A1A FAMILY EYECARE

Medical History Questionnaire

Today's Date: _____ Last Eye Exam: _____

Name: _____ Date of Birth: _____

Last First MI

Sex: ☐ M ☐ F Social Security #: _____ Cell Phone: _____

Address: _____ Home Phone: _____

_____ E-Mail: _____

City State Zip code

Last Medical Exam: _____ Primary Care Doctor: _____ Dr.'s Phone: _____

MEDICAL HISTORY

Do you have any allergies to medications? ❑ No ❑Yes If yes, explain: _____

_____

_____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

_____

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

_____

_____

Are you pregnant and/or nursing? ❑No ❑Yes

Have you had any of the following:

❑ Crossed Eyes ❑ Lazy Eye ❑ Drooping Eyelid ❑ Prominent Eyes

❑Glaucoma ❑Retinal Disease ❑Cataracts ❑Eye Infections ❑Eye Injury _____

❑Other: _____

Do you wear glasses? ❑No ❑Yes If yes, how old is your present pair of glasses? _____

Do you currently wear prism glasses? ❑No ❑Yes If yes, what office prescribed them? _____

Do you wear contact lenses? ❑No ❑Yes If no, are you interested in trying contact lenses? ❑ Yes ❑ No

Type of contact lenses: ❑ Soft ❑ Hard ❑ Scleral Are they comfortable? ❑ Yes ❑ No

Contact Lens Brand: _____How old is your present pair of lenses? _____

Do you drive? ❑ No ❑ Yes If yes, do you have visual difficulty when driving? ❑ No ❑ Yes

If yes, please describe: _____

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	❑	❑	❑	_____
Cataract	❑	❑	❑	_____
Cross Eyes	❑	❑	❑	_____
Glaucoma	❑	❑	❑	_____
Macular Degeneration	❑	❑	❑	_____
Retinal Detachment	❑	❑	❑	_____
Arthritis	❑	❑	❑	_____
Cancer	❑	❑	❑	_____
Diabetes	❑	❑	❑	_____
Heart Disease	❑	❑	❑	_____
High Blood Pressure	❑	❑	❑	_____
Kidney Disease	❑	❑	❑	_____
Lupus	❑	❑	❑	_____
Thyroid Disease	❑	❑	❑	_____
Other_____	❑	❑	❑	_____

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❑ I would prefer to discuss my Social History information directly with my doctor.

Do you use tobacco products? ❑No ❑Yes If yes, type/amount/how long: _____

Do you drink alcohol? ❑No ❑Yes If yes, type/amount/how long: _____

Do you use illegal drugs? ❑No ❑Yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with:

❑ Gonorrhea ❑ Hepatitis ❑ HIV ❑ Syphilis

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	❑	❑	❑
INTEGUMENTARY (Skin)	❑	❑	❑
NEUROLOGICAL			
Headaches	❑	❑	❑
Migraines	❑	❑	❑
Seizures	❑	❑	❑
EYES			
Loss of Vision	❑	❑	❑
Blurred Vision	❑	❑	❑
Distorted Vision/Halos	❑	❑	❑
Loss of Side Vision	❑	❑	❑
Double Vision	❑	❑	❑
Dryness	❑	❑	❑
Mucous Discharge	❑	❑	❑
Redness	❑	❑	❑
Sandy or Gritty Feeling	❑	❑	❑
Itching	❑	❑	❑
Burning	❑	❑	❑
Foreign Body Sensation	❑	❑	❑
Excess Tearing/Watering	❑	❑	❑
Glare/Light Sensitivity	❑	❑	❑
Eye Pain or Soreness	❑	❑	❑
Chronic Infection of Eye or Lid	❑	❑	❑
Sties or Chalazion	❑	❑	❑
Flashes/Floaters in Vision	❑	❑	❑
Tired Eyes	❑	❑	❑
ENDOCRINE			
Thyroid/Other Gland	❑	❑	❑

SYSTEM	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	❑	❑	❑
Sinus Congestion	❑	❑	❑
Runny Nose	❑	❑	❑
Post-Nasal Drip	❑	❑	❑
Chronic Cough	❑	❑	❑
Dry Throat/Mouth	❑	❑	❑
RESPIRATORY			
Asthma	❑	❑	❑
Chronic Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑
VASCULAR / CARDIOVASCULAR			
Diabetes	❑	❑	❑
Heart Pain	❑	❑	❑
High Blood Pressure	❑	❑	❑
Vascular Disease	❑	❑	❑
GASTROINTESTINAL			
Diarrhea	❑	❑	❑
Constipation	❑	❑	❑
GENITOURINARY			
Genitals/Kidney/Bladder	❑	❑	❑
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	❑	❑	❑
Muscle Pain	❑	❑	❑
Joint Pain	❑	❑	❑
LYMPHATIC / HEMATOLOGIC			
Anemia	❑	❑	❑
Bleeding Problems	❑	❑	❑
ALLERGIC/IMMUNOLOGIC	❑	❑	❑
PSYCHIATRIC	❑	❑	❑

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

_____

_____

_____

_____

Doctor's Signature:_____ Date:_____

NOTICE OF PRIVACY PRACTICES

Effective Date of this notice: April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

A1A Family Eyecare – (904) 992-9991
4788 Hodges Blvd, Unit 205, Jacksonville, FL 32224

Rowe Family Eyecare – (904) 824-0212
1100-4 S Ponce De Leon Blvd, St. Augustine, FL 32084

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment

We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff, or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for an infection and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work, and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. We have an open waiting room. We will attempt to keep your personal health information (PHI) to the minimum.

For Payment

We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders

We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

Treatment Alternatives

We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services

We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

You may revoke your Consent at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures that occurred before that time.

If you do revoke your Consent, we will not be permitted to use or disclose information for purposes of treatment, payment, or healthcare operations, and we may therefore choose to discontinue providing you with health care treatment and services.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law

We will disclose health information about you when required to do so by federal, state, or local law.

Research

We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation

If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security, and Intelligence

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information

about foreign military personnel to the appropriate foreign military authority.

Worker's Compensation

We may release health information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose health information about you for public health reasons in order to prevent or control disease, injury, or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications, or problems with products.

Health Oversight Activities

We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons, or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners, and Funeral Directors

We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends

We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment, you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you are critically ill and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or x-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. We must obtain your Authorization separate from any Consent we may have obtained from you. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the Authorization and Consent mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment, or health care operations, we will have to have both your signed Consent and a special written Authorization that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to our privacy official in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to you health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend

If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Medical Record Amendment/Correction Form to our privacy official. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
b) Is not part of the health information that we keep.
c) You would not be permitted to inspect and copy.
d) Is accurate and complete.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, and health care operations. To obtain this list, you must submit your request in writing to our privacy official. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We Are Not Required to Agree to Your Request

If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit the Request for Restriction on Use & Disclosure of Medical Information and/or Confidential Communication form to our privacy official.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the Request for Restriction on Use & Disclosure of Medical Information and/or Confidential Communication to our privacy official. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact our privacy official.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our privacy official. You will not be penalized for filing a complaint.

A1A FAMILY EYECARE

Privacy Acknowledgement Form

Name: _____ Today's Date: _____ / _____ / _____
Last First MI

Sex: M F Marital Status: _____ DL# _____ State Issued _____

If student: Grade _____ School _____

Parent's Name (If Minor) _____ Employer: _____

Responsible party for account: _____ DOB:_____ Phone:_____

Who may we thank for referring you to this office? _____

Insurance Information

Primary Medical Insurance Provider: _____ Insurance ID#: _____

Primary Insured's Name: _____ DOB: _____

Vision Insurance Provider: _____ Insurance ID#: _____

Primary Insured's Name: _____ DOB: _____

- All professional services, which includes eye examinations and office visits, must be PAID IN FULL when services are rendered.
- All materials, such as glasses and contact lenses must be PAID IN FULL before orders are placed.
- Any balance incurred as a result of not having a required referral or correct insurance information will be your responsibility.
- If your claim is denied for any reason or we have not received payment within 4-6 weeks from filing, you are responsible for the balance due within 30 days.
- We do not accept personal checks.

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, _____, have reviewed/received a copy of A1A Family Eyecare's Notice of Privacy Practices.

Patient/Guardian Signature: _____ Date: _____

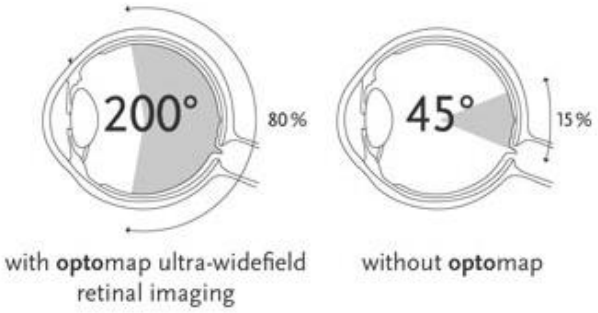
A1A FAMILY EYECARE

Dilation vs. Optomap Form

OPTOMAP RETINAL IMAGING

We are pleased to be able to offer the Optomap Retinal Image Exam which allows our doctors to review an ultra-widefield view of the retina. Your retina (located in the back of your eye) is the only place in the body where blood vessels can be seen directly. This means that in addition to eye conditions (example: glaucoma, macular degeneration, retinal detachment), signs of other systemic disorders (example: diabetes, hypertension, stroke) can also be seen in the retina. Early signs of these conditions can show on your retina long before you notice any changes to your vision or feel pain. Getting an Optomap image is fast, painless and comfortable. Nothing touches your eye and is suitable for the whole family. Under normal circumstances, dilation drops are not necessary, but your eye care practitioner will decide if your pupils need to be dilated depending on your conditions.

Optomap	Dilation
NO blurred vision	Blurred near vision for 4-6 hours
NO light sensitivity	Light sensitivity for 4-6 hours
Shortens office visit (takes less than 2 mins)	Longer office visit to wait for drop to take effect (additional 30-45 minutes)
80% of your retina in one panoramic image	15% of your retina viewable at one time
You can see your retina	Only the doctor can see the retina



Our doctors recommend that **ALL** patients have a thorough examination of their retina every year. Without the Optomap or a dilated examination, the doctor cannot fully assess the health of your eye. There is an additional fee of $39.00 for the Optomap. In most cases, this procedure is not covered by insurance. Dilation may still be required in rare instance.

___ I understand the above and elect to have my eyes dilated *(no additional charge)*.

___ I understand the above and elect to have the Optomap Retinal Imaging *($39.00)*.

___ I would like to refuse both the dilation and Optomap against my doctor's recommendation.

Patient Name _____

Patient/Guardian Signature_____ Date _____