

Daniel B Pope, M.D. *William H. McSwain, M.D.*

Ophthalmic Physicians and Surgeons
426 Manatee Ave. W
Bradenton, FL 34205
(941) 708-9000

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.

This Notice of Privacy Practices is required by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. If you have any questions about this notice, please contact our HIPAA Privacy Officer, Cheryl Hoopingarner at 941-708-9000.

Our Practice Regarding Protected Health Information (PHI)

This notice describes Daniel B. Pope, M.D., P.A (herein referred to as "The Eye Depot") practices regarding your PHI. The terms "we" and "our" in this notice refer to The Eye Depot. The Eye Depot includes the following physicians:

- Daniel B. Pope, M.D.
- William H. McSwain, M.D.

Our Duties to You Regarding Your PHI

The HIPAA Privacy Rule requires The Eye Depot to:

- Ensure that your PHI is properly safeguarded
- Notify you if we determine that your PHI was inappropriately used or disclosed
- Provide you this notice of our legal duties and privacy practices for the use and disclosure of your PHI
- Follow the terms of the notice currently in effect

Our Right to Revise This Notice. We may change this notice and our privacy practices at any time. Any revised notice will apply to the PHI we already have about you at the time of the change and any PHI we create or receive after the change takes effect. We will advise you of important changes and post the revision on our website.

How to Obtain a Copy of This Notice. This notice is available in paper copy at our office located at 426 Manatee Avenue West, Bradenton, Florida 34205 and is also available on our website. You can ask for a paper copy at your next appointment or call and request that we mail a copy to you, even if you have previously agreed to receive this notice electronically.

How We May Use or Disclose Your PHI Without Your Authorization

Treatment. To provide, coordinate, or manage your health care. For example, we may disclose your PHI to another physician, or health care provider, such as a specialist, pharmacist, or laboratory, who, at the request of your provider, becomes involved with your health care.

Payment. To obtain payment for your health care services. This may include certain activities needed to approve or pay for your health care services, such as using or disclosing your PHI to obtain approval for a surgery.

Health Care Operations. To support the daily activities related to health care. These activities include, but are not limited to, quality assessment activities, patient safety, investigations, oversight of staff performance, practitioner training, licensing, communications about a product or service, and conducting or arranging for other health care related activities. We do not use or disclose any genetic information for underwriting purposes.

Business Associates. To certain companies ("business associates") that provide various services to The Eye Depot (for example, billing, transcription, software maintenance, legal services, and managed care support). The law requires that business associates protect your PHI and comply with the same HIPAA Privacy standards that we do.

Public Health. To public health authorities and parties regulated by them, as permitted by law. Examples of why they may need your PHI include prevention or control of disease, injury, or disability.

Reporting Victims of Abuse, Neglect, or Domestic Violence. To government authorities that have authority to receive such information, including a social service or protective service agency.

Communicable Diseases. To a person who might be at risk of contracting or spreading a communicable disease or condition.

Workers' Compensation. To workers' compensation programs.

Health Oversight. To a health oversight agency legally authorized for audits, investigations, and inspections. Such activities may include the health care system, government benefit programs, civil rights laws, and other government regulatory programs.

Required by Law. To government and other entities as required by federal or state law (including DoD and Military Department regulations). For example, we may be required to disclose your PHI to the Department of Health and Human Services (HHS) investigating HIPAA violations.

Legal Proceedings. To parties and entities in proceedings of courts and administrative agencies, including in response to a court order or subpoena.

Inmates. To a correctional facility with respect to inmates.

Coroners, Funeral Directors, and Organ Donations. To coroners, medical examiners, or funeral directors, and to determine the cause of death or for the performance of other duties. PHI also may be used and disclosed for cadaver organs, eyes, or tissue donations.

Law Enforcement. To law enforcement authorities. For example, to investigate a crime involving injury to the eye.

Research. To researchers. The Eye Depot reviews research proposals and protocols to ensure the privacy of your PHI requested for such research activities.

Avert Threats. To prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Disclosures by the Health Plan. To parties that need your PHI for health plan purposes such as enrollment, eligibility verification, coordination of coverage, or other benefit programs.

Minors and Other Represented Beneficiaries. To parents, guardians, and other personal representatives, generally consistent with the law of the state where treatment is provided.

How We May Use or Disclose Your PHI Unless You Object

Individuals Involved in Your Health Care. To the following persons or entities:

- A member of your family, or any other person you identify who is involved, before or after your death, in your health care or payment for care, unless we are aware of a deceased individual's contrary preference
- A person who is responsible for your care who needs to know about your location or general eye health

Uses and Disclosures Requiring Your Authorization

Any use or disclosure of your PHI not described in this notice requires your written authorization. Some uses and disclosures, even if included in this notice, would not be permitted without your written authorization. These include the following three activities in which The Eye Depot does not engage:

- Sharing your psychotherapy notes with a third party who is not a part of your care
- Sending information to encourage you to buy a product if we are paid to send that information or make that communication
- Selling your PHI

If you authorize us to share your PHI, you can revoke your authorization at any time by contacting our HIPAA Privacy Officer, but your revocation will only apply to information not already disclosed.

Your Rights Regarding Your Health Information

You may exercise the following rights through a written request to our Privacy Officer. Depending on your request, you may also have rights under the Privacy Act of 1974.

Right to Inspect and Copy. As allowed by law, you may inspect and request a copy of your medical or billing records (including an electronic copy, if we maintain the records electronically). You have the right to have the information sent directly to a party you designate, such as your physician. In limited situations, we may deny your request or part of it, but if we do, we will tell you why in writing and explain your right to review, if any.

Right to Request Restrictions. You may ask us not to share any part of your PHI for treatment, payment, or health care operations. You may also request that we limit the information we share about you to someone who is involved in your care or the payment of your care. In your request, you must tell us what information you want restricted, and to whom you want the restriction to apply. Neither The Eye Depot nor it's physicians is required to agree to your request. We will not deny a request to restrict disclosure of your PHI to a health plan, where the PHI relates to the care which you paid for in full out of pocket. We will not use or disclose your PHI in violation of a restriction to which we agreed, unless your PHI is needed for emergency treatment. We permit you, The Eye Depot or it's physicians to end a previously agreed-upon restriction at any time by providing written notice.

Right to Request Confidential Communications. You may request that we communicate with you in a certain way or at a certain location (e.g., only at home or only by mail). We will accommodate reasonable requests.

Right to Request Amendment. You may request an amendment to your PHI if you believe there is an error. You must tell us what you would like corrected or added to your information and why. If we approve your request, we will make the correction or addition to your PHI. If we deny your request, we will tell you why and explain your right to file a written statement of disagreement.

Right to an Accounting of Disclosures. You may request that we provide you with an accounting of when your PHI was disclosed outside of The Eye Depot, but an accounting will not include certain disclosures (e.g. for treatment purposes). You are entitled to one disclosure accounting in a 12- month period at no charge. We may charge a fee for additional requested accountings. Your request must state the time period for which you want to receive the accounting, which may be up to six years before the date of your request.

Complaints

If you believe that The Eye Depot has violated the HIPAA Privacy Rule, you may file a written complaint with our HIPAA Privacy Officer. We will not take any action against you for filing a complaint.

Contact Information

You may contact our HIPAA Privacy Officer, Cheryl Hoopingarner at 426 Manatee Avenue West, Bradenton, Florida 34205 or by phone at (941) 708-9000

Do We Have Permission to:

Mail medical information to your home? YES_____NO_____

Leave a detailed message on your home/cell answering machine for:

Appointment Information? YES_____NO_____

Billing Information? YES_____NO_____

Other Medical Information? YES_____NO_____

Leave a detailed message on your work answering machine for:

Appointment Information? YES_____NO_____

Billing Information? YES_____NO_____

Other Medical Information? YES_____NO_____

I give permission to share information with the following person(s):

Appointment Information: _____Relation/Phone #:_____

Billing Information: _____Relation/Phone #:_____

Medical Information (lab & biopsy results): _____Relation/Phone #:_____

With my consent, The Eye Depot may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. Please refer to The Eye Depot Notice of Privacy Practices for a more complete description of such uses and disclosures. By signing this form, I am consenting to The Eye Depot use and disclosure of information according to the Notice of Privacy Practices and acknowledge receiving a copy of Notice of Privacy Practices.

I authorize release of any medical information necessary to all my insurance companies to process any claims. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment direct to The Eye Depot. I understand that I am responsible for all co-pays, deductibles, and uncovered services. I authorize use of this form for all my insurance submissions. I authorize The Eye Depot to release information concerning my treatment to any of my other physicians. I authorize my signature to be placed "on file" for purposes of Medicare and insurance claim for submission. Under penalty of perjury, I declare that I have read the foregoing and the facts alleged are true, to the best of my knowledge and belief.

Patient Signature: _____ Date:_____

Witness Signature (Eye Depot employee): _____ Date:_____

Medical History Questionnaire

Name: _____ **Date:**_____

Date Of Birth: _____ **Date Of Last Eye Exam**: _____

List any **medications** you currently take (Rx and over-the-counter): _____

Are you **ALLERGIC** to anything? ☐ **YES** ☑ **NO**

If **YES**, list your allergies: _____

List all **MAJOR ILLNESSES** or **INJURIES** (glaucoma, diabetes, high blood pressure, heart attack, trauma, etc.):

List any **SURGERIES** you have had (cataract, appendectomy):

Do you **CURRENTLY** have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)	☐	☑	
GENERAL / CONSTITUTIONAL (fever, fatigue, weight loss, weight gain)	☐	☑	
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)	☐	☑	
CARDIOVASCULAR (high BP, racing pulse, etc.)	☐	☑	
RESPIRATORY (congestion, wheezing, short of breath, etc.)	☐	☑	
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)	☐	☑	
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, etc.)	☐	☑	
FEMALES Are you pregnant? Nursing?	☐	☑	
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)	☐	☑	
SKIN (pimples, warts, growths, rash, etc.)	☐	☑	
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)	☐	☑	
PSYCHIATRIC (anxiety, depression, insomnia)	☐	☑	
ENDOCRINE (diabetes, hypothyroid, etc.)	☐	☑	
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, etc.)	☐	☑	
ALLERGIC / IMMUNOLOGIC (sneezing, redness, itching, hives, lupus, etc.)	☐	☑	

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply) ? ☐ **YES** ☑ **NO** ☐ **UNKNOWN**

Poor Vision, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis

Other heritable disease:

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? ☐ **YES** ☑ **NO**

Have you ever had a blood transfusion? ☐ **YES** ☑ **NO**

Do you drink alcohol?..... ☐ **YES** ☑ **NO** If YES, how much? _____

Do you smoke?..... ☐ **YES** ☑ **NO** If YES, how much? _____ How many years? _____

Physician's Signature _____ ***Date*** _____