KLEIMAN | EVANGELISTA
EYE CENTERS OF TEXAS

MEDICAL FORM
(please fill in all information)

LAST NAME _____ FIRST _____ M.I. _____

SPOUSE/PARENT NAME _____

CELL PHONE _____ SECONDARY PHONE _____

HOME ADDRESS _____ APT# _____

CITY & STATE _____ ZIP CODE _____

DATE OF BIRTH _____ SEX M ☐ F ☐ SOCIAL SECURITY # _____

EMAIL _____ Current Optometrist _____

Pharmacy Name/Address/Phone _____

Family Physician (PCP) _____ Referred By _____

EMERGENCY CONTACT PERSON

Name _____

Address _____

Phone Number _____

Relationship To Patient _____

PRIMARY INSURANCE INFORMATION

Primary Insured's Name _____

Patient's Relationship to Primary Insured _____ Self _____ Spouse _____ Child _____ Parent

Primary Insured's Social Security Number# _____ Date of Birth _____

Primary Insured's Employer _____

Insurance Plan Name _____

Insurance ID number _____ Group number _____

SECONDARY INSURANCE INFORMATION

Primary Insured's Name _____

Patient's Relationship to Primary Insured _____ Self _____ Spouse _____ Child _____

Primary Insured's Social Security Number# _____ Date of Birth _____

Primary Insured's Employer _____

Insurance Plan Name _____

Insurance ID number _____ Group number _____

Filling your insurance is not a guarantee of payment, if payment is not received you as a patient will be ultimately responsible for all unpaid services.

BY SIGNING THIS FORM, I ACKNOWLEDGE THE ABOVE AND UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PROVIDE THE PHYSICIAN WITH ALL CORRECT INSURANCE INFORMATION. IF THE CLAIM IS DENIED FOR ANY REASON I WILL BE FINANCIALLY RESPONSIBLE FOR MY OFFICE VISIT.

_____

SIGNATURE OF PATIENT DATE

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MEDICAL FORM
Page 2
(please fill in all information)

MEDICAL HISTORY	YES	NO
HEART DISEASE	☐	☐
DIABETES	☐	☐
GLAUCOMA	☐	☐
HIGH BLOOD PRESSURE	☐	☐
SURGERIES	☐	☐
BLEEDING DISORDERS	☐	☐

ALLERGIES TO MEDICINES _____

OTHER _____

LIST ANY MEDICATIONS YOU ARE TAKING

_____

_____

_____

_____

_____

_____

_____

PATIENT SIGNATURE ON FILE X _____

REVIEW OF SYSTEMS:

Do you currently have any of the following problems:	YES	NO	IF YES, PLEASE EXPLAIN
Chronic fever, unexpected weight loss/gain, fatigue, night sweats?	☐	☐	
Ear/nose/throat problems (e.g. hearing loss, sinus problems, sore throat)?	☐	☐	
Respiratory problems (e.g. shortness of breath, wheezing, coughing)?	☐	☐	
Heart problems (e.g. chest pressure or discomfort, irregular heartbeat)?	☐	☐	
Gastrointestinal problems (e.g. constipation, heartburn, abdominal pain, diarrhea, vomiting)?	☐	☐	
Urinary problems (e.g. pain or discomfort, blood in urine)?	☐	☐	
Cold intolerance, heat intolerance, polydipsia or polphagia?	☐	☐	
Neurologic problems (e.g. dizziness, numbness, weakness, headaches)?	☐	☐	
Emotional changes?	☐	☐	
Skin problems (e.g. rashes, excessive dryness)?	☐	☐	
Musculoskeletal problems (e.g. muscle aches, joint pains, swollen joints)?	☐	☐	
Bruising and easy bleeding?	☐	☐	
Environmental allergies or food allergies?	☐	☐	

FAMILY AND SOCIAL HISTORY

Do any medical diseases run in your family? (e.g. diabetes, high blood pressure, cancer, heart, strokes, etc.)

YES ☐ NO ☐ If yes, please explain _____

Do you smoke? YES ☐ NO ☐ How much? _____ Do you drink alcohol? YES ☐ NO ☐ How much? _____

If employed, how many hours per week do you work? _____ Occupation _____

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EYE CENTERS OF TEXAS

REFRACTION POLICY

(please fill in all information)

A refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contact lenses. It is NOT a covered service by Medicare or most insurance plans. These plans consider a refraction a “vision” service not a “medical” service.

Our office fee for a refraction is $47.00; this fee is collected at the time of service in addition to any co-payment your plan may require. We do not file the charge of the refraction with any insurance plans. If you are confident that your insurance will reimburse you, we are happy to provide receipts and documentation for you to submit this fee to your insurance company for reimbursement.

You will not be given your prescription until the refraction fee has been paid.

Patient’s Signature _____ Date _____

Notice of Privacy Practices

Effective Date 10/14/2006 Revised Date 05/03/2018

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.

Your Health Information is personal, and we are committed to protecting it.

For purposes of this Notice, "we" or "Affiliated Covered Entities" means Walnut Hill Surgery Center, LLC, Mt. Pleasant Surgical Center, LLC, ASC Lone Tree LLC (d/b/a: ICON Surgery Center of Denver; ICON EYECARE), Swagel-Wootton Eye Center, Inc. (d/b/a: Swagel Wootton Eye Institute; Swagel/Wootton Eye Center; Swagel/Wootton/ Hiatt Eye Center; Hiatt Eye Center), South Arlington Surgical Providers, Inc. (d/b/a Same Day Surgicare), Day Surgery of Grand Junction, LLC (d/b/a: Day Surgery of Grand Junction; ICON EYECARE), Total Vision Eye Care Group, LLC (d/b/a ICON EYECARE), Icon Eyecare Texas Operations, Inc., Arlington Ophthalmology Association, PLLC (d/b/a: Kleiman Evangelista Eye Center; KE Eye Centers of Texas), DECA Holdings, PLLC, Arlington Anesthesia Group, PLLC, Dallas Eye Care Associates, PLLC (d/b/a: KE Eye Centers of Texas; ICON EYECARE), Minadeo Eye Center, PLLC (d/b/a: KE Eye Centers of Texas; ICON EYECARE), and SWH Optometry, PC, which have been designated as a single covered entity for HIPAA Privacy Rule compliance purposes.

If you have any questions please contact our HIPAA Privacy Officer (contact information below). We are required by law to: Maintain the privacy of your protected health information, give you this notice of our duties and privacy practices regarding health information about you, and follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION:

Described as follows are the ways we may use and disclose health information that identifies you (Health Information, or PHI). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to us and stating that you wish to revoke permission you previously gave us.

Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care. ***Payment***. We may use and disclose Health Information so that we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment. However, if you pay for your services yourself (e.g. out-of-pocket and without any third party

contribution or billing), we will not disclose Health Information to a health plan if you instruct us to not do so.

Health Care Operations. We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information for care coordination or quality improvement/assurance activities. Subject to the exception above if you pay for your care yourself, we also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operations.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you. We will not, however, send you communications about health-related or non-health-related products or services that are subsidized by a third party without your authorization.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort. ***Research***. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through an approval process. Even without approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising and Marketing. Health Information may be used for fundraising communications, but you have the right to opt-out of receiving such communications. Except for the exceptions detailed above, uses and disclosures of Health Information for marketing purposes, as well as disclosures that constitute a sale of Health Information, require your authorization if we receive any financial remuneration from a third party in exchange for making the communication, and we must advise you that we are receiving remuneration.

As Required by Law. We will disclose Health Information when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for

such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. ***Lawsuits***. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person

or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Other Uses. Other uses and disclosures of Health Information not contained in this Notice may be made only with your written authorization, which may be revoked by you at any time.

YOUR RIGHTS: You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to our office.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to our office.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to our office.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our office. ***We are not required to agree to all such requests***. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For

example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing, to our office. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site www.iconlasik.com. To obtain a paper copy of this notice please request it in writing.

Right to Electronic Records. You have the right to receive a copy of your electronic health records in electronic form.

Right to Breach Notification. You have the right to be notified if there is a Breach of privacy such that your Health Information is disclosed or used improperly or in an unsecured way.

CHANGES TO THIS NOTICE: We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office, and will provide it to you upon request. The notice will contain the effective date on the first page.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our HIPAA Privacy Officer by calling **(720) 442-0249** or with the Secretary of the Department of Health and Human Services.
You will not be penalized for filing a complaint.

[*Patient Acknowledgement Page Follows*]

PATIENT ACKNOWLEDGEMENT

By signing below, I acknowledge that I have been provided this Notice of Privacy Practices of the Affiliated Covered Entities and I authorize each of the Affiliated Covered Entities to use and disclose my medical or insurance information as necessary to process my medical claims and coordinate or manage my health care in a manner consistent with the information contained in this Notice of Privacy Practices. Additionally, in the event that a family member or caregiver attends my office visit and is in the exam room at the time of my evaluation and / or treatment, I expressly authorize each of the Affiliated Covered Entities and their respective staff members to discuss freely my condition, treatment, or diagnosis with any such person. I further authorize the entities listed on the first page of this document to communicate information regarding my condition, treatment, or diagnosis as follows:

Home Phone: _____

May we leave messages? YES / NO (circle your preference)

Cell Phone: _____

May we leave messages? YES / NO (circle your preference)

Email Address: _____

May we send you messages? YES / NO (circle your preference)

May we call out your name in our lobby? YES / NO (circle your preference)

With whom may we discuss financial issues relating to your condition, treatment, and diagnosis? (Please provide name and contact information below.)

_____

_____

I have reviewed and consent to this Notice of Privacy Practices.

Signature: _____ **Date:** _____

If signed by an authorized legal representative and not the patient himself / herself, please identify the name of the authorized legal representative and the basis for his or her authority to sign on the patient's behalf:

_____