HIPAA ACKNOWLEDGEMENT OF RECEIPT

HERITAGE VISION CENTER, PC

The United States Federal Government enacted the Health Insurance Portability and Accountability Act (known as HIPAA) in 1996 to provide data privacy and security provisions for safeguarding medical information. We take the protection of your personal information very seriously here at Heritage Vision Center. Please refer to the Notice of Privacy Practices from the American Optometric Association that has been made available to you today which describes these provisions. Then sign the option below that directs Heritage Vision Center regarding your wishes on the handling of your personal health information.

(Please Sign One)

I acknowledge that I have been informed of the Health Insurance Portability and Accountability Act (HIPAA). I **DO NOT** release my personal information to any other person or party unless required by contract (i.e., insurance company, etc.).

Patient Name: _____

Patient or Guardian Signature: _____ Date: _____

OR

I acknowledge that I have been informed of the Health Insurance Portability and Accountability Act (HIPAA). I **DO** release my personal information to the following persons (please circle all persons that you approve): *Spouse, Father, Mother, Adult Children, Others as noted*: _____

Patient Name: _____

Patient or Guardian Signature: _____ Date: _____

HERITAGE VISION CENTER PATIENT REGISTRATION FORM

Jacquelyn Delplanche, O.D., M.Ed., and Curtis Delplanche, MD, O.D. Owners
20 NW 185TH Ave Aloha, Oregon 97006
Phone: 503-629-5200 – Fax: 503-629-0419

WELCOME TO OUR OFFICE! PLEASE TAKE A FEW MINUTES TO COMPLETE THIS FORM:
PATIENT'S INFORMATION:

PATIENT'S NAME_____ (Preferred Name)_____
STREET ADDRESS: _____
CITY: _____STATE:_____ ZIP:_____
PATIENT'S SOCIAL SECURITY NUMBER (**SSN**) _____
PATIENT'S DATE OF BIRTH:_____AGE:_____
GENDER:_____ ETHNICITY/RACE:_____
PHONE: (CELL) _____(DAY) _____(EVE) _____
EMAIL:_____
MARITAL STATUS; Married: _____Single: _____ Other:_____
SPOUSE'S NAME: (Or Parent's if a minor) _____
EMPLOYMENT COMPANY:_____FT:__PT: __Student:___ FT:__PT: __
WHAT BRINGS YOU IN TODAY? _____
ARE YOU INTERESTED IN CONTACTS? Yes: _____No:_____ Maybe:_____
HOW DID YOU HEAR ABOUT OUR OFFICE? Friend: _____Insurance Co____ Internet_____

FINANCIAL INFORMATION: Payment for your personal balance is required at the time services are rendered. If glasses or contacts are ordered, a minimum payment of half of the total balance is required before the order will be placed. The remaining balance must be paid in full before materials will be dispensed to the patient. For your convenience, we accept personal checks, Visa, MasterCard, Discover, American Express and Care Credit cards.

PATIENT'S VISION INSURANCE:

INSURANCE COMPANY:_____SUBSCRIBER NAME: _____
INSURANCE ID:_____ SUBSCRIBER SSN: _____
GROUP NUMBER:_____SUBSCRIBER DOB: _____
RELATIONSHIP TO PATIENT:_____SUBSCRIBER EMPLOYER:_____

This office also performs medically necessary vision tests for ailments such as Diabetes, Glaucoma, Cataracts, Trauma and various eye health problems. These exams/procedures are billed to the individuals' medical insurance.

THIS SECTION IS FOR MEDICAL INSURANCE INFORMATION:

INSURANCE COMPANY:_____SUBSCRIBER NAME: _____
INSURANCE ID:_____SUBSCRIBER SSN: _____
GROUP NUMBER:_____SUBSCRIBER DOB: _____
RELATIONSHIP TO PATIENT:_____SUBSCRIBER EMPLOYER: _____

PRIMARY CARE PHYSICIAN (PCP) NAME:_____
PCP PHONE NUMBER:_____ PCP FAX NUMBER:_____

I hereby authorize payment of my insurance benefits directly to Heritage Vision Center, PC and/or doctor(s). If the account goes to collections for nonpayment, I understand that I will be responsible for all collection fees. I agree to be financially responsible for all non-covered services and materials that I receive from Heritage Vision Center.

Patient or Guardian Signature:_____ DATE:_____

Patient History Questionnaire

Today's Date _____

IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.

Last Name _____ First Name _____ MI _____
Address _____ City _____ State_____ Zip _____
Work Phone _____ Home Phone_____
Date of Birth_____ Occupation_____ Employer _____
Emergency Contact Name _____ Phone Number_____
Date of Last Eye Exam _____ Dilated? Yes/No · Referred By_____
Primary Vision Coverage _____ Secondary Coverage _____

Medical Information

How is your general health? _____
Do you take medications for any of these systems? **(Please circle yes or no.)**

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High blood pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain _____
Diabetes Yes/No_____ Type _____ Date of diagnosis _____
Allergies to medication Yes/No Which? _____ Reactions? _____
Other health problems _____
Current medication(s)_____
Have you had any operations? Yes/No Kind? _____ When? _____
Name of family doctor and/or primary care physician _____
Date of last visit _____ Date your blood pressure was last checked _____

Family History

High blood pressure	Yes/No	Relation	_____	Macular degeneration	Yes/No	Relation	_____
Diabetes	Yes/No	Relation	_____	Retinal detachment	Yes/No	Relation	_____
Glaucoma	Yes/No	Relation	_____	Cataracts	Yes/No	Relation	_____

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind?_____
Have you had any eye operations? Yes/No Type _____ Date _____
Have you had an eye injury? Yes/No Kind_____ Date _____

Do you have glaucoma?	Yes/No	Cataracts?	Yes/No	Dry eyes?	Yes/No
Macular degeneration?	Yes/No	Retinal detachment?	Yes/No	Blurred vision?	Yes/No
Do you wear glasses?	Yes/No	Contact lenses?	Yes/No	Type	_____

Additional information _____

Doctor Use Only

Reviewed by _____ ❍ No changes Date _____
Reviewed by _____ ❍ No changes Date _____
Reviewed by _____ ❍ No changes Date _____

DILATED FUNDUS EXAMINATION (DFE) CONSENT FORM

The doctors and staff at Heritage Vision Center, PC strive to provide our patients with the highest quality of vision care possible. As part of this commitment, we offer our patients the option to have a Dilated Fundus Examination (DFE), which is an integral component of our comprehensive visual examination. There is no additional charge for the DFE if it is done on the same day as the comprehensive visual examination, although there is an additional fee if it is done at a later date.

The Dilated Fundus Examination involves instilling eye drops that dilate the pupils to allow your doctor a better view inside your eyes. The internal health of the eye cannot be fully evaluated without dilating the pupil and many ocular diseases cannot be detected without the DFE. The DFE is recommended for most patients on a yearly basis, especially adults.

The DFE typically consists of instilling two drops in each eye, although occasionally more drops may be necessary. The first eye drop is a yellow-colored anesthetic (benoxinate hydrochloride 0.4% with fluorescein sodium 0.25%), which will numb the front portion of the eye (cornea). Your doctor will then check your eye pressures with a probe that briefly touches your corneas to test for glaucoma. The numbing effect usually begins within one minute and lasts approximately 15 minutes. It is important that you do not rub your eyes to avoid scratching them. This drop can stain soft contact lenses.

The second eye drop (usually tropicamide 0.5% or 1%) will begin dilating the pupils and relaxing the focusing muscles in the eyes within several minutes after installation. These effects last approximately 4-6 hours, but occasionally they may last longer. Other eye drops (such as phenylephrine and/or cyclopentolate) may be used in certain circumstances, such as assessing children with certain eye disorders, and in these cases the dilation may last considerably longer.

During the time that your eyes are dilated, you will likely experience increased light sensitivity (especially to sunlight), mild eye irritation, difficulty focusing on near objects (especially reading), and possibly some blurring at a distance. We recommend wearing sunglasses after the DFE and our office will supply you with a free pair of disposable sunglasses.

Most patients are able to safely drive after the DFE, although some patients may have difficulty driving, especially those that are far-sighted without correction. The DFE can be rescheduled for a different time to allow for alternative driving arrangements to be made if desired. If you do not feel that you can drive safely after the DFE, please tell our staff.

As with any medical procedure, there are potential risks with the DFE, but these are rare. The most significant risk is the very small possibility (less than one in 5,000) of developing angle-closure glaucoma. Your doctor will screen you for this potential risk before doing the DFE. However, if you experience any unusual symptoms after the DFE, such as worsening eye pain, please call our office immediately or go to the emergency department. Light sensitivity is expected after the DFE.

Please check the appropriate box below noting your desires regarding the DFE and sign the form after you have read and understood the risks and benefits of the DFE. If you have any questions, please ask your doctor or our staff.

_____ **YES**...I would like to have the DFE done as part of my comprehensive vision examination today, and I understand the benefits and risks of the DFE as detailed above.

_____ **NO**...I do not want to have the DFE done as part of my comprehensive vision examination today, but I wish to reschedule it for another day. I understand that there is an additional $50.00 fee if the DFE is done at a later date.

_____ **NO**...I do not want to have the DFE done either today or later. I understand that my doctor cannot fully evaluate my eye health without performing the DFE, and thus I waive any liability against my doctor and Heritage Vision Center, PC that may result from vision loss and/or complications from any undetected ocular disorders.

Patient Name: _____ **DOB:** _____

Patient or Guardian Signature: _____ **Date:** _____