**TERRY E. ROBINSON, M.D.**
**EYE PHYSICIAN AND SURGEON**
500 COFFMAN STREET, SUITE 109
LONGMONT, CO 80501

# PATIENT INFORMATION

Please PRINT CLEARLY and fill in ALL areas

LAST NAME_____ FIRST NAME_____ MI_____

NAME YOU PREFER_____ EMAIL ADDRESS_____

ADDRESS_____
Address City State Zip

HOME PHONE_____-_____-_____WORK PHONE_____-_____-_____CELL PHONE_____-_____-_____

Gender: MALE ☐ FEMALE ☐ Marital Status: SINGLE ☐ MARRIED ☐ OTHER ☐ Spouse/Partner Name _____

SOCIAL SECURITY NUMBER _____-_____-_____ DATE OF BIRTH _ _ / _ _ / _ _ _ _
M M D D Y Y Y Y

Do You Drive? Y ☐ N ☐ DRIVERS LICENSE_____
Number State

EMPLOYER'S NAME_____PHONE_____-_____-_____

EMPLOYER ADDRESS_____
Address City State Zip

PRIMARY CARE DOCTOR_____ PHONE_____-_____-_____

PHARMACY_____ PHONE_____-_____-_____

EMERGENCY CONTACT_____PHONE_____-_____-_____

WHO REFERRED YOU TO OUR OFFICE?_____

## PATIENT INSURANCE INFORMATION

We require current copies of your insurance card(s) before we will file the claim on your behalf.

PRIMARY MEDICAL INSURANCE_____ ID#_____

POLICY HOLDER NAME_____POLICY HOLDER DOB _ _ / _ _ / _ _ _ _
M M D D Y Y Y Y

SECONDARY MEDICAL INSURANCE_____ ID#_____

POLICY HOLDER NAME_____POLICY HOLDER DOB _ _ / _ _ / _ _ _ _
M M D D Y Y Y Y

VISION INSURANCE _____ ID#_____

POLICY HOLDER NAME_____POLICY HOLDER DOB _ _ / _ _ / _ _ _ _
M M D D Y Y Y Y

I authorize release of any medical or other information necessary to process my claims, and payment of Medicare, Medigap or other authorized medical benefits to this provider for services rendered. I also acknowledge and assume full financial responsibility for the health care services rendered to me (or my dependent minor) if these are not covered under my commercial insurance plan (copayments, refractions, deductibles, etc.); or the services have otherwise not been approved for payment by my insurance plan; or my eligibility is not in effect as of the date of the service.

PATIENT SIGNATURE_____ DATE _____
or Legal Representitive / Guarantor

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# MEDICAL HISTORY

NAME _____ DATE _____ DATE OF BIRTH _ _ / _ _ / _ _ _ _
M M D D Y Y Y Y

OCCUPATION _____

PRIMARY PHYSICIAN _____

WHO REFERRED YOU TO OUR OFFICE? _____

LIST CURRENT PRESCRIPTION & OVER-THE-COUNTER MEDICATIONS (or attach list) _____

_____

_____

LIST CURRENT EYE DROPS _____

ALLERGIC TO ANY DRUGS / MEDICATIONS? Y ☐ N ☐ If yes, please list _____

LIST ALL PREVIOUS SURGERIES (cataract, appendectomy, etc.) _____

_____

Do You Drive? Y ☐ N ☐ Do you drink Alcohol? Y ☐ N ☐ How much per day / week / month: _____

Do you Smoke? Y ☐ N ☐ Packs / day: _____ Use Medical Marijuana? Y ☐ N ☐ Use recreational drugs? Y ☐ N ☐

## Present Medical Conditions

**At your exam today, are you currently experiencing any problems with the following?**
**Please (circle) any current symptoms or problems you are experiencing today:**

| | Self | Family |
|---|---|---|
| **General (Constitutional):** chills \| fatigue \| fever \| sweats \| weight loss \| other: | Y / N | Y / N |
| **Ear, Nose, Throat (ENMT):** earache \| nasal congestion \| nosebleeds \| sore throat \| sinus pain \| other: | Y / N | Y / N |
| **Heart (Cardiovascular):** chest pain \| increased heart rate \| leg swelling \| palpitations \| high blood pressure high cholesterol \| other: | Y / N | Y / N |
| **Breathing (Respiratory):** asthma \| cough \| difficulty breathing \| shortness of breath \| wheezing \| other: | Y / N | Y / N |
| **Digestion (Gastrointestinal):** constipation \| diarrhea \| indigestion \| nausea \| reflux \| vomiting \| other: | Y / N | Y / N |
| **Genitourinary:** kidney problems \| STD \| problems with urination \| other: | Y / N | Y / N |
| **Skin (Integumentary):** change in hair texture \| change in nails \| rash \| rosacea \| other: | Y / N | Y / N |
| **Musculoskeletal:** arthritis \| back pain \| gout \| joint pain \| muscle pain \| other: | Y / N | Y / N |
| **Neurological:** gait problems \| loss of coordination \| memory loss \| slurred speech \| stroke \| other: | Y / N | Y / N |
| **Blood (Hematological):** abnormal bleeding \| large lymph nodes \| swollen glands \| anemia \| other: | Y / N | Y / N |
| **Immune (Immunologic):** food allergies \| immune disorders \| seasonal allergies \| infection \| other: | Y / N | Y / N |
| **Endocrine:** diabetes \| hypoglycemia \| low thyroid \| high thyroid \| other: | Y / N | Y / N |
| **Mood (Psychiatric):** anxiety \| depression \| panic disorder \| other: | Y / N | Y / N |

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NAME _____ DATE _____

## Eye Medical History

| | Self | Family |
|---|---|---|
| **Cataracts:** | Y / N | Y / N |
| **Corneal Problems:** | Y / N | Y / N |
| **Diabetic Changes:** | Y / N | Y / N |
| **Eye Injury:** | Y / N | Y / N |
| **Eyelid Problems:** | Y / N | Y / N |
| **Eye Muscle Problems:** | Y / N | Y / N |
| **Glaucoma:** | Y / N | Y / N |
| **Inflammation / Iritis:** | Y / N | Y / N |
| **Lazy Eye, Crossed Eyes:** | Y / N | Y / N |
| **Macular Degeneration:** | Y / N | Y / N |
| **Retinal Problems: Tear / Detachment R L Eye** | Y / N | Y / N |
| **Eye Surgical Procedures: Cataract, LASIK, RK** | | |

## History of Medical Conditions

**circle all that apply**

| | Self | Family |
|---|---|---|
| **Arthritis:** Fibromyalgia, Lupus, Osteoarthritis, Rheumatoid Arthritis | Y / N | Y / N |
| **Cancer:** Breast, Colon, Liver, Lung, Prostate, Skin, other: | Y / N | Y / N |
| **Cardiovascular:** Arrhythmia, Atria Fibrillation, Bypass, Congestive Heart Failure, Heart Attack, High Blood Pressure, High Cholesterol, High Lipids, Stent | Y / N | Y / N |
| **Diabetes:** Type I, Type II, Number of years: Blood Sugar HgB A1C: | Y / N | Y / N |
| **GI:** Crohn's, Colitis, Gastroesophageal Reflux, Hepatitis A/B/C, Pancreatitis, Ulcers | Y / N | Y / N |
| **Hematological:** Anemia, Bleeding Problems | Y / N | Y / N |
| **Infections:** AIDS, Herpes, HIV | Y / N | Y / N |
| **Neurologic:** Alzheimer's, Epilepsy, Migraines, MS, Stroke, TIA's | Y / N | Y / N |
| **Psychiatric:** Anxiety, Bipolar, Depression, Panic Disorder | Y / N | Y / N |
| **Pulmonary:** Asthma, COPD, Sarcoidosis, Tuberculosis | Y / N | Y / N |
| **Thyroid:** Graves Disease, Hyperthyroid, Hypothyroid, Radioactive Iodine | Y / N | Y / N |
| **Other:** | | |

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# FINANCIAL POLICY

Eye care insurance, whether medical or vision, has been made needlessly complex by the government and the insurance industry. Our office makes every effort to diligently stay abreast of the ever changing rules and regulations which we are contractually obligated to follow. It is dificult to always know what treatment is or is not covered by any particular plan. We highly recommend that you find out in advance exactly what your individual eye care insurance covers so that there will be no confusion on the day of your visit.

If you are eligible for Medicare or Medigap benefits, or you have commercial medical insurance, we will make every effort to help you receive your maximum allowable benefits. Our office participates with most major insurance plans. We require current copies of your insurance card(s) before we will file the claim on your behalf. Incorrect insurance information supplied to us may result in you being responsible for full payment. We will file your primary and secondary claims for you. If we do not participate with your insurance plan, payment is expected at time of service.

Co-payments or other patient due amounts are expected at the time of service and will be collected when you check in. Almost all insurance plans now require a co-payment to see a specialist. Please check with your insurance company prior to your visit to verify the amount of your specialist co-payment. This amount may be different from your primary care co-payment.

The majority of health insurance plans no longer cover the checking and updating of your eyeglass prescription known as “refraction.” We recommend getting a refraction once a year or if you feel that your vision has changed. This helps ensure that you can see the clearest that you are able. If you wish to have your eyeglasses checked and your prescription updated, please inform the front desk at check in. There is a charge of $30 for this service if it is not covered by your insurance plan.

Accounts thirty days past due are subject to collection proceedings unless prior arrangements have been made. Accounts placed for collection will incur an additional delinquent account fee. We will do our best to work with you to avoid past due situations and to accomodate unusual financial challenges. Please talk with us and keep us informed before you are past due.

Please inquire about CASH PAY prices if you do not have insurance.

PATIENT SIGNATURE_____ DATE _____
or Legal Representitive / Guarantor

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# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**
**PLEASE REVIEW IT CAREFULLY.**
**THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

## OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 1, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

## USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, letters, or email).

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**PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $ .10 for each page to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. {You must make your request in writing.} Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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**QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Ms. Ronda Borrego, Office Manager

Telephone: 303-776-3937

E-mail: info@longmonteyecare.com

Address: 500 Coffman Street, Suite 109, Longmont, Colorado 80501

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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy and understand this medical practice's **NOTICE OF PRIVACY PRACTICES**. I further acknowledge that a copy of the current **NOTICE OF PRIVACY PRACTICES** is available at the front desk, and that I will be offered a copy of any amended **NOTICE OF PRIVACY PRACTICES** upon request.

In summary, the **NOTICE OF PRIVACY PRACTICES**:

1) outlines to whom we may legally disclose your health information, including your health insurance plan so we may obtain payment for our services.

2) states that we will not disclose your health information in any other way, without your written authorization.

3) outlines your rights as a patient, including the
   - right to limit what information is disclosed
   - right to request confidential communication
   - right to inspect and copy your records
   - right to amend your records
   - right to receive a copy of the **NOTICE OF PRIVACY PRACTICES**

4) gives us the permission to change our **NOTICE OF PRIVACY PRACTICES** at any time in the future, at which point you will be notified again

5) informs you how to handle a complaint if you feel your privacy has been violated

Your signature (below) acknowledges that you have received a copy and understand this medical practice's **NOTICE OF PRIVACY PRACTICES**.

PRINT NAME _____ PHONE_____-_____-_____

PATIENT SIGNATURE_____ DATE _____

If not signed by the patient, please indicate relationship:

☐ parent or guardian of minor patient
☐ guardian or conservator of an incompetent patient

NAME OF PATIENT _____

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# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**SECTION A: PATIENT GIVING CONSENT**

NAME:_____

ADDRESS: _____

TELEPHONE_____-_____-_____ E-MAIL ADDRESS: _____

PATIENT NUMBER: _____SOCIAL SECURITY NUMBER _____-_____-_____

**SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Ms. Ronda Borrego, Office Manager

Telephone: 303-776-3937

E-mail: info@longmonteyecare.com

Address: 500 Coffman Street, Suite 109, Longmont, Colorado 80501

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**SIGNATURE**

I, _____ , have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**
**Include completed Consent in the patient's chart.**