303 Mulberry NE • Albuquerque, NM 87106
(505) 243-9739 phone • (505) 842-0650 fax • (800) 321-4977 toll free Familykidseye.com

Thank you for making an appointment at our office. Your appointment is with one of our specialists and you may be here for 1 to 2 hours. Sometimes the doctor may have an unexpected delay in the office or surgery. If this happens, the wait time may be longer. Most of the time, a longer wait is because the doctor needs to spend more time with a patient than expected. We will also give you or your child more time if needed. The doctor/patient relationship does not begin until the patient arrives at a first appointment and is evaluated by the physician.

You can download and print our registration and health history forms online. The doctor will need to review your completed forms before he or she sees you. If you download the forms, please complete and bring them with you to your appointment.

PLEASE BRING THE FOLLOWING ITEMS TO YOUR APPOINTMENT

- Current eye glasses
- Current medical insurance card
- Written insurance referral (this includes Tricare and some other plans)
- Payment for co-payments and/or deductibles
- List of current medicines including eye drops, vitamins, and over-the-counter medicines
- Someone to drive you home – you may have trouble driving with your eyes dilated
- Toys, snacks, books, or other items you may want while waiting (let us know if we can help you)

If you have a medical diagnosis, we will file your medical insurance for you. If you are not sure if we are on your insurance plan, please check with them before your visit. We will collect payments for non-covered services, deductibles and/or copayments at the time of your appointment. If you need to order contact lenses, you must pay for those when we order them. If you need to make special payment arrangements, please contact us before your appointment.

The doctor will do a *refraction* as part of a complete eye examination. The refraction is the part of the eye examination when we find out if you or your child needs glasses. Most insurance companies consider refractions a routine and/or a non-covered service.

The doctor will probably need to dilate your eyes during the eye examination. This will mean you or your child will be sensitive to light and may not be able to see as clearly for a few hours. We have dark shades if needed. Although many people do not have problems driving after dilation, we suggest you have someone drive you home.

Please contact us if you have any questions before your appointment. We look forward to seeing you!

FAMILY EYE CARE | CHILDREN'S EYE CENTER
OF NEW MEXICO

Adult Registration Form and Health History

Today's Date:

PATIENT INFORMATION

LAST NAME		FIRST NAME		MIDDLE INITIAL
ADDRESS		CITY	STATE	ZIP
HOME PHONE		CELL PHONE		WORK PHONE

AGE	DATE OF BIRTH	SOCIAL SECURITY NUMBER	❑ FEMALE ❑ MALE	❑ SINGLE ❑ MARRIED ❑ WIDOWED ❑ DIVORCED

E-MAIL ADDRESS	WHO REFERRED YOU TO OUR OFFICE?	WHO IS YOUR PRIMARY CARE PROVIDER (PCP)?

EMPLOYER INFORMATION

EMPLOYER			
ADDRESS	CITY	STATE	ZIP

BILLING INFORMATION

PERSON RESPONSIBLE FOR PAYMENT OF BILL		RELATIONSHIP TO PATIENT	
ADDRESS	CITY	STATE	ZIP

INSURANCE COMPANY	SUBSCRIBER	RELATIONSHIP TO PATIENT

CURRENT EYE PROBLEM

WHY DID YOU COME TO THE EYE DOCTOR TODAY?	WHAT DO YOU WANT THE DOCTOR TO DO FOR YOU?

CURRENT HEALTH STATUS AND PAST HEALTH HISTORY

DO YOU WEAR GLASSES?	❑ YES	❑ NO
DO YOU WEAR CONTACT LENSES?	❑ YES	❑ NO
HAVE YOU EVER HAD AN EYE INJURY?	❑ YES	❑ NO
DO YOU SMOKE? (NOW OR IN THE PAST)	❑ YES	❑ NO

ALLERGIES ❑ NONE KNOWN ❑ YES (PLEASE LIST BELOW)

CURRENT HEALTH PROBLEMS

❑ SEASONAL ALLERGIES	❑ HEART PROBLEMS	❑ HIGH BLOOD PRESSURE	❑ CANCER	❑ DIABETES
❑ SEIZURES	❑ LIVER PROBLEMS	❑ KIDNEY DISEASE	❑ LUNG PROBLEMS	❑ EMOTIONAL
❑ CATARACTS	❑ GLAUCOMA	❑ CROSSED OR LAZY EYE	❑ MACULAR PROBLEMS	❑ OTHER ___________

MEDICATIONS		PREVIOUS SURGERIES	
MEDICATION	DOSE AND FREQUENCY	SURGERY	YEAR

PLEASE COMPLETE THE BACK OF THIS FORM →

DO YOU HAVE ANY OF THE FOLLOWING PROBLEMS?

GENERAL/HORMONAL
- ❑ FATIGUE
- ❑ FEVER/CHILLS
- ❑ NIGHT SWEATS
- ❑ HOT FLASHES
- ❑ INTOLERANCE TO HEAT
- ❑ INTOLERANCE TO COLD
- ❑ WEIGHT CHANGE
- ❑ APPETITE CHANGE
- ❑ EXCESSIVE THIRST
- ❑ HOARSENESS
- ❑ VOICE CHANGES
- ❑ NONE

BLOOD/LYMPH NODES
- ❑ ANEMIA OR LOW IRON
- ❑ ABNORMAL BLEEDING
- ❑ SWOLLEN NODES
- ❑ BRUISING
- ❑ NONE

SKIN/HAIR/NAILS
- ❑ COLOR CHANGES
- ❑ CHANGE IN MOLE
- ❑ ITCHING
- ❑ IRRITATION
- ❑ RASHES
- ❑ GROWTHS
- ❑ HAIR CHANGES
- ❑ NAIL CHANGES
- ❑ NONE

EARS/NOSE/THROAT
- ❑ HEADACHES
- ❑ HEARING LOSS
- ❑ RINGING IN EARS
- ❑ NOSEBLEEDS
- ❑ RUNNY NOSE
- ❑ SINUS PROBLEMS
- ❑ BLEEDING GUMS
- ❑ PAIN IN EARS
- ❑ PAIN IN NOSE
- ❑ PAIN IN THROAT
- ❑ CHANGE IN TASTE
- ❑ MOUTH SORES
- ❑ DRY MOUTH
- ❑ NONE

EYES
- ❑ VISION LOSS
- ❑ BLURRED VISION
- ❑ DISTORTED VISION
- ❑ DOUBLE VISION
- ❑ FLOATERS
- ❑ LIGHT FLASHES
- ❑ OTHER VISION CHANGES
- ❑ TEARING
- ❑ DRY EYES
- ❑ LIGHT SENSITIVITY
- ❑ DROOPY EYELID
- ❑ REDNESS
- ❑ DRAINAGE OR MUCOUS
- ❑ ITCHING
- ❑ PAIN OR DISCOMFORT
- ❑ NONE

MUSCLES/BONES/JOINTS
- ❑ JOINT PAIN
- ❑ JOINT STIFFNESS
- ❑ JOINT HEAT
- ❑ MUSCLE ACHES & PAINS
- ❑ MUSCLE STIFFNESS
- ❑ WEAKNESS
- ❑ CRAMPING
- ❑ PARALYSIS
- ❑ DIFFICULTY MOVING
- ❑ BACK PROBLEMS
- ❑ NONE

LUNGS
- ❑ COUGH
- ❑ SPUTUM PRODUCTION
- ❑ WHEEZING
- ❑ SHORTNESS OF BREATH
- ❑ COUGHING UP BLOOD
- ❑ PAIN IN LUNGS
- ❑ NONE

HEART
- ❑ CHEST PAIN
- ❑ PAIN IN ARM OR JAW
- ❑ PALPITATIONS
- ❑ EXERCISE INTOLERANCE
- ❑ EXTREMITY PAIN
- ❑ EXTREMITY CHANGES
- ❑ FEELING LIGHTHEADED
- ❑ FAINTING
- ❑ SWEATING
- ❑ NONE

STOMACH BOWELS
- ❑ BLOOD IN STOOLS
- ❑ VOMITING BLOOD
- ❑ DIARRHEA
- ❑ CONSTIPATION
- ❑ NAUSEA
- ❑ VOMITING
- ❑ TROUBLE SWALLOWING
- ❑ HEARTBURN
- ❑ FOOD INTOLERANCE
- ❑ NONE

KIDNEYS BLADDER/GENITALS
- ❑ URINATING FREQUENTLY
- ❑ PAINFUL URINATION
- ❑ INCONTINENCE
- ❑ BLOOD IN URINE
- ❑ URINATING AT NIGHT
- ❑ KIDNEY PAIN
- ❑ GENITAL DRAINAGE
- ❑ SORES ON GENITALS
- ❑ NONE

NEUROLOGIC
- ❑ DIZZINESS
- ❑ NUMBNESS
- ❑ TINGLING OR BURNING
- ❑ MEMORY LOSS
- ❑ KNOCKED OUT
- ❑ SUDDEN VISION LOSS
- ❑ TROUBLE WALKING
- ❑ DISORIENTATION
- ❑ NONE

PSYCHIATRIC
- ❑ DEPRESSION
- ❑ MOOD CHANGES
- ❑ HALLUCINATIONS
- ❑ NIGHTMARES
- ❑ ANXIETY
- ❑ BEHAVIOR CHANGES
- ❑ NONE

FAMILY AND SOCIAL HISTORY

DO OR DID ANY OF YOUR BLOOD RELATIVES (LIVING OR DEAD) HAVE ANY OF THE FOLLOWING?

- ❑ YES ❑ NO AMBLYOPIA
- ❑ YES ❑ NO PROBLEMS WITH ANESTHESIA
- ❑ YES ❑ NO ARTHRITIS
- ❑ YES ❑ NO BLINDNESS
- ❑ YES ❑ NO CROSSED OR WANDERING EYE
- ❑ YES ❑ NO DIABETES
- ❑ YES ❑ NO EYE CANCER
- ❑ YES ❑ NO GLAUCOMA
- ❑ YES ❑ NO GENETIC PROBLEMS
- ❑ YES ❑ NO HEART DISEASE
- ❑ YES ❑ NO HIGH BLOOD PRESSURE
- ❑ YES ❑ NO CATARACTS IN CHILDHOOD
- ❑ YES ❑ NO KIDNEY DISEASE
- ❑ YES ❑ NO LAZY EYE
- ❑ YES ❑ NO LUPUS
- ❑ YES ❑ NO NEUROLOGICAL PROBLEMS
- ❑ YES ❑ NO EARLY DEATH
- ❑ YES ❑ NO RETINAL PROBLEMS
- ❑ YES ❑ NO STROKE
- ❑ YES ❑ NO THYROID PROBLEMS

SOCIAL ASSESSMENT

- ❑ YES ❑ NO I LIVE ALONE
- ❑ YES ❑ NO I HAVE TRANSPORTATION
- ❑ YES ❑ NO I HAVE ADEQUATE SHELTER
- ❑ YES ❑ NO I HAVE HELP WHEN NEEDED

OFFICE USE ONLY	PATIENT NOTES

REVIEWED BY: ❑TODD GOLDBLUM, MD ❑JOHN HICKOX, MD ❑REBECCA LEENHEER, MD

PROVIDER SIGNATURE: DATE(S):

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a surgery may require that your relevant protected health information be disclosed to the health plan to obtain approval for the surgery.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment, employee review, training of staff, licensing, and conducting or arranging for other business activities.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: public health issues as required by law, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. We must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with these requirements.

We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and abide by the same HIPAA Privacy standards as outlined in this Notice of Privacy Practice.

Other Permitted Uses and Disclosures Requiring Your Written Authorization

Unless noted above in our Use and Disclosures, all other permitted uses and disclosures of your protected health information will be made only with your consent, authorization or opportunity to object unless required by law. This includes:

- Most uses and disclosure of psychotherapy notes
- Uses and disclosure for marketing purposes
- Disclosures that constitute a sale of your protected health information

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. (Please note reasonable fees may apply.) Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

If your protected health information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. If the protected health information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form.

We have up to 30 days to make your protected health information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information. Although we are not obligated to comply with all requests to restrict the disclosure of your protected health information, we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your personal health information for treatment purposes.

You have the right to request to receive confidential communications. We may call you with appointment reminders, cancellations, and may leave voice mail message at your home or place of employment. You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You have the right to request an amendment to your protected health information. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures. You have the right to receive an accounting of all disclosures except for the following disclosures: disclosures pursuant to an authorization,

disclosures for purposes of treatment, payment, healthcare operations; disclosures required by law, that occurred prior to April 14, 2003; or disclosures six years prior to the date of this request.

You have the right to receive a Breach Notification. You have the right to receive a notification upon a breach of any of your unsecured protected health information.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and the new terms will apply to all the information we have about you. We will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may file a complaint or report a problem to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

For More Information or to Report a Problem Please Contact Us At:
Debbie Casaus
Family Eye Care and Children's Eye Center of New Mexico
303 Mulberry Street NE
Albuquerque, NM 87106
Phone: (505) 243-9739
Fax: (505) 842-0650

If we are unable to resolve your complaint, the HIPAA regulation enables you to address your concern:

Secretary of the Department of Health and Human Services (HHS)
200 Independence Ave., SW
Washington, DC 20201

We will never retaliate against you for filing a complaint. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

This Notice of Privacy Practices became effective on October 13, 2015. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

______________________________ ______________________________
Signature of Patient or Personal Representative Date Signed

____
Name of Patient or Personal Representative (please print)

____
Description of Personal Representative's Authority