Christine Chen & Associates, OD, PA

Welcome! Thank you for choosing our office for your eye care needs.
Please take a moment to complete this *yearly* questionnaire.

Today's Date ________________

PATIENT INFORMATION

☐ NEW PATIENT ☐ PREVIOUS PATIENT

LAST NAME	FIRST NAME & MIDDLE INITIAL	DATE OF BIRTH (M / D / Y) / /
STREET ADDRESS	CITY	STATE & ZIP CODE
OCCUPATION / EMPLOYER	HOME PHONE NUMBER	CELL / OFFICE PHONE NUMBER

CHIEF COMPLAINT

WHAT IS THE MAJOR PURPOSE OF YOUR VISIT TODAY? ☐ GLASSES ☐ CONTACT LENSES ☐ OTHER (Please explain)

ARE YOU HAVING ANY PROBLEMS WITH YOUR CURRENT CONTACT LENSES OR GLASSES? NO / YES (IF YES, PLEASE DESCRIBE BELOW)

PATIENT EYE HISTORY

DATE OF LAST EYE EXAM	DOCTOR / LOCATION	

HAVE YOU EVER BEEN DIAGNOSED WITH, OR TREATED FOR, ANY OF THE FOLLOWING? ❑ NO

- ❑ Cataract
- ❑ Age-related Macular Degeneration
- ❑ Glaucoma
- ❑ Diabetes
- ❑ Diabetic Retinopathy
- ❑ Dry Eye
- ❑ Eye Infection, inflammation, or allergy
- ❑ Floater and/or Flashes
- ❑ Iritis or Uveitis
- ❑ Retinal Defects or Degenerations
- ❑ Other ____________________________

DO YOU EXPERIENCE THE FOLLOWING EYE / VISION CONCERNS? ❑ NO

- ❑ Redness
- ❑ Burning
- ❑ Itching
- ❑ Tearing
- ❑ Discharge
- ❑ Blurred vision
- ❑ Eye strain
- ❑ Eye pain
- ❑ Severe light sensitivity
- ❑ Frequent headaches
- ❑ Poor night vision
- ❑ Bothersome light glare
- ❑ Double vision
- ❑ Total loss of vision
- ❑ Other ____________________

REVIEW OF SYSTEMS

PLEASE MARK THE **SIGNIFICANT** HEALTH HISTORY FORM BELOW:

❑ NO HEALTH CHANGES (*FOR PREVIOUS PATIENTS ONLY*)

Constitutional ❑None
- ❑ Developmental disability
- ❑ Weight Loss
- ❑ Other / Medications

Ears, Nose, Mouth & Throat ❑None
- ❑ Upper respiratory tract infection
- ❑ Other / Medications

Neurological ❑None
- ❑ Multiple sclerosis
- ❑ Epilepsy
- ❑ Other / Medications

Psychiatric ❑None
- ❑ Depression
- ❑ Panic disorder
- ❑ Schizophrenia
- ❑ Other / Medications

Cardiovascular ❑None
- ❑ Heart disease
- ❑ Hypertension
- ❑ Stroke
- ❑ Other / Medications

Respiratory ❑None
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Other / Medication

Gastrointestinal ❑None
- ❑ Crohn's
- ❑ Colitis
- ❑ Ulcer
- ❑ Digestive
- ❑ Other / Medication

Genitourinary ❑None
- ❑ Urinary tract infections
- ❑ Kidney ailments
- ❑ STD: Herpes, Chlamydia, HIV
- ❑ Other / Medications

Musculoskeletal ❑None
- ❑ Fibromyalgia
- ❑ Muscular dystrophy
- ❑ Osteoarthritis
- ❑ Other / Medications

Integumentary ❑None
- ❑ Eczema
- ❑ Rosacea
- ❑ Psoriasis
- ❑ Other / Medications

Endocrine ❑None
- ❑ Type 1 diabetes
- ❑ Type 2 diabetes
- ❑ Thyroid dysfunction
- ❑ Hormonal dysfunction
- ❑ Other / Medications

Blood / Lymphatic ❑None
- ❑ Anemia
- ❑ Leukemia
- ❑ Other / Medications

Allergic / Immunologic ❑None
- ❑ Drug allergy
- ❑ Environmental allergy
- ❑ Rheumatoid arthritis
- ❑ Lupus
- ❑ Other / Medication

SOCIAL HISTORY

Do you drink alcohol?	❑ No	❑ Yes
Do you use tobacco?	❑ No	❑ Yes
Do you smoke?	❑ No	❑ Yes

CONTACT LENS HISTORY

DO YOU CURRENTLY WEAR CONTACT LENS? ❑ No ❑ Yes

Brand of Contacts ________________

Disinfection Solution ______________

Do you ever sleep in your contacts ?
❑ No ❑ Yes

How often do you dispose of your contacts:
Daily / Biweekly / Monthly

ARE YOU INTERESTED IN WEARING / TRYING CONTACT LENS?
❑ No ❑ Yes

FAMILY HISTORY

- ❑Cataracts M / F / MGP / PGP / Sib / Child / Other
- ❑Glaucoma M / F / MGP / PGP / Sib / Child / Other
- ❑Macular Degeneration M / F / MGP / PGP / Sib / Child / Other
- ❑Corneal Disease M / F / MGP / PGP / Sib / Child / Other
- ❑Lazy Eye M / F / MGP / PGP / Sib / Child / Other
- ❑Diabetes M / F / MGP / PGP / Sib / Child / Other
- ❑Heart Disease M/ F/ MGP/ PGP/ Sib/ Child/ Other
- ❑Other

ADVANCED ULTRA-WIDE FIELD RETINAL IMAGING:

In a continued effort to bring the most advanced technology to our patients, we are proud to announce Ultra-Wide Field (UWF) Eidon Retinal Imaging as a new **required** standard of care at our clinic.

Our doctors are concerned about the health of your eyes including retinal problems such as macular degeneration, retinal holes or tears, retinal detachment, and glaucoma as well as systemic diseases such as diabetes, high blood pressure and high cholesterol. These conditions can lead to serious ocular or health problems, including partial loss of vision or blindness, and can often develop without warning or symptoms.

The UWF Eidon Retinal Imaging benefits include:

• Provides a high resolution, detailed image of the surface of the retina the doctors will use to better discuss your examination today.

• Provides a digital image that is a permanent record in your medical file which gives the doctors a year to year comparison for tracking, monitoring and diagnosing potential eye disease.

• Allows the doctors approximately FIVE times wider view inside the eye than can be seen without dilation.

• The imaging procedure is painless and quick, taking approximated two minutes per eye.

The doctors at our clinic strongly believe in the use of this technology as an integral tool in determining and monitoring your eye health; we now incorporate it as a **required** standard of care. This advanced screening technology is not included in most vision insurance plans and, therefore, there will be an **additional copay of $39**, due at time of service.

Christine Chen & Associates, O.D., P.A.

DILATION: (**No additional charge* – Part of your routine comprehensive examination)

Purpose: Dilating the pupils of your eyes is an important component of every comprehensive eye examination. It allows your doctor to examine the structures of the eye, to detect systemic and/or eye diseases/conditions including, but not limited to, ***high blood pressure, diabetes, glaucoma, macular degeneration, and cataracts****.*

Procedure: Dilating the pupils includes putting a series of drops in your eyes, followed by waiting a period of approximately 15 to 20 minutes. Your doctor will then examine your eyes using different instruments.

Side Effects: Most patients experience only mild side effects from the medication (drops) used. These side effects include light sensitivity and blurring of your near or up-close vision for typically 3 to 6 hours. *Most* patients *can drive* home after the exam. Disposable sunglasses are provided to reduce discomfort caused by sunlight.

Please select:
- ❑ I elect to be dilated today.
- ❑ I **REFUSE** to be dilated today. I fully understand that refusal to dilate may cause the doctor to be unable to detect certain disease(s) in my eyes with the potential for partial or total permanent loss of my vision. Being so advised, I hereby decline to have my eye dilated.

FINANCIAL RESPONSIBILITY – Authorization for Assignment & Release of Records

I hereby authorize insurance benefits to be paid directly to Christine Chen & Associates, OD, PA ("the office") for services rendered. ***I am** financially responsible for any **balance unpaid*** by my insurance. By signing below, I also authorize the office or insurance company to release any information from my records necessary for claim processing.

I am responsible for providing my vision insurance **PRIOR** to service. Insurance eligibility & verification will **NOT BE ADDRESSED ON OR AFTER DATE OF APPOINTMENT.** Once services are rendered and payments are made, the office will only provide a detailed receipt so I may file for reimbursement myself. The office does not guarantee repayment by your insurance provider. The office is NOT responsible for filing for insurance coverage that is NOT PROVIDED **BEFORE** time of service. **NO REFUNDS** will be given.

HIPAA PRIVACY NOTICE – Acknowledgement of Receipt

Please carefully read over the Notice of Privacy Practices attached. The notice describes how health information about you may be used and disclosed and how you can access to this information. I acknowledge that I have received a copy of Christine Chen & Associates, O.D., P.A. Notice of Privacy Practices.

AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

All doctors practicing within Target Optical are *independent*. The Target Optical personnel, who are ***not** employees of Christine Chen & Associates, O.D., P.A.*, aid our office in tasks including, but not limited to, scheduling appointments, answering phones, collecting fees, preparing patients and patient records, and assisting in contact lens fittings.

I understand and authorize the use or disclosure of my identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Persons/organizations authorized to use or disclose the information: The office of Dr. Christine Chen & Associates, O.D., P.A.
2. Persons/organizations to receive the information: Target Optical
3. Specific description of information that may be used or disclosed:
   a. My name,
   b. date of birth,
   c. address,
   d. telephone number,
   e. e-mail address,
   f. vision and/or medical insurance information, &
   g. next appointment date(s) and time(s)
4. As part of our recall program, the information will be used for the purposes of:
   a. Providing Target Optical coupons and service and product information, either from this office or directly from Target Optical; and
   b. To compare mailing lists with to help avoid duplicate mailings.
   c. To make phone calls to remind patients of their appointments. We will use the phone number you provide and the call may be live or prerecorded.
5. I understand that *this authorization is **voluntary*** and that ***I may refuse*** to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.
6. The organization authorized to use or disclose the information will NOT receive compensation for doing so.
7. I understand I may inspect or copy the information used or disclosed.
8. I understand that I may revoke this authorization at any time by notifying Christine Chen & Associates, O.D., P.A. in writing, expect to the extent that:
   a. Action has been taken in reliance on this authorization; or
   b. if this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Updated 01/2021

Print Patient Name (or Parent/Guardian Name if minor)	**Patient Signature (Parent/Guardian Signature if minor)**	**Relationship to patient or representative's authority to act for the patient**	**Date**

Christine Chen & Associates, O.D., P.A.

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 you 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 right 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 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practice 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 our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. In the event we make a material change in our privacy practice, we will change this Notice and provide it to you.

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.

USE & DISCLOSURE 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 an optician, ophthalmologist, or other healthcare provider providing treatment to you for: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; (c) the referral of a patient for health care from one health care provider to another; or (d) recall information.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. This may include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medically necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure of consumer reporting agencies of information relating to collection of premiums or reimbursement.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include things such as 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.

Marketing Health Products or Services: We will ***not*** use your health information for marketing communications without your prior written authorization. We may provide you with information regarding our products or services that we offer related to your health care needs. We will ***never sell*** your health information without your prior authorization.

To You, Your Family & 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 another 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 or, if you are not able to agree, if it is necessary in our professional judgment.

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, prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses of 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 also will 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.

Required by Law: We may use or disclose health information to appropriate authorities if we reasonable 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 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 officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders & Treatment Alternatives: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters) or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

PATIENT RIGHTS

Access: You have the right to review 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 an alternative format, we will charge a cost-based fee for providing your information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contacting us using this 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, where you have provided authorization and certain other activities, for the last 6 years, but not for disclosures made prior to 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 theses additional restrictions, but if we do, we will abide by our agreement (except in emergency).

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

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

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

QUESTIONS & 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 use 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 & Human Services. 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 PERSON

Christine Chen & Associates, O.D., P.A.
Attn: Dr. Christine Chen
P.O. Box 10473
Tampa, FL 33679
Tel. 813-402-0424
Fax 813-402-0425

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
Toll Free: 1-877-696-6775