IMAGE OPTICAL

501 Baptist Drive. Suite 160
Madison, MS 39110
601-790-9820
FAX 601-790-9822
ImageOpticalms.com

Patient Information

Date _____ Please complete the **FRONT and BACK** of each page

Last Name _____ First Name _____ MI _____

Address _____City _____State _____ Zip _____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

SS# _____ Date of Birth _____ Age _____

E-Mail Address _____ **Gender** ☐Male ☐Female

Marital Status ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated **Ethnicity** ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Other_____ **Preferred Language** ☐ English ☐ Spanish ☐ Other _____

Employer _____Occupation _____

Employer Address_____

Spouse's Name _____ Date of Birth _____ SS# _____

Spouse's Employer _____ Work Phone (_____) _____

Person to contact in case of an emergency _____ Phone (_____) _____

Referred By ☐ TV ☐ Radio ☐ Billboard ☐Yellow Pages ☐ Insurance ☐ Website ☐ Brochure ☐ Self ☐ Print ☐ Family ☐ Friend ☐ Patient ☐ Physician **(Name of Dr., Friend, Patient)**_____

Preferred Method of Communication ☐Mail ☐Phone ☐Text Message Other_____

If Under 18 years of Age Please Complete

Mother's Last Name _____ First Name _____ MI _____

SS# _____ Date of Birth _____

Employer _____ Work Phone (_____) _____ Ext _____

Address if different from above _____

Father's Last Name _____ First Name _____ MI _____

SS# _____ Date of Birth _____

Employer _____ Work Phone (_____) _____ Ext _____

Address if different from above _____

Preferred Pharmacy Information

Pharmacy Name_____ Pharmacy Phone (_____)_____

Pharmacy Address_____City_____State_____Zipcode_____

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PLEASE GIVE ALL INSURANCE CARDS TO THE RECEPTIONIST

Primary Insurance _____ Policy # _____

Address _____ Group # _____

NOTE: IF THE NAME OF THE POLICY IS OTHER THAN THE PATIENT PLEASE COMPLETE THE FOLLOWING INFORMATION.

Subscriber/ Owner _____ Relation to patient _____

Social Security #_____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Secondary Insurance _____ Policy # _____

Address _____ Group # _____

Subscriber/ Owner _____ Relation to patient _____

Social Security #_____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

PLEASE READ AND SIGN THE STATEMENT BELOW

I request that assignment of my healthcare insurance benefits be made to Image Optical for any services furnished to me. I authorize the release of any medical information necessary to process these claims.

In order to decide if glasses are necessary and to get the correct prescription you must be refracted. Medical insurance plans will not cover this. You will be responsible for this fee on the date of service.

I understand and agree with the above information.

Patient Signature _____ Date_____

I understand that I, the patient or patient representative, are responsible for payments of charges for services rendered. A service charge of 1-1/2 % plus collection fees may be added to any outstanding balance due from patient. I give my consent to receive communications from servicers and collectors of my accounts, through 1) cell, landline, or text number that I provide, 2) email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

_____ Date _____

Responsible Party / Patient

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RECORD OF MEDICAL CARE PATIENT HISTORY QUESTIONNAIRE

INSTRUCTIONS: Please answer the following questions about your medical status and history.

Birth Date: ___/___/___ Last Medical Exam: ___/___/___ Last Eye Exam: ___/___/___

Name of Medical Doctor: _____ Medical Dr.'s Phone #: _____

Do you have **allergies to medications**: □ YES □ NO If yes, please list:

_____

List any Medications you take (**Including** oral contraceptives, aspirin, **eye drops** over the counter medications and home remedies):

□ **None**

_____

List any medical conditions (i.e., high blood pressure, diabetes, etc.) that you have had in the past or are currently experiencing.

_____

Have you **ever** taken Flomax or generic Flomax (Tamsulosin, Rapiflo, Avodart)? □ YES □ NO _____

Do you wear Contact Lenses □ Yes □ No If yes, please list Brand/ Strength/Power_____

List all major injuries, surgeries, heart attacks, strokes, and/or hospitalizations you have had:

(Include EYE Surgery, Laser, Injury) □**None**

_____

_____

Mark any of the following that you have / had: □ None □ Crossed eyes □ lazy eye □ drooping eyelid □ prominent eyes

□ glaucoma □ retinal disease or detachment □ cataracts □ eye infection □ eye injury □ Other _____

REVIEW OF SYSTEMS

INSTRUCTIONS: Do you currently or have you ever had any problems in the following areas:
(IF YES, please explain and list medications).

Neurologic		Explain			Explain
Headaches	□ YES □ NO	_____	Migraine Headache	□ YES □ NO	_____
Seizures	□ YES □ NO	_____	Ocular Migraine	□ YES □ NO	_____
Eyes					
Loss of vision	□ YES □ NO	_____	Blurred Vision	□ YES □ NO	_____
Distorted vision	□ YES □ NO	_____	Halos / Glare	□ YES □ NO	_____
Loss of side vision	□ YES □ NO	_____	Loss of central vision	□ YES □ NO	_____
Double vision	□ YES □ NO	_____	Mucous discharge	□ YES □ NO	_____
Dryness	□ YES □ NO	_____	Sandy / gritty feeling	□ YES □ NO	_____
Itching	□ YES □ NO	_____	Burning	□ YES □ NO	_____
Foreign Body Sensation	□ YES □ NO	_____	Excess tearing / watering	□ YES □ NO	_____
Eye Pain / Soreness	□ YES □ NO	_____	Redness	□ YES □ NO	_____
Seeing flashes / floaters	□ YES □ NO	_____	Tired eyes	□ YES □ NO	_____
Chronic infections	□ YES □ NO	_____	Stye / Chalazion	□ YES □ NO	_____

PATIENT NAME _____ DATE _____

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PATIENT HISTORY QUESTIONNAIRE (cont.)

Ear, Nose, Mouth, and Throat Explain

- Allergies □ YES □ NO
- Sinus congestion □ YES □ NO_____
- Post-nasal drip □ YES □ NO _____
- Dry throat / mouth □ YES □ NO _____
- Hay Fever □ YES □ NO _____
- Runny Nose □ YES □ NO _____
- Chronic cough □ YES □ NO _____

Respiratory

- Asthma □ YES □ NO _____
- Emphysema □ YES □ NO _____
- Chronic bronchitis □ YES □ NO _____

Cardiovascular

- High Blood Pressure □ YES □ NO _____
- Heart Pain □ YES □ NO _____
- Vascular Disease □ YES □ NO _____

Psychiatric

- Depression □ YES □ NO _____
- Anxiety □ YES □ NO _____
- ADD / ADHD □ YES □ NO _____

Gastrointestinal Explain

- Diarrhea □ YES □ NO_____
- Constipation □ YES □ NO _____

Genitourinary

- (genitals / kidney / bladder) □ YES □ NO _____

Bones / Joints / Muscles

- Rheumatoid Arthritis □ YES □ NO _____
- Joint Pain □ YES □ NO _____
- Muscle Pain □ YES □ NO _____

Lymphatic / Hematologic

- Anemia □ YES □ NO _____
- Bleeding □ YES □ NO _____

Endocrine

- Thyroid/other glands □ YES □ NO _____
- Diabetes □ YES □ NO _____
- High Cholesterol □ YES □ NO _____

SOCIAL HISTORY

INSTRUCTIONS: Please answer the following questions related to your social history

Tobacco: □ Current Every Day □ Current Some Day □Former □Never

Alcohol: □ Current Every Day □ Current Some Day □Former □Never

Illegal Drugs: □ Current Every Day □ Current Some Day □Former □Never

Infection/Exposure: □ Gonorrhea □ Syphilis □ HIV □ Hepatitis □ No Known Infection/Exposure

FAMILY HISTORY

INSTRUCTIONS: Please note any FAMILY history (parents, grandparents, siblings, and/or children, living or deceased) of the following medical conditions.

- Blindness □ YES □ NO _____
- Crossed Eyes □ YES □ NO _____
- Macular Degeneration □ YES □ NO _____
- Cataract □ YES □ NO _____
- Glaucoma □ YES □ NO _____
- Retinal Detachment / Disease □ YES □ NO _____
- Arthritis □ YES □ NO _____
- Diabetes □ YES □ NO _____
- High Blood Pressure □ YES □ NO _____
- Lupus □ YES □ NO _____
- Cancer □ YES □ NO _____
- Heart Disease □ YES □ NO _____
- Kidney Disease □ YES □ NO _____
- Thyroid Disease □ YES □ NO _____
- Other _____

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IMPORTANT MEDICAL INSURANCE INFORMATION

Thank you for choosing to trust *Image Optical* with your eye care. Our goal is to provide the best care and patient experience available. The information below is provided in an effort to help clarify the role and medical insurance in your care at our office. Image Optical does not participate in Vision Plans.

_____ *(Initial)*
If your visit results in a medical diagnosis (e.g. dry eye, cataract), your medical insurance will be filed. If you would like to file a claim against your vision plan, please request a copy of your superbill upon checkout.

_____ *(Initial)*
Because there is great variability in the benefits among individual Medical Insurance, it is not possible for us to determine on the date of service the exact amount you will owe to the doctor for the exam, refraction, the contact lens fitting process, and/or contact lens supply. Please understand there is a possibility you will be billed further for any amount your insurance plan deems non-covered. The amount you may have paid in the office is an estimate only.

_____ *(Initial)*
If you do not have a medical diagnosis, and the exam, refraction, the contact lens fitting process, and/or contact lens supply is your financial responsibility.

We hope this information is helpful in explaining the role of Medical Insurance. We also have a dedicated billing staff that is available to assist you at any time at your request. We thank you again for choosing us to be your eye care provider.

Patient Signature _____ Date_____

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Authorized Release of Personal Medical Information

Please list family member/others who may need to speak with any of our staff regarding, but not limited to, your medical information such as:

- Coordination of Care
- Billing / Insurance
- Scheduling

Name_____Relationship_____Phone Number_____

Name_____Relationship_____Phone Number_____

Name_____Relationship_____Phone Number_____

Please list any Specific Instructions or Limitations:

_____

_____

_____

This authorization will remain in effect unless request is received by our office in writing.

By signing this form, I authorize the release of my personal medical information to above persons.

_____ _____

Patient / Authorized Signature Date

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Patient Acknowledgement of Receipt of Notice of Privacy Practices And Patient Rights and Responsibilities

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice of Privacy Practices before signing this acknowledgement.

A copy of our Patient Rights and Responsibilities has also been provided to you, and explains your rights as a patient in the event that an in office or surgical procedure is to be performed.

As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a copy by requesting a copy in writing from:

Privacy Officer
Image Optical
501 Baptist Drive
Suite 160
Madison, Mississippi 39110

By signing this form, you acknowledge that you have received and reviewed a copy of our Notice of Privacy Practices and our Patient Rights and Responsibilities, and have no further questions regarding these forms.

Patient Signature _____ Date_____

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Please read each statement and initial documenting that you reviewed and understand the policies.

Breach of Security Statement

In the event of a security breach or other system wide correspondence that requires my notification, I authorize you to contact me by the email address I provided to you.

_____
Initial

I understand that:

- If I do not have access to email, that I will be informed by phone or mail;
- That I am responsible for giving you any updates of my email address; and that Image Optical will not be held responsible if they are unable to contact me if I have not done so.

Fee for Release of Records

_____
Initial

I understand that there may be a charge for providing me or my representative(s) with copies of my medical records in accordance with the guidelines provided by the MS State Board of Medical Licensure.

Fee for Completion of Forms

_____
Initial

I understand that there may be a charge for completing forms such as, but not limited to, appeals or prescriptions, insurance, and physicals.

Fee for Same Day Work-In

_____
Initial

If I have a medical problem and seen as a same day work in patient, I may be charged CPT Code 99058. This charge may not be paid for by my insurance company.

Signature _____

Printed Name_____

Date_____

Notice of Privacy Practices

Image Optical, LLC

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.

Effective: April 14. 2014

The physicians and staff of Image Optical, LLC, are legally required to protect the privacy of your health information and to abide by the requirements stated in this document. This Notice of Privacy Practices describes our legal duty to protect the privacy of your health information and the policies and procedures this office has in place to do so.

Our office is required to prominently post the most current notice at all times. A copy of the current Notice of Privacy Practices for Image Optical LLC, will be given to each patient on their first visit. You will be asked to sign an acknowledgement that you received a copy. A copy of this notice will be provided to any individual upon request.

If you need additional information about anything contained in this notice please contact our Privacy Officer by calling 601-790-9820. We encourage you to ask questions about anything that you do not understand.

The Image Optical, LLC, reserves the right to change its Notice of Privacy Practices without advance notice to you and apply the revised Notice of Privacy Practices to your health information. Any changes that are made will be highlighted on the most current Notice of Privacy Practices that is posted in our office so that they are easily recognized. If changes are made to this Notice of Privacy Practices, you will be provided a copy of the revised Notice on your first visit following the revision.

The Image Optical, LLC, has policies and procedures to insure that your health information is protected. These include specific guidelines for how and when your health information is used, when and how it is disclosed, how confidentiality is maintained, who has access to your health information, and when your health information can be shared with others.

Our office with use and disclose your health information to provide your care and treatment, bill and collect payment of services received and carry out the routine health care operations of this office. The uses and disclosures include but are not limited to the following:

- *Administrative functions within the office-assembling health information, filing records, scheduling appointments, reminding patients of appointment and other scheduled activities, billing and collecting for services*
- *Record creation, documentation and monitoring of your health status*
- *Communication among the workforce of this office, either verbally or in writing, information that is required for them to perform the functions of their job*
- *Consulting with other providers and their workforce, providing health information as required and making referrals*
- *Verifying your benefits and eligibility with your insurance company*
- *Obtaining authorization from your insurance company as required*
- *Calling in prescriptions to your pharmacy*
- *Providing health information as needed for scheduling appointments for diagnostic tests, surgery, admission, consultations, home health and other services that you may require*
- *Providing health information to your insurance company as requested for their administrative requirements*

Our office may contact you directly by phone, answering machine, fax, electronically or by mail for any of the following activities:

- *Providing appointment reminders for this office*
- *Scheduling appointments for this office and/or other offices as necessary and providing you with appointment information*
- *Describing or recommending treatment alternatives*
- *Providing pre-test instructions and test results*
- *Providing information about health related benefits and services that may be of interest to you such as classes or educational opportunities*

Notice of Privacy Practices

If **Image Optical, LLC**, needs to treat you in an emergency situation, you will be provided with a copy of the Notice after your emergency has been taken care of and a good faith effort will be made to obtain your acknowledgement of receipt of this Notice.

Your health information may be used and disclosed without your authorization in the following circumstances if you are informed and given the opportunity to agree or object. If you are not present or the opportunity for you to agree or object cannot be provided, we may decide whether the disclosure is in your best interest based on professional judgment.

- *To a family member or other relative, close personal friend, or other person identified by you, the health information relevant to that person's involvement in your care or payment*
- *For suspected child abuse or neglect as required by law*
- *To a public or private organization authorized by law to assist in disaster relief efforts as required by law*

Notice of Privacy Practices

Your health information may be used without your authorization or the opportunity for you to agree or object in the following circumstances as required by law.

- *To the Food and Drug Administration to report adverse events including adverse drug reactions and product defects or problems as required by law*
- *To your employer if you have a work related injury or illness or a workplace related medical surveillance as required by law*
- *To a government authority if you are a victim of abuse, neglect or domestic violence (you must be informed of such a report unless, in the exercise of professional judgment it puts you at risk of serious harm) as required by law*
- *To a health oversight agency as authorized by law including audits; civil, administrative or criminal investigations; inspections; licensure or disciplinary actions are required by law*
- *In response to a court order or court-ordered warrant, a subpoena or summons issued by a judicial officer, a grand jury subpoena or administrative request as required by law*
- *To law enforcement officials for the purpose of identifying or locating a suspect, fugitive, material witness or missing person as required by law*
- *To law enforcement officials if you are suspected to be a victim of a crime as required by law*
- *To law enforcement officials of a death if we suspect that the death may have resulted from criminal conduct as required by law*
- *To a coroner or medical examiner for the purpose of identification, determining a cause of death or other duties authorized by law*
- *To a funeral director as necessary to carry out their duties as required by law*
- *To organ procurement organizations engaged in procurement, banking or transplantation of cadaver organs, eyes, or tissue as required by law*

All other uses and disclosures of your health information will require your specific authorization.

You have the following rights regarding your health information:

- *The right to request restrictions on how your health information is used or disclosed. Every effort will be made to honor your request but we are not required to agree to a requested restriction*
- *The right to receive confidential communications of health information*
- *The right to see and received a copy of your health information*
- *The right to request an amendment or correction to your health information*
- *The right to receive an accounting or list of each time your health information has been disclosed. The first accounting within a twelve-month period is provided at no cost to you. The provider may charge a reasonable cost-based fee for each subsequent request within the twelve month period.*

If you believe your privacy rights have been violated, you may make a complaint to our Privacy Officer by calling 601-790-9820 or in writing to the office address. You may also make a complaint to the Secretary of Health and Human Services at the address listed below. The complaint must be in writing and contain the name of the physician or office, describe the act or omission believed to be in violation and must be filed with 180 days of the incident. You will not suffer any retaliation for filing a complaint.

Secretary of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

William Ashford, M.D., Kevin Kosek, M.D., Elizabeth Wyatt Mitchell, M.D.

*Note: Image Optical, LLC

Patient Rights and Responsibilities

Patient rights and responsibilities are established with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his family, his physician, and the facility caring for the patient. Patients shall have the following rights without regard to age, race, sex, national origin, religion, cultural, physical handicap or personal value and belief systems.

Standard 1.
That the patient will receive the care necessary to help regain or maintain their maximum state of health and, if necessary, cope with deaths.

Standard 2.
That the facility personnel who care for the patient are qualified through education and experience to perform the services for which they are responsible. The patient has the right to identify the professional status of all individuals providing services to them.

Standard 3.
That the patient will be treated with consideration, respect, dignity, and full recognition of individuality; including privacy in treatment and in care. Facility personnel will keep adequate records and will treat with confidence all personal matters that relate to the patient.

Standard 4.
That the patient is provided to the extent known by the physician, complete information regarding diagnosis, treatment and prognosis as well as alternate treatments or procedures and the possible risks and side effects associated with treatment. If medically inadvisable to disclose to the patient such information, the information is given to a person designated by the patient or to a legally authorized individual.

Standard 5.
That the patient or responsible person will be fully informed of the scope of services available in the facility, provisions for after hours and emergency care, payment policies, and related fees for services. The patient will accept personal financial responsible for any charges not covered by his/her insurance.

Standard 6.
That the patient will be a participant in decisions regarding the intensity and scope of treatment. Circumstances under which the patient may be unable to participate in his/her plan of care are recognized. In these situations, the patient's rights shall be exercised by the patient's designated representative or other legally designated person.

Standard 7.
That the patient will have the right to refuse treatment to the extent permitted by the law and to be informed of the medical consequences of such refusal. The patient will be requested to sign a release of responsibility form and if refused, a registered letter will be sent.

Standard 8.
That plans will be made with the patient and family so that continuing services will be available to the patient throughout the period of need. The plans should be timely and involve the use of all appropriate personnel and community resources.

Patient Rights and Responsibilities

Standard 9.
That the patient and family are responsible for providing to their caregivers the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, unexpected changes in the patient's condition, medications, including over-the-counter and dietary supplements, any sensitivities or allergies, or any other patient health matter.

Standard 10.
That patient disclosures and records are treated confidentially. That the patient has the right to approve or refuse the release of medical records to any individual outside the facility, except as required by law or third party payment contract.

Standard 11.
That the patient has the right to be informed of any human experimentation or research/educational projects affecting his/her care or treatment and refuse participation in such experimentation or research without compromise to the patient's usual care. The patient also has the right to review this decision periodically.

Standard 12.
That the Surgery Center provides for and welcomes the expression of grievances/complaints and suggestions by the patient at all times. This feedback allows the Center to understand and improve the patients care and environment.

Standard 13.
That the patient has the right to change primary or specialty physicians if other qualified physicians are available.

Standard 14.
That the patient has the right to be free from all forms of abuse or harassment.

Standard 15.
That the patient has the right to exercise his or her rights without being subjected to discrimination or reprisal.

Standard 16.
That the patient has the right to present a Advanced Directive, living will, or healthcare proxy. These documents express the patient's choices about future care or name someone to decide if the patient cannot speak for himself/herself. The patient who has an Advanced Directive must provide a copy their physician for their wishes to be made known and honored.

Standard 17.
That the patient has a right to be fully informed before any transfer to another facility or organization.

Standard 18.
That the patient be respectful of the health care providers, staff, and other patients.

Standard 19.
That the patient has a responsibility to observe the prescribed rules of the Surgery Center for their stay and treatment and, if instructions are not followed, forfeits the right to care at the center and is responsible for the outcome.

Image Optical, LLC:

Owners: William C. Ashford, M.D.
Elizabeth Wyatt Mitchell, M.D.
Kevin Kosek, M.D.