Welcome to our Office

Patient Name_____

(Last) **(First)**

Address_____**City**_____**Zip**_____

Date of Birth_____**Social Security**_____**Sex M**_____**F**_____

Are you: (please circle one) Minor Married Divorced Widowed Single Title MR MRS

Home Phone:_____**Cell:**_____**Daytime phone**_____

EMail_____**Occupation:**_____**Employer:**_____

RESPONSIBLE PARTY

Name_____**Relationship to Patient**_____

Address (if different form above)_____

Date of Birth_____**Social Security**_____**Phone**_____

MEDICAL & VISION INSURANCE

MAJOR Medical_____**Member ID**_____

Member date of birth_____**Member Name**_____

***VISION INSURANCE*:**_____**Member ID:**_____

Member date of birth_____**Name**_____**Relationship**_____

Regarding insurance: While it is our pleasure to complete insurance forms, we do not accept assignment of benefits withour prior authorization. *We can not bill your insurance company unless you give us your current information*. Your insurance policy is a contract betweenyou and your insurance company: we are not a party to that contract. If your insurance company has not responded with payment after 45 days from the date of service, you may receive a bill for payment due. It is your rsponsibility to provide your insurance company with correct information at all times and to be aware of your policy's benefits. Please be aware that some, and perhaps all, of the services provided may be a non-covered service and considered reasonable and necessary under the MediCare Program and/or other medical insurances.

MEDICAL INFORMATION

***What is YOUR General Health*?**_____

Do you have any problems with the following symptoms? (please circle all that apply)

EYES	**Gastrointestinal**	**Integumentary (skin)**	**Blood/Lymph**
Ears/nose/throat	**Genitourinary**	**Nervous**	**Respiratory**
Cardiovascular	**Musculoskeletal**	**Endocrine (glands)**	**Mental**
Allergic/Immune	**High Blood Press**	**High Cholesterol**	**Diabetes**

Please Circle if any apply to you:

Diabetes Type 1 Type II Allergies Headaches Operations_____

Allergy to Medications_____

Other known health problems:_____

CURRENT MEDICATIONS:_____

Do you use: Cigarettes/tabacco_____Alcohol?_____Other substance?_____

Do you have (please circle): GLAUCOMA DRY EYE CATARACTS
BLURRED VISION EYE INJURY_____

*****Do you currently wear glasses?_____**

*****Do you currently wear contacts?_____Brand?_____**

Have you had any EYE OPERATIONS?_____

Family Doctor_____Tetanus shot_____

FAMILY HISTORY

			Relationship to you (mother, father, grandparent)
HIGH BLOOD PRESSURE	**Y**	**N**	_____
DIABETES	**Y**	**N**	_____
GLAUCOMA	**Y**	**N**	_____
MACUALR DEGENERATION	**Y**	**N**	_____
RETINAL DETACHMENT	**Y**	**N**	_____
CATARACT	**Y**	**N**	_____

FINANCIAL POLICY **Thank you for choosing us as your vision care provider. We are committed to your treatment being successful. Please understand that payment for professional services is due upon completion of the examination. Any balance over 30 days is subject to a 5% monthly finance charge. Accounts requiring collecyion assistance are subject to an additional 68% in collection agency fees. There is a $30 charge for all return checks.**

AUTHORIZATION **I certify that I have read and undestand that all information and questions have been answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I hearby consent for the use or disclosure of my indivually identifiable health information to carry out treatment, payment, or health-care operations. This includes assignment of benefits from insurance companies. This consent is authorized for the following health care providers: Dr Kristyna Lensky Sipes. I understand that I have the right to request that this provider restrict how protected health information is used or disclosed to carry out treatment, payment, or health-care operation. i have the right to revoke consent in writing except that the provider has taken prior revocation. I understand this authorization is voluntary.**

SIGNATURE OF PATIENT ***DATE***

_____ _____

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the the terms of this Notice of Privacy Practice until we choose to change it. We reserve he right 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 pracrtices 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 Practice, we will post the new one in our office and have the copies available in our office.

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 Helath 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, fax, or Email 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 the office contact person at the address or phone number shown at the begining of this Notice.

aCKNOWLEDGEMENT OF RECIEPT

I acknowledge that I received a copy of Stanford Ranch Optometry Notice of Privacy Practices

Patient name_____

Signature_____

I authorize _____access to my records.

Effective date of notice: 1/1/2015

Stanford Ranch Optometry

2351 Sunset Blvd 190, Rocklin CA 95765

916-624-9396 Fax 916-624-9215 Email stanfordranchoptometrykl@gmail.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESSTO 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 your health information and what rights you have regarding it.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record. You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).

Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting us at the number listed above. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: 1) Share information with your family, close friends, or others involved in your care. 2) Share information in a disaster relief situation. 3) Include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission: 1) Marketing purposes. 2) Sale of your information. 3) Fundraising - We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways. 1) Treat you. We can use your health information and share it with other professionals who are treating you. 2) Run our organization. We can use and share your health information to run our practice, improve your care, and contact you when necessary. 3) Bill for your services. We can use and share your health information to bill and get payment from health plans or other entities.

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.
Help with public health and safety issues. We can share health information about you for certain situations such as: 1) Preventing disease. 2) Helping with product recalls. 3) Reporting adverse reactions to medications. 4) Reporting suspected abuse, neglect, or domestic violence. 5) Preventing or reducing a serious threat to anyone's health or safety.
Do research. We can use or share your information for health research.
Comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests. We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests. We can use or share health information about you: 1) For workers' compensation claims. 2) For law enforcement purposes or with a law enforcement official. 3) With health oversight agencies for activities authorized by law. 4) For special government functions such as military, national security, and presidential protective services.
Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

1) We are required by law to maintain the privacy and security of your protected health information. 2) We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 3) We must follow the duties and privacy practices described in this notice and give you a copy of it. 4) We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. 5) For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html. 6) Changes to the Terms of this Notice.

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office.

APPOINTMENT REMINDERS

We may call or write to remind you 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.