DANIEL & DAVIS OPTOMETRY

Susan L. Daniel, O.D. • Christopher Davis, O.D. • Camilla E. Dukes, O.D., F.C.O.V.D. • Jonathan Jenness, O.D.

Thank you for choosing Daniel and Davis Optometry for your eye health needs. We ask that you review and complete the following items in preparation for your evaluation.

Welcome to Our Office – This is a general form that gives us basic information about yourself. The form requires two signatures – one signature that allows us to assist you in obtaining payment from your insurance, and the second signature acknowledges the validity of the information that you have provided on the form.

Office Policies – This form explains our office policies in detail, including our policies on payments, contact lens evaluations, vision insurances, and medical insurances. Please sign the bottom of this form to acknowledge that you understand these policies.

Notice of Privacy Practices and *Acknowledgement of Receipt* – The HIPAA Notice of Privacy Practices details our office's privacy policy and discusses how we make use of your personal health information. The federal government requires that we give this notice to you, and that you verify that you have received this notice by signing the Acknowledgement of Receipt. Please keep the notice for your records, return to us the signed acknowledgment.

Also enclosed are driving directions should you need assistance in finding our facility.

Please bring your completed paperwork, along with any eyeglasses or contact lenses that you currently use, with you to your exam. Do not hesitate to contact us should you have any questions regarding this material. We look forward to seeing you for your evaluation.

HOW TO SAVE AND SEND YOUR PAPERWORK

This is a PDF document with form fields.

To fill out this document, simply click each field and enter the appropriate information.

Once you have completed the paperwork, save the form with your information by going to File→Save or by using Ctrl+S.

The file name should be your name, followed by today's date. For example:

John Smith 01-01-2001.pdf

Please then send an email to info@drsofoptometry.com with the PDF attached before your scheduled appointment.

Thank you!

DANIEL & DAVIS
OPTOMETRY

Susan L. Daniel, O.D. • Christopher Davis, O.D. • Camilla E. Dukes, O.D., F.C.O.V.D. • Jonathan Jenness, O.D.

WELCOME TO OUR OFFICE

Today's Date: _____

Name _____

Preferred name / nickname: _____

Date of birth _____ Age: _____ Sex: ❒ M ❒ F

Race _____ Ethnicity _____

Street Address _____

City _____ Zip: _____

Home/Daytime phone _____

Cell phone _____

Email address _____

Preferred method of communication:

❒ Home phone ❒ Daytime phone ❒ Cell phone ❒ Email

Employer _____

Occupation _____

Hobbies/Sports _____

Special Needs _____

Spouse (or parent) name _____

Spouse (or parent) daytime phone _____

Vision Insurance ❒ VSP ❒ MESC ❒ CompBenefits/Humana ❒ UFCW

Medical Insurance _____ ❒ HMO ❒ PPO ❒ POS

Patient's Social Security Number _____

Insured's Social Security Number _____

Pharmacy Preference _____

How did you hear about our office?

❒ Friend or relative. Who? _____

❒ Another health care practitioner. Who? _____

❒ School District. Which one? _____

❒ Previous patient. Who? _____

❒ Participating eye care plan. Which one? _____

❒ Walk in ❒ Internet ❒ Other _____

Method of payment:

❒ Check ❒ Cash ❒ Visa / MC / Discover / AMEX

❒ Insurance – Please specify type: _____

❒ School District Contract – Which one? _____

Insurance Authorization

I certify that the information given by me in applying for insurance and/or Medicare payments is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Daniel and Davis Optometry on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature below authorizes the release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

☐ By checking this box and entering my name below, I understand that I am signing this authorization.

_____ _____

Signature Date

Please tell us why you are here today:

Do you currently wear glasses? ❒ Yes ❒ No

Do you currently wear contact lenses? ❒ Yes ❒ No If yes, contact lens type: _____ Brand: _____

How often do you wear your contacts? _____ For how many hours/day? _____ Contact lens solution: _____

Are you interested in laser vision correction? ❒ Yes ❒ No

Please check any/all of the following symptoms that you experience:

❒ Eye discomfort	❒ Loss of vision	❒ Dryness	❒ Tired eyes
❒ Sensitivity to sunlight	❒ Blurred vision	❒ Redness	❒ Floaters or spots
❒ Sandy or gritty feeling	❒ Distorted vision	❒ Itching	❒ Flashes of light
❒ Sties or chalazions	❒ Halos	❒ Burning	❒ Problems with glare or reflection

PERSONAL Ocular History Please check all of the following eye conditions that apply to you:

❒ Blindness ❒ Eye injury ❒ Glaucoma ❒ Retinal disease
❒ Cataracts ❒ Eye surgery ❒ Lazy eye ❒ Vision training / eye exercises
❒ Color blindness/deficiency ❒ Eye turn ❒ Other_____

PERSONAL Medical History Please check all of the following medical conditions that apply to you; elaborate if necessary:

❒ Blood pressure: ❍ High ❍ Low ❒ Asthma ❒ Dizziness / Fainting ❒ Migraines
❒ Cholesterol, elevated ❒ Arthritis / Rheumatoid ❒ Head injury ❒ Stroke
❒ Diabetes: ❍ Type 1 ❍ Type 2 ❒ Brain injury ❒ Headaches ❒ Seizures
❒ Stroke ❒ Developmental delay ❒ Hypothyroidism ❒ STDs

❒ Allergies:_____ ❒ Lung disorders: _____
❒ Cancers/tumors:_____ ❒ Neuro-developmental disorders: _____
❒ Heart/vascular disorders:_____ ❒ Psychiatric disorders: _____
❒ Kidney disorders:_____ ❒ Thyroid disorders: _____
❒ Liver disorders:_____ ❒ Other: _____

Do you have any history of surgery? ❒ Yes. ❒ No. If yes, what were they?_____

Do you currently: ❒ Smoke? ❒ Drink? ❒ Use narcotics? If so, how often? _____

Are you currently under the care of a physician? ❒ Yes ❒ No

Primary care physician:_____ City:_____ Date of last physical: _____

List all of your current medications:

Medication	Dosage	What is it for?

Medication **allergies**: _____

FAMILY History: Please check all of the conditions that apply to your family. If appropriate, please **specify the condition** within each category. Please also identify the **specific family member(s)** with each condition. Finally, use 'M' to designate maternal relatives and 'P' to designate paternal relatives.

Examples: *Hypertension, Grandmother-M* or *Lung Cancer, Uncle-P*

❒ Blindness:_____ ❒ Glaucoma: _____
❒ Cataracts:_____ ❒ Retinal disease: _____
❒ Color blindness/deficiency:_____ ❒ Vision training / Eye exercises: _____
❒ Eye turn / Lazy eye:_____ ❒ Other: _____

❒ Arthritis:_____ ❒ Headaches/Migraines: _____
❒ Asthma:_____ ❒ Heart disorders: _____
❒ Bronchitis:_____ ❒ Lung disorders: _____
❒ Cancers/tumors:_____ ❒ Multiple sclerosis: _____
❒ Chromosomal imbalance:_____ ❒ Neuro-developmental disorders: _____
❒ Developmental delay:_____ ❒ Psychiatric disorders: _____
❒ Diabetes:_____ ❒ Stroke: _____
❒ Endocrine Disorders: _____ ❒ Seizures/Epilepsy: _____
❒ Gastrointestinal Disorders: _____ ❒ Thyroid disorders: _____

The information I have provided on this form is true and complete to the best of my knowledge.

☐ By checking this box and entering my name below, I understand that I am signing this document.

_____ _____
Signature Date

Drs. Daniel and Davis Optometry
3144 El Camino Real, Suite #202 ▪ Carlsbad, California 92008
(760) 434-3314 Phone ▪ (760) 434-5624 Fax

OFFICE POLICIES

We are committed to offering the best and most thorough care possible. Please review policies listed below, as they are important to understanding the services offered at our office, how your payments are processed and how your insurance is billed.

Professional fees are due at the time services are rendered. Full payment is required when an order for glasses or contacts is placed. Professional fees are non-refundable. We accept Visa, MasterCard, Discover, American Express, and checks with valid identification. We also accept assignment on many types of vision insurance. There is a 25% service charge on all cancelled orders once the job has been started.

CONTACT LENS POLICIES

Contact lenses are medical devices that require a comprehensive vision and eye health evaluation before they are prescribed. If contact lenses are appropriate for you, follow-up medical management is required. We will release your prescription to you after the doctor has determined that the contact lenses meet all the criteria for proper eye health and visual acuity specific to your case.

If you are unable to adapt to your contact lenses, you have within 90 days the option to: (1) change to a different type of contact lens and pay the difference should there be any, or (2) apply the amounts paid less the professional fees toward the purchase of glasses. No cash refunds will be given, only office credit with the return of contact lenses in good condition.

Package prices for the various types of contact lenses include a comprehensive vision and eye health evaluation, all follow-up medical management and care, as well as the contact lenses.

EYEWEAR FOR SPORTING AND RECREATIONAL ACTIVITIES:

Standard frames and lenses are not recommended for sports and recreation activities. Standard frames and lenses can cause injury to your eyes and eyesight with impact. We recommend a pair of safety or sports lenses and frames for all patients engaging in any sporting or sport-like activities.

RETURNED CHECK POLICY

Any check returned to us as insufficient funds shall be charged a $25 service fee in addition to the value of the check. Additional fees as high as three times the amount of the check as well as collection fees may be charged if prompt payment of the returned check is not made.

VISION SERVICES AND VISION INSURANCE

Drs. Daniel and Davis Optometry accepts plans from four vision insurance providers: **Vision Service Plan (VSP), Medical Eye Services (MESC), CompBenefits, and United Food and Commercial Workers (UFCW).** Vision insurance generally provides coverage for your yearly eye exam, which includes the comprehensive screening of your eyes' health, and prescription of corrective glasses (if necessary).

Your vision insurance plan may also provide nominal coverage for frames, spectacle lenses, and/or contact lens evaluations and supply.

We do our best to verify insurance eligibility prior to any rendered services, so that we are able to notify you of any areas of concern prior to your appointment. Vision insurances have a large number of different vision plans with varying copays, exam coverage, material coverage, fee schedules, and eligibility dates.

If you have any questions regarding your eligibility for any services or materials, we will assist you as much as possible and provide as much information as we are able to attain. However, we strongly encourage you to research your insurance coverage thoroughly – both VSP and MESC provide member information that can be accessed on their respective websites or by calling their member information phone lines. If your insurance is provided to you as a benefit of your employment, your Human Resources or Insurance Benefits contact may also be a good resource for determining the details of your eligibility.

In some cases, the doctor may request a follow-up evaluation to your comprehensive eye exam based on a particular diagnosis or prescription that is slightly more involved. These visits are not covered by vision insurance, and payment for these services is expected at the time services are rendered. You may ask the doctor if you have questions regarding the cost for this follow-up care.

MEDICAL SERVICES AND MEDICAL INSURANCE

In the event of a medical visit, **Drs. Daniel and Davis Optometry does not belong to any network of medical insurance providers except Medicare. Therefore, besides Medicare, we do not accept payments from any medical insurances**. We may still request a copy of your medical insurance card so that we may be able to assist you as much as possible in submitting a claim to your own insurance for reimbursement.

Medical visits may include, but are not limited to, eye infections, eye-related emergencies, eye-related allergic reactions, and foreign body removal. The cost for these services, and any subsequent follow-up appointments, can often only be determined after the patient is evaluated by the doctor. For such visits and follow-up appointments, payment is expected at the time services are rendered.

We encourage you to call our office or come in immediately when such medical conditions or emergencies arise, as we are often able to treat you in a timelier manner than your primary healthcare provider or any urgent care or emergency room. After your initial evaluation and diagnosis, you may elect to continue follow-up care with your primary healthcare physician, who may be able to bill your insurance directly should this be your preference.

In addition, many vision therapy services that are not typically covered by standard vision insurances such as VSP or MESC may qualify for reimbursement by your medical insurance. Again, we encourage you to research your insurance thoroughly to determine what services may or may not be covered. Our office will assist you as much as possible with the procedure codes and diagnosis codes that medical insurances use to determine coverage and payment.

If you have any further questions regarding our office policies, your payments or insurance, our doctors and staff will assist you as much as possible.

I have read and understand the above policies regarding payments and insurance billing for services rendered at Drs. Daniel and Davis Optometry.

☐ By checking this box and entering my name below, I understand that I am signing this document.

Signature: _____ Date: _____

Printed Name: _____

The Health Insurance Portability and Accountability Act ("HIPAA")
NOTICE OF PRIVACY PRACTICES

DANIEL & DAVIS
OPTOMETRY
3144 El Camino Real, Suite 202, Carlsbad, CA 92008
(760) 434-3314 | (760) 434-5624 Fax
Office Contact Person: Alice Amaro

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.

Drs. Daniel and Davis Optometry will ask you to sign an Acknowledgment that you have received this Notice of Privacy Practices. We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes, in accordance with the HIPAA Privacy regulation, how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS
The most common reason why we use or disclose your health information is for treatment, payment, or health care operations.

Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids or services; or getting copies of your health information from another professional that you may have seen before us.

Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office.

Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION
In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker"s compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS
We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES
We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes you may initiate the process if it"s your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION
The law gives you many rights regarding your health information.

RESTRICTION REQUESTS. You have the right to ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.

ALTERNATIVE MEANS OF COMMUNICATION. You have the right to ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using email to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.

ACCESS. You have the right to ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.

HEALTH CARE INFORMATION AMENDMENTS. You have the right to ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address or fax shown at the beginning of this Notice.

ACCOUNTING. You have the right to get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.

NOTICE OF PRIVACY PRACTICES. You have the right to get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office and have copies available in our office.

COMPLAINTS
If you think we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address or fax shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION
If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

EFFECTIVE DATE
This Notice of Privacy Practices is effective as of April 14, 2003.

DANIEL & DAVIS
OPTOMETRY
3144 El Camino Real, Suite 202, Carlsbad, CA 92008
(760) 434-3314 | (760) 434-5624 Fax

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

☐ By checking this box and entering my name below, I understand that I am signing this acknowledgement of receipt.

_____
Patient Name (please print)

_____
Signature

_____
Date

The above patient has refused to sign this “Acknowledgement of Receipt” when asked on this date.

_____
Employee Name (please print)

_____
Signature

_____
Date

DANIEL & DAVIS OPTOMETRY

DRIVING DIRECTIONS

3144 El Camino Real, Suite 202
Carlsbad, CA 92008
(760) 434-3314

From North:

- --- Interstate 5S
- --- Freeway 78E
- --- Exit El Camino Real
- --- Turn right onto El Camino Real
- --- Make a u-turn at Carlsbad Village Drive
- --- Turn right at first driveway

From East:

- --- Freeway 78W
- --- Exit El Camino Real
- --- Turn left onto El Camino Real
- --- Make a u-turn at Carlsbad Village Drive
- --- Turn right at first driveway

From South:

- --- Interstate 5N
- --- Exit Carlsbad Village Drive
- --- Turn right onto Carlsbad Village Drive
- --- Turn left on El Camino Real
- --- Turn right at first driveway

Carlsbad Medical Dental Plaza – 3144 El Camino Real
Take elevator to 2nd Floor
Suite 202 is to the right as you exit the elevator