What should you bring … ?

As your doctor, the more information we have the better the treatment we can prescribe for you and your eyes:

Please bring to your exam:

The patient forms

Medical insurance card and vision insurance card (if provided by your insurance company)

Current glasses

Current sunglasses

Contact lens prescription (or boxes)

Current list of any medications

Please plan approximately one hour for your appointment. By arriving to your appointment 5 minutes early, we are generally able to start your appointment at your scheduled time.

6772 New Albany-Condit Rd (SR 605) (614) 933-0575

NAME____ **DOB**____________________

FAMILY HISTORY: (M) Mother, (F) Father, (B) Brother, (S) Sister, (A) Aunt, (U) Uncle, (GM or GF) Grandparent

Diabetes____________	High Blood Pressure____________	Heart Disorder____________
Cancer ____________	Glaucoma____________	Macular Degeneration____________
"Cross Eyes" ____________	"Lazy Eye"____________	Color Blind____________
		Other____________

PERSONAL HISTORY:
PLEASE CIRLE THE APPROPRIATE *YES* OR *NO* ANSWER

	DATE	DATE	DATE
	(Complete first column only)	(Last two columns to be completed	at later exams)
Do you have or ever had:			
Diabetes	Y N	Y N	Y N
High Blood Pressure	Y N	Y N	Y N
Heart Disorder	Y N	Y N	Y N
Cancer	Y N	Y N	Y N
Stroke	Y N	Y N	Y N
Thyroid disorder	Y N	Y N	Y N
Major Surgery	Y N	Y N	Y N
Explain:			
Glaucoma	Y N	Y N	Y N
Macular Degeneration	Y N	Y N	Y N
"Cross Eyes"	Y N	Y N	Y N
"Lazy Eyes"	Y N	Y N	Y N
Color Blind	Y N	Y N	Y N
Injury or Surgery to eye	Y N	Y N	Y N
Explain:			
Other eye diseases:			
Explain			
Permanent head or eye injuries	Y N	Y N	Y N
Explain:			
Other :			
Explain			

CURRENT SYMPTOMS:

Eyes itch, burn or water excessively?	Y N	Y N	Y N
Frequent Headaches?	Y N	Y N	Y N
See double?	Y N	Y N	Y N
Use a computer? Hrs per day?	Y N	Y N	Y N
Smoke? Packs per day?	Y N	Y N	Y N
Frequently drink alcohol? Drinks per week?	Y N	Y N	Y N
Currently pregnant?	Y N	Y N	Y N

Name of physician ____________________

List *all* medications:

List *all* allergies:

List sports, hobbies, or activities:

Are you interested in:

Contact Lenses	Y N	Y N	Y N
Refractive surgery	Y N	Y N	Y N
Orthokeratology	Y N	Y N	Y N

Sorensen & Sorensen
Optometrists
Dr. Kevin C. Sorensen **Dr. Heather W. Sorensen**

We are excited to offer a VISUAL FIELD SCREENING to all of our patients. During your comprehensive examination your visual system and ocular structures will be evaluated for any visual abnormalities and pathology. However, the Visual Field instrument tests different areas within your visual system including your visual pathway through the brain. The screening may aid the doctor in evaluating diseases in their earliest stages.

The VISUAL FIELD SCREENING can aid in detecting eye diseases such as pituitary tumors, glaucoma, retinal and optic nerve disease, and retinal disturbances due to vascular problems or medications. It is especially important for patients with any systemic health problem, such as diabetes or hypertension, as well as any patient suffering from headaches.

Many diseases do not cause symptoms and this test is one more way to ensure disease is detected as early as possible.

We strongly recommend this test for all of our patients five years of age and older and recommend it be repeated yearly to monitor for any changes that may have occurred during the year.

Unfortunately, most insurance companies do not cover the cost of this test. However, we offer this test for a nominal fee of $10.

Please check the appropriate box below and sign.

(________) I would like a Comprehensive Examination (including the VISUAL FIELD SCREENING)

(________) I understand the importance of the VISUAL FIELD SCREENING and understand this test would be in my best interest, but, at this time, I prefer the General Eye Examination only. (Does not include Visual Field Screening).

Signed____Date_______/____/201__
Parent or Guardian Signature if under 18 years of age

**Please note that while this test is "optional" for some people, it represents preventative health care for others. It may be required to "rule-out" certain eye diseases. In the latter case, you may be able to submit your bill for the visual field screening to your major medical insurance company for reimbursement.

SORENSEN & SORENSEN, OPTOMETRISTS FINANCIAL POLICY:

Please review our Policy below, we will have you sign you agree to it before your visit at the office.

*Patient refers to patient or guarantor

When making an appointment at Sorensen & Sorensen, Optometrists a time has been reserved for your care, therefore a patient or dependent agrees to be held by our financial policy. If any questions remain, please call our office at 614-933-0575 for clarification.

Patients or their guarantor are responsible for timely payment of services or products ordered through our office. Upon request, we will provide an estimate of cost of specific services or cost of products. However, it is not possible to give exact charges for certain services until the doctor has seen the patient.

NO SHOW POLICY: ***The time of your appointment has been reserved for you and the Doctor is setting aside time for your care.*** Therefore, any patient who does not give 48 hours notice of a cancellation or does not show for a same day appointment will be charged $40. Your insurance company will not cover this fee and the charge will need to be paid before services will be rendered. We attempt to call patients as a reminder of an appointment, however, this is a courtesy we provide and has no effect on the no show policy.

PAYMENT: Payment is expected at time of service. We accept cash, check, Visa, Mastercard, Discover and Care Credit. A service charge is added to any credit card charge over the phone.

If you are later billed for charges not covered by your insurance company, payment is expected upon receipt of the bill. If payment is not received after 2 billing cycles, you will be charged $15.00. If payment is not received after 3 billing cycles, you will be turned over to our collection agency.

CONTRACTED MANAGED CARE: We are happy to work with your insurance company. However, it is your responsibility to bring your ***vision and medical insurance card*** to every visit. If you fail to bring your insurance card, you will need to pay for charges in full and then submit your receipt to your insurance company.

As a courtesy we attempt to call your insurance company and check on patient benefits. However, it is your responsibility to understand your insurance benefits. As per instructions from insurance companies, your insurance company does not guarantee payment for services until we have billed them. Therefore, a patient is responsible for any overages not covered by your insurance company.

We file to primary insurances only. If you have a secondary insurance that is not linked to your primary insurance you will be required to pay us and submit your receipts to your secondary insurance.

COPAY: As required by your contract with your insurance company, a copayment is a portion of the fees a patient or dependent is required to pay. A copayment is required to be paid at the time of service.

NON-COVERED SERVICES: Fees not covered by your insurance company will require payment at time of service.

NON-CONTRACTED MANAGED CARE: We have not contracted with certain managed care plans and we are not contractually obligated to accept the payment made by your insurance company as the “payment in full.” If your insurance company pays a portion of the fees, you will be responsible for the remaining balance.

REFERRALS: Some insurance companies require a referral from your primary care physician. It is your responsibility to know if your insurance company requires this and to obtain the referral before services are rendered in our office.

PAYMENT PLANS: If you are experiencing financial hardship and cannot make payment, it is your responsibility to call our office immediately. Under special circumstances, we will work out a payment plan with you. You will be required to pay 50% of your bill and we will extend a three month payment plan of equal payments for the remaining balance. Any products ordered will be held until full payment is received. Any failure to pay the monthly payments will render your account in delinquent status and will require your account to be transferred to our collection agency.

CARE CREDIT: We are happy to accept Care Credit for any purchase over $50.00. However, insurance benefits and/or discounts given on services or products cannot be combined with Care Credit.

RETURNED CHECK FEE: Any check returned for non-payment will be assessed a returned check fee by our collection agency.

NOTICE OF PRIVACY PRACTICES

SORENSEN & SORENSEN, OPTOMETRISTS

5495 New Albany Road West
New Albany, Ohio 43054
614-933-0575/ fax 614-933-0573

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 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 or 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 for anything but the above reasons, we will ask you for special written permission.

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 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 donation;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized governmental functions, such as protection of the president or high ranking governmental officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of the members of the foreign services;
- 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 respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your care.

APPOINTMENT REMINDERS

We may call or write to remind 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 at 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 can not 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 or fax 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 costs. If you want to ask for confidential communications, send a written request to the office contact person at the address or fax 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 or fax 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 our 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 or fax 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 disclosure. You are entitled one such list per year without charge. If you want more frequent lists, you will have to pay for them in advanced. We will usually respond to your request within 60 days of receiving it, but by law we can have on 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 or fax 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 address or fax 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 or fax 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 our office at the address or phone number shown at the beginning of this Notice.

Previous page for your records, please sign this page and bring it to your appointment.

ACKNOWLEDGEMENT OF RECEIPT

I Acknowledge that I received a copy of Sorensen & Sorensen, Optometrists Notice of Privacy Practices.

Patient Name____

Signature____ Date_________________