

## **Macadam Vision Clinic welcomes you to our office!**

As a new patient to our practice, we would like to offer a warm welcome and our thanks for choosing us to provide your eye health and vision care. In order for us to establish your file, and provide the most beneficial use of your time with us, the doctor has asked you to complete the following tasks and bring the results to your appointment. The doctor needs this in order to give you the best care possible.

**Completed Welcome to the Office Form:** This diagnostic information includes personal and family information needed to establish your file, as well as your current eye health and vision status. Your responses will guide our doctors and staff, and remind us to address any significant issues during your visit.

**Completed Medical and Eye Health History:** Since many general health conditions may be associated with visual symptoms and/or eye health problems, this important record (now required by state health boards and virtually any medical and optical insurance plans) will allow us to care for you as a “whole person” rather than just a pair of eyes. This form includes a complete list of prescription and non-prescription medication, which may be brought in as a separate list for us to photocopy if you prefer.

**Completed Digital Retinal Photography Form:** You may choose from one of two retinal health evaluation options.

**Insurance cards or claim forms:** For any optical and/or medical insurance for which you may be covered. (Even for “routine” visits, if a medical eye condition is discovered during your examination we can submit a claim to your health insurance for the medical evaluation portion of your examination).

**If you were informed that we are not a provider of your vision benefits coverage, please call the number on the back of your insurance card and get answers to the following questions.**

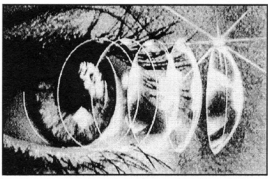
If we do not have this information, you will be responsible for paying us for all charges at the time of service and then seeking reimbursement from your coverage:

- Do I have “out of network” vision exam coverage?
- Do I have eyeglasses or contact lens materials coverage?
- Do I have medical coverage?
- Do I have a co-payment?
- Are my family members covered?
- Do I need to satisfy a deductible?

**Eyeglasses:** Please bring ALL pairs of eyeglasses you currently use, including prescription or non-prescription reading glasses, sunglasses, etc. We have instruments to compare the optical power of your old lenses with your new exam findings, thus enabling us to determine and explain how your vision has changed over time. We can also evaluate the condition and fit of your current eyewear.

**Contact Lenses:** It is best to wear your current contacts to your appointment if possible. Next best is to bring them along in your case. If you wear planned replacement or disposable lenses, it is very helpful if you bring along your cartons or lens packets that indicate the lens series, power, manufacturer, etc.

Completing the task list for the items that apply to you will assure you of receiving the most thorough and professional care possible and in a very efficient manner. We look forward to your visit!



# MACADAM VISION

WELCOME TO OUR OFFICE

Dedicated to your vision for life

## PATIENT INFORMATION

Today's Date \_\_\_\_\_

Name \_\_\_\_\_  
(Last, First, Middle Initial)

Nickname \_\_\_\_\_

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Mr. \_\_\_\_\_ Mrs. \_\_\_\_\_ Ms. \_\_\_\_\_ Miss. \_\_\_\_\_ Other \_\_\_\_\_

Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Communication Info: Please Circle Preference  
Cell, Home, Work, Email, US Mail

Home ( ) \_\_\_\_\_ - \_\_\_\_\_

Work ( ) \_\_\_\_\_ - \_\_\_\_\_

Cell ( ) \_\_\_\_\_ - \_\_\_\_\_

Email \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

The new Health Care Act requires we ask the following questions to be in accordance with "Meaningful Use" of Electronic Health Records. Meaningful Use: An incentive to improve the health of the nation by ensuring that patients receive well-coordinated care within and across all healthcare organizations, settings, and levels of care.

(You may enter "Decline to provide")

SSN \_\_\_\_\_

Marital Status \_\_\_\_\_

Primary Language \_\_\_\_\_

Special Needs \_\_\_\_\_

Race \_\_\_\_\_

Ethnicity (Hispanic/Latino) YES / NO

Mother's Maiden Name \_\_\_\_\_

Birth State \_\_\_\_\_

## NEW PATIENTS ONLY:

Who may we thank for referring you to our office?

Name of friend or relative \_\_\_\_\_

If not referred, how did you choose our office?

Yellow Pages  Insurance List

Signage

Internet: Insurance List

Our Website

Yellow Pages

Other \_\_\_\_\_

## INSURANCE INFORMATION

Vision Insurance Co. \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber Ins. ID# \_\_\_\_\_

VSP Patients- last 4 digits of SSN: \_\_\_\_\_

Subscriber Birth Date \_\_\_\_\_

Primary Medical Insurance \_\_\_\_\_

Subscriber Name \_\_\_\_\_

Subscriber Ins. ID# or SSN: \_\_\_\_\_

Subscriber Birth Date \_\_\_\_\_

Person responsible for account:  Self

Other \_\_\_\_\_  
(Last, First, Middle Initial)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City/State/Zip)

\_\_\_\_\_  
(Phone Number)

Mother \_\_\_\_\_ Father \_\_\_\_\_ Guardian \_\_\_\_\_

Do you participate in a flex spending account?

Yes

No

Dr. Initials \_\_\_\_\_

## LIFESTYLE QUESTIONS

**Do you.....(check box if your answer is yes)**

- ..work at a computer?
- ..spend time outdoors? How much? \_\_\_Hrs/week
- ..have prescription sunwear?
- ..want information on Laser Vision Correction surgery?
- ..have interest in pharmaceutical grade supplements for eye health?
- ..have more than 1 pair of current Rx eyewear?
- ..have family members in need of eye care?
- ..have children?
- ..headaches...Mild? Moderate? Severe?

**What is the major purpose of this visit?**

\_\_\_\_\_

**Any problems with your current contact lenses or glasses?**

\_\_\_\_\_

**Do you suffer allergies? Y / N Allergic to:** \_\_\_\_\_

\_\_\_\_\_

**Medical Allergies? Y / N What happens?** \_\_\_\_\_

\_\_\_\_\_

## SOCIAL HISTORY

Drug Abuse: Yes \_\_\_\_\_ No \_\_\_\_\_  
If Yes: Name of drug \_\_\_\_\_

Alcohol Use: Yes \_\_\_\_\_ No \_\_\_\_\_  
If Yes: # of drinks per week \_\_\_\_\_

Tobacco Use: Yes \_\_\_\_\_ No \_\_\_\_\_  
If Yes:  
Smoked for \_\_\_\_\_ years  
Packs per day \_\_\_\_\_

Hobbies \_\_\_\_\_

Name of Family Doctor \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Date of last tetanus shot: \_\_\_\_\_

## FAMILY MEDICAL/EYE HISTORY

I have been diagnosed with: (check those that apply)

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Glaucoma</li> <li><input type="checkbox"/> Cataracts</li> <li><input type="checkbox"/> Macular Degen</li> <li><input type="checkbox"/> Eye Injury</li> <li><input type="checkbox"/> Retinal Disease</li> <li><input type="checkbox"/> Other Diseases</li> <li><input type="checkbox"/> Blindness</li> <li><input type="checkbox"/> Strabismus</li> <li><input type="checkbox"/> Amblyopia</li> <li><input type="checkbox"/> Diabetes</li> <li><input type="checkbox"/> Dry Eye</li> <li><input type="checkbox"/> Other</li> <li><input type="checkbox"/> Other</li> </ul> | <p>Do you have a family history of:<br/>(Please list the relationship of the family member to you)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> _____</li> <li><input type="checkbox"/> _____</li> <li><input type="checkbox"/> _____</li> <li><input type="checkbox"/> _____</li> <li><input type="checkbox"/> _____</li> <li><input type="checkbox"/> _____</li> <li><input type="checkbox"/> _____</li> <li><input type="checkbox"/> _____</li> <li><input type="checkbox"/> _____</li> <li><input type="checkbox"/> _____</li> <li><input type="checkbox"/> _____</li> <li><input type="checkbox"/> _____</li> </ul> |
|---|---|

## PATIENT MEDICAL HISTORY

Please list all medications that you are taking:  
(include eye drops, birth control, supplements)

\_\_\_\_\_

**Would you consider your overall health good? Y / N**

Have you ever been diagnosed or treated for the following health problems?

	Yes	No
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>
Ear, Nose, Mouth, Throat	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (skin)	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Hematologic/Lymphatic	<input type="checkbox"/>	<input type="checkbox"/>
Allergy/Immune	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

**Are you Diabetic? Y / N Type I, Type II (non-insulin dependent)**

Surgical History Procedures and Dates: \_\_\_\_\_

\_\_\_\_\_

## Personal Eye Health History

	Yes	No
Have you had any eye surgeries?.....	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any eye injuries?.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have..... blurred vision? other eye problems?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear glasses?	<input type="checkbox"/>	<input type="checkbox"/>
Date of Last Eye Exam _____ By Whom? _____		
Were your eyes dilated? <input type="checkbox"/> ..Yes <input type="checkbox"/> ..No <input type="checkbox"/> ..Can't remember		
Have you ever tried contact lenses? <input type="checkbox"/> ..Yes <input type="checkbox"/> ..No		
Do you currently wear contact lenses? <input type="checkbox"/> ..Yes <input type="checkbox"/> ..No		
What kind? _____ Solutions used _____		
Are you satisfied with the vision and comfort of your contact lenses? <input type="checkbox"/> ..Yes <input type="checkbox"/> ..No		

**The information in this confidential case history form is critical to the evaluation of your vision and health.**

*We are dedicated to improving our patients' quality of life by providing a clinical experience that invokes a sense of caring expertise memorable to the point of enthusiastic comment.*

Dr. Initials \_\_\_\_\_

## MACADAM VISION CLINIC FINANCIAL POLICY

We want you to feel comfortable with our office regarding your financial and insurance matters and thereby prevent misunderstandings. We believe that you, our patients deserve the highest quality care we can provide at a reasonable cost. While we take advantage of every possible avenue to keep costs down, we are committed to not sacrificing quality for less expensive care. Please contact us if you have any questions regarding our services or our financial policies.

Often the assumption is made that if a person has insurance, then it is the insurance company who owes the doctor for his services. This assumption is incorrect. The insurance policy is between the patient and the insurance company alone. The patient is responsible for the bill regardless of insurance coverage determination. We will do our best as a courtesy to assist you in determining eligibility and benefits and billing your primary insurance company. We charge \$25.00 to bill a secondary insurance. It is your responsibility to know the terms and any exclusions of your insurance coverage and to ensure your insurance carriers cooperation with us. Some insurance plans state that patients will be covered up to 50%, 80% or 100%. These are not percentages of what we charge but are percentages of the insurance company's "usual and customary" reimbursement. Another term similar to "usual and customary" is "maximum allowable." This term represents the maximum a patient's policy is allowed to pay toward a given service not the maximum we are allowed to charge.

**Patients without insurance** are required to pay in full at time of service. We offer a 30% time of service discount on professional services to our patients without insurance.

**Patients with non-contract insurance** are also offered a 30% time of service discount on professional services if they pay in full and bill their insurance themselves. We will provide the necessary paperwork to send to your insurance.

**Patients with contract insurance** are, at time of service, expected to pay their co-pay and what we estimate to be their portion not covered by their insurance. If we underestimate the portion not covered then the patient is responsible for the balance. If your personal payments plus the insurance payment exceed the total cost of service, the excess will be sent to you promptly after we receive insurance payment.

**Vision-insurance and medical insurance** serve two different functions. Vision insurance is in place to defray the cost of a vision examination for glasses or contacts and an eye health screening. Medical insurance defrays the cost of evaluation and management of disease or disease risk the vision exam may have revealed. You may be asked after your vision examination to return to our clinic for evaluation and management of eye disease or eye disease risk under your medical insurance. Medical insurance (not vision insurance) would also defray the cost of a visit for an eye disease or injury presentation. (E.g. pink eye, corneal abrasion or foreign body, glaucoma, cataract etc.) Medical presentation patients are expected at time of service to pay for a minimal Level 1 Evaluation/Management visit. We will bill medical insurance for the actual Evaluation/Management Level performed (1-5) and the patient is responsible for the balance or we will refund the overage after insurance payment is received.

- If there is no payment from your insurance company to our office within 45 days of service you are responsible for that balance at that time.
- Any balances unpaid after 30 days will be subject to a \$5.00/month finance charge. Attorney or collection fees incurred while we attempt to collect balances will be your responsibility.
- We accept Visa, MasterCard and Discover credit cards. We do not accept post-dated checks.
- There will be a \$50.00 charge for all returned checks.

Assignment and release: Your signature below hereby authorizes your insurance benefits to be paid directly to Greg W. Schober O.D. P.C. It also authorizes the doctor to release any information required for payment and processing of any and all insurance claims. Please sign below to acknowledge your understanding of the information on this sheet.

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Signature of Patient, Parent or Guardian

Date

## Digital Retinal Photography

We, at Macadam Vision, are proud to provide our patients with a highly advanced Digital Retinal Photograph Service, which scans the retina to rule out or screen for eye diseases and dramatically improve our ability to view your retinal health.

### EARLY DETECTION OF EYE DISEASE IS CRUCIAL

The doctors recommend most patients have Digital Retinal Photography once a year so we can view and record your retina at up to 100 times normal size.

With this service you can expect:

- An annual eye wellness screening photograph
- An in depth view of the retinal surface
- A discussion with you and the doctor regarding the images
- A permanent record for your medical file, for year to year comparison and diagnosis
- A quick, easy, comfortable experience
- Typically no dilation drops
- The ability to e-mail images to you or others in the future
- This technology allows the doctors to fully screen for and evaluate retinal problems such as macular degeneration, glaucoma, retinal holes, detachments and diabetic retinopathy all of which can lead to partial loss of vision or blindness. Also systemic diseases such as diabetes and high blood pressure can be detected during a retinal exam.

Insurance is designed to cover a basic exam only. It does not cover advanced procedures such as Digital Retinal Photography. Our doctors recommend this service to our patients at an additional \$29.00 charge.

I am a Diabetic (Standard of practice is to be dilated and have a Digital Retinal Photo.

I would like to have my retinal health evaluated with Digital Retinal Photography

I DO NOT wish to have Digital Retinal Photography. I choose instead to have a dilated retinal exam. Side effects will include blurred vision and light sensitivity and may include headache. Symptoms may last typically 4 and rarely 36 hours.

Patient: \_\_\_\_\_ Date \_\_\_\_\_

# HIPAA Notice of Privacy Practices

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**Macadam Vision Clinic**  
**5901 S.W. Macadam Ave. Suite #105**  
**Portland, OR 97239**  
**(503) 222-2990**

**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.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

## **1. Uses and Disclosures of Protected Health Information**

### **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use 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. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. 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 hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.**

**You may revoke this 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**

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**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 for the purposes of treatment, payment or healthcare operations. 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.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications 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 may have the right to have your physician amend your protected health information.** If we deny your request for 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 we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

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. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

(Name and Signature of Patient, Parent or Guardian)