Patient # _______

Commerce Vision Group
Dr. Brenda Rosado

Date ____/____/_______

Patient Name: Last: ______________________ First: ______________________
Address: ______________________ **Phone:** (_____) ______________________
City, State, Zip: ____________, ______ ____________ **Cell:** (_____) ______________________
E-Mail: ______________________ **Text Messaging:** Yes No
Birthdate: _____/_____/________ **Gender:** M F **Social Security #** _____-_____-________
Ethnicity/Race: ______________________ **Language Preference:** ______________________
Employer: ______________ **Occupation:** ______________ **Hobbies:** ______________

General Health History (Please list **any** and **all** known problems): *Check here if None:* ☐

Seasonal Allergies	Hypertension	Heart Disease	High Cholesterol	Thyroid Disease
Digestive Problems	Urinary Disorder	Autoimmune Disorder	Skin Disorder	Blood Disorder
Arthritis	Back Pain	Neurologic Disorder	Psychiatric Disorder	Asthma

Diabetes (Please include date of diagnosis): ______________
Other health issues (please specify): ______________________
Smoking Status: Never smoked Occasional Everyday *If Smoker, Years Smoked:* _______

Medication History (Please list ***any*** and ***all*** medications currently taken): *Check here if None:* ☐
____
____
Allergies to Medications: ______________________ *Check here if None:* ☐

Personal Eye History (Please list ***any*** and ***all*** known eye problems) *Check here if None:* ☐

Glaucoma	Cataracts	Keratoconus	Lazy Eye	Macular Degeneration
Eye Injury	Eye Infection	Eye Surgery	Floaters	Retinal Detachment
Allergies	Dry Eye	Color Deficiency	Pterygium	Diabetic Retinopathy

Other (Please specify): ______________________
Do you wear glasses?: Yes No For: Distance Near Computer
Do you wear contact lenses?: Yes No Type/Brand: ______________________
Are you interested in LASIK?: Yes No Done in past (Please list year): ______________

Family Health History (Please list ***any*** and ***all*** known problems) *Check here if None:* ☐

Hypertension	Relationship: ______________	Glaucoma	Relationship: ______________
Diabetes	Relationship: ______________	Cataracts	Relationship: ______________
Thyroid Disease	Relationship: ______________	Macular Degeneration	Relationship: ______________
Cancer	Relationship: ______________	Keratoconus	Relationship: ______________

Other (Please list any other known conditions not listed above): ______________________

Emergency Contact: ______________ Relationship: ______________ Phone: (_____) ______________
Primary Care Physician: ______________________ Phone: (_____) ______________
Vision Insurance: ______________________ **Health Insurance:** ______________________

Authorization Signature: ______________________
How did you hear about us? ______________________

All information disclosed on this form is strictly confidential and conforms to HIPAA regulations.

NOTICE OF PRIVACY POLICY AND HIPAA COMPLIANCE

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. "Health information" for the purposes of this Notice refers to any information that identifies you and is created, received, maintained, or transmitted by us in the course of providing health care items or services to you.

We are required by the Health Insurance portability and Accountability Act of 1009 (HIPAA) and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal dutied and provacy practices with respect to such infrmation, and to abide by the terms of this Notice. The Notice contains a patient's rights section describing your right under the law. You ascertain that by your signature you have reviewed this Notice before signing this consent. The terms of the Notice may change, if so, you will be notified at your next visit to update your signature.

HIPAA allows for the use of personal protected health information to be used for treatment, payment, or healthcare operations. Examples of how we use or disclose your health 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 filed; referring you to another doctor for eye care; or getting copies of your health information from another professional you may have seen before us. Examples of how we use or disclose your health insurance information for payment purposes are: asking you about your heath or vision care plans; preparing and sending bills or claims; and collectiong unpaid amounts. "Health care operations" mean those administrative and managerial functions we must carry out to run our office, for example: financial or billing audits; internal quality assurance; participation in managed care plans; and record storage. You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction in all cases. Requests must be submitted in writing

By signing this form, you consent to our use and disclosure of your protected healthcare information and potential anonymous usage in publication. You have the right to revoke this consent in writing, with signature. Revocation will not apply retroactively.

By signing this form, I understand that:

- My protected health information may be used or disclosed for treatment, payment, or healthcare operations
- The office reserves the right to change the privacy policy as allowed by law
- I, the patient, have the right to restrict the use of my protected health information with a written request, though the practice is not required to agree to those restrictions.
- I, the patient, may revoke this consent in writing at any time and all full disclosures will them will cease
- I, the patient, may request to inspect or obtain a copy of my health information by making a written request. I understand that if I request a copy of my health information, I may be charged a fee for the cost of copying, mailing, or other supplies.
- The practice may condition receipt of treatment upon execution of this consent

May we phone, email, or send you a text to confirm appointments? YES NO

May we we a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with designated individuals? YES NO

If yes, please name individuals allowed to recieve your health information:____
____
____

Patient Name: ____
(Please Print)

Signature of Patient or Legal Guardian of Patient: ____

COMMERCE VISION GROUP, LLC

FINANCIAL POLICY

The doctors and staff are committed to providing you with thorough, professional eye care. If you have medical insurance that covers eye care or other vision insurance, we will be glad to complete any forms you may have and assist you in obtaining your maximum allowed benefits.

Payment for services is due at the time the services are rendered unless other payment arrangements have been made and approved by our staff. We prefer payment in full when ordering glasses and contacts. However, a deposit of 50% can be made to initiate the order on glasses orders. The remaining balance will be due at dispensing.

We accept **CASH, CHECKS, VISA, MASTERCARD, DISCOVER and CARE CREDIT.** There will be a $35 charge for any returned check fee for non-sufficient funds.

Insurance: We participate and accept assignments on several vision and medical plans. This means at the time of the exam, you will be responsible for any co-payments, deductibles or fees for non-covered services. We will bill and receive payment directly from your insurance carrier for covered services. You will be responsible for any remaining balance.

There will be a $45 refraction fee, if we file your medical insurance and you receive a prescription for glasses or contacts. The refraction is not covered under any medical insurance plan; therefore, it is the patient's responsibility and paid at the time of service.

If you need a referral from your primary provider it is your responsibility to obtain that referral prior to your examination. A referral with an authorization number is not a promise to pay for that visit. If for some reason you were not eligible for services at the time of the examination, your insurance may deny payment and you will still be responsible. Your insurance coverage is a contract between you and your insurance company. Our fees for covered services normally fall within acceptable ranges set by most insurance companies and are usually covered up to the maximum allowance set by each carrier. Not all services are a covered benefit in all contracts and routine eye care and or other selected procedures may be specifically excluded making the patient responsible for the charges.

We must emphasize that as eye care professionals our relationship is with you and your insurance company. You are ultimately responsible for all fees for other services and materials delivered to you by this office. We realize that temporary financial problems may affect timely payment on your account. If such problems do arise we encourage you to contact us promptly and we will assist you in providing you a payment arrangement.

Our employees will be happy to assist you if you have any questions about the above information or your insurance coverage.

Thank you for choosing ***COMMERCE VISION GROUP*** for your ***EYE CARE*** needs.

______________________________________ ___________________________

Signature Date