Boerne Vision Center
EYECARE EYEWEAR

GENERAL INFORMATION

Office Use Only	Date	Patient ID

Patient's Last Name	First	MI
Street Address, City, State, Zip		
Phone, cell	Phone, other	
Email	Primary Care Doctor	
Patient Social Security Number	Date of Birth	Sex: *(Male | Female)*
Marital Status	(*married* | *single* | *divorced* | *legally separated* | *widowed)*	
Race: (*Asian* | *Black* | *Native American* | *Pacific Islander* | *White* | *Other* | *Mixed-race)*		Ethnicity: (*Hispanic* | *not Hispanic)*
Emergency Contact Name	Phone	Relationship

INSURANCE INFORMATION

Vision Insurance	*NA* | *BlueVision* | *Eyemed* | *VSP* | *Other:*		
Vision Insurance Member Name	Vision Insurance Member Date of Birth		
Vision Insurance Member ID#	Vision Insurance Employer		
Primary Medical Insurance	*NA* | *Aetna* | *BCBS* | *Humana* | *Medicare* | *Other:*		
Primary Member Name	Primary DOB	Primary Employer	
Insurance ID#	Insurance Policy #/ Group ID #		
Primary Member Social Security #	Your Relationship to Primary Member: *Self* | *Spouse* | *Dependent* | *Other:*		
Secondary Medical Insurance	*NA* | *AARP* | *Aetna* | *BCBS* | *Humana* | *Medicare* | *Other:*		
Secondary Member Name	Secondary Member Date of Birth		
Secondary Medical Insurance ID#	Secondary Medical Insurance Policy #/Group ID#		
Secondary Member Social Security#	Relationship to Secondary Insurance: *Self* | *Spouse* | *Dependent* | *Other:*		.

MEDICAL INFORMATION

Age	Height	Weight	Allergies	
Diabetes *(NA | Type 1 | Type 2 | Other)*		Insulin *(Yes | No)*	HbA1c:	How many years
Date of last eye exam	Last eye doctor		Location of last eye exam?	
Currently Wear Glasses? *(Yes | No | readers)* *(Sunglasses | Single vision | Bifocals | Trifocals | Progressives)*		How old are the glasses?		
Currently wearing which brand of contact lenses?			*(None | Dailies | 2 week | Monthly | RGPs)*	

Reason for Today's Visit: Vision *(Eye Exam | Glasses | Contacts)*
Medical: *(Diabetes | Dry Eyes | Glaucoma | Macular Degeneration | Red Eye | Stye)*
Other:

EYE HISTORY

Are you currently experiencing, or have experienced, any of the following? (Circle all that apply.)

Blurry Vision	Burning	Discharge
Double Vision	Dryness	Tearing/Watering
Eye Infection	Eye Pain	Floaters or Spots
Halos	Headaches	Itching
Light Flashes	Light Sensitivity	Redness
Sandy or Gritty Feeling		Other_____

Have you or a family member experienced, or been treated for, any of the following? (Circle and list family members)

Cataracts	yes	no	family _____
Crossed Eye	yes	no	family _____
Glaucoma	yes	no	family _____
LASIK | PRK | RK	yes	no	family _____
Lazy Eye	yes	no	family _____
Macular Degeneration	yes	no	family _____
Retinal Detachment	yes	no	family _____

Other Past Eye Problems_____

Past Eye Surgeries *NA | Cataracts | LASIK | Lasers | Other*:

Current Medications (Include eye drops / over-the-counter / prescription drug name and dosage.)

Major Illnesses/Surgeries/past injuries:

Medication Drug Allergies
*No known Drug Allergy | Yes:*_____

Reaction_____

Occupation/Employer_____
(retired | student | full-time | part-time)

SOCIAL HISTORY
What are your hobbies?_____
Hours on a computer?_____
Smokes or Tobacco Use?
(Yes | Former Smoker | Socially | Never Smoked)

Alcohol consumption? *(Daily | Weekly | Monthly | Socially | No)*

Illicit or recreational drugs use?_____

REVIEW OF SYSTEMS

(Circle all that apply.)

Cardiovascular
Chest Pain
Irregular Heart Beat
Shortness of Breath

Constitutional
Fatigue
Fever
Night Sweat
Weight Gain
Weight Loss

Genitourinary
Genital Discharge
Genital Lesions
Painful Urination
Urgency

HEENT
Dizziness
Hearing Loss
Hoarseness
Ringing in Ears
Sore Throat

Hematologic
Bleeding
Bruising
Tender Nodes

Metabolic
Cold Intolerance
Excess Hunger
Excessive Thirst
Frequent Urination
Heat Intolerance

Musculoskeletal
Back pain
Joint Pain
Muscle Aches
Stiffness
Swelling

Neurological
Balance Problem
Headache
Numbness
Tingling

Psychiatric
Anxiety
Depression
Insomnia
Irritability

Respiratory
Cough
Trouble Breathing
Wheezing

Skin
Hair Loss
Rash
Skin Lesions

Allergies
Itching
Hives
Chronic Runny Nose
Seasonal Allergies
*Cedar | Oak | other*_____

Blood Pressure Control
Good BP control
Borderline BP Control
Poor BP Control
Unknown BP Control

Diabetes Control
Good control
Borderline Control
Poor Control
Unknown Control

Pregnancy
Pregnant
1st | 2nd | 3rd Trimester
Not Pregnant

Please list any other problems you may be experiencing_____

I hereby authorize the release of any medical information necessary for the procession of insurance. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to Dr. Susan Johnson O.D. (**HERE IN AFTER REFERRED TO AS THE "DOCTOR").** This assignment will remain in effect until revoked by me in writing received by the doctor. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize the doctor to submit all insurance claims for services or benefits I will receive from the doctor, directly or indirectly, in my name. I agree that my address in such insurance claims will be that of the doctor and hereby order all issuers of insurance claim checks to mail such checks directly to the doctor. I further agree that when the doctor receives any insurance claim check as provided above, I will immediately visit the doctor's office and endorse all insurance claim checks as payable in full to the doctor. The above agreements are made in partial consideration for the services and benefits I will receive from the doctor. However, I will pay for services rendered in the event my insurance company disputes my claim or does not pay in a timely manner.

Signature_____ **Date**_____

Boerne Vision Center
EYECARE EYEWEAR

Boerne Vision Center, PA
Dr. Susan L. Johnson
124 E Bandera Rd Suite #403
Boerne, TX 78006

OFFICE POLICIES AND PROCEDURES

EXAM TYPES

MEDICAL EXAM: This exam is to evaluate and diagnose overall eye health where there are underlying systemic, medicinal, or vision issues to include red eyes, dry eye syndrome, allergic disorders, diabetic retinopathy, glaucoma, etc. If any type of prescription other than for vision correction is provided, the exam will be considered a medical exam.

ROUTINE VISION: A basic vision exam to provide an overall eye health evaluation and refraction. NO other vision problems exist. If a routine exam is scheduled, but the doctor must treat you for other vision problems, a medical exam will be billed.

CONTACT LENSES PATIENT AGREEMENT

An additional exam and fee for a contact lenses fitting and evaluation to include a trial pair of contact lenses and up to 3 follow-up visits to confirm the proper fit and comfort of contact lenses within 60 days. *(There will be no refund on custom lenses, opened boxes of lenses or colored lenses. There will be NO refund of the exam, fitting, or annual contact lens examination fee.)*

•$50 Simple Evaluation (Basic spherical fitting or returning patient in same modality)
•$60 Intermediate Fit (Astigmatism or Colored Contact Lens)
•$75 Complex Fit (Monovision, Multifocal or new patient to contact lenses)

Under doctor's request, the patient may be provided with personalized instruction concerning the safe care and usage of contact lenses. If additional time is needed, it will be necessary to schedule a second 30-minute training session at a different time. Upon completion of successful insertion and removal, the patient may begin wearing the contact lenses and we may schedule the first follow-up appointment within two weeks.

I want a contact lens exam (check one)? ☐YES ☐RESCHEDULE ☐DECLINE

DILATION OF THE EYES

If the doctor feels it is necessary, the doctor will dilate your eyes. Dilation is a procedure where drops are instilled in the eyes to enlarge your pupils. This provides the doctor with a more thorough evaluation of the structures inside your eyes, for the detection of eye diseases such as Glaucoma, Cataracts, Tumors, Retinal Detachment, Diabetes, Hypertension, etc. Dilation may temporarily blur your vision and make you more sensitive to light (disposable sun shades will be provided). This process is included in the exam price and there is no extra charge if performed the same day. If rescheduled for another day, a $45.00 rescheduling will apply.

DILATION DISCLAIMER

During your eye exam, it is possible the doctor may desire to perform a pupillary dilation. Should you elect to receive such treatment, you acknowledge the fact Susan L. Johnson, O.D. or other contracted Optometrists, and Boerne Vision Center, P.A. recommend you do not drive a vehicle or operate any machinery for a period of at least two (2) hours thereafter. Dilation affects individuals in different ways, and in some patients can continue to adversely alter vision beyond such period of time. As a condition of performing a pupillary dilation, you agree to INDEMNIFY and DEFEND Susan L. Johnson, O.D., other contracted Optometrists, Boerne Vision Center, P.A. and all its agents and employees from any and all claim(s) and/or lawsuit(s) from third parties allegedly attributable to this procedure. Further, also as a condition of the dilation, you agree to RELEASE, ACQUIT, and FOREVER DISCHARGE Susan L. Johnson, O.D., and other contracted Optometrists, Boerne Vision Center, P.A. and all its agents and employees from any and all liability to third parties alleged to be attributed to this procedure.

Is it okay to dilate your eyes (check one)? ☐YES ☐RESCHEDULE ☐DECLINE

Dilation Acknowledged and Agreed Signature: _____

☐SELF ☐PARENT ☐GUARDIAN

INSURANCE ASSIGNMENT

• I certify that I, and/or my dependent(s) have insurance coverage and assign directly to Boerne Vision Center, P.A. all benefits, for services rendered.

• Boerne Vision Center, P.A. DOES NOT GUARANTEE that my insurance will pay my claim even if benefits are verified before the appointment.

• I further expressly agree & acknowledge that my signature on this document authorizes Boerne Vision Center, P.A. to submit claims for services rendered without obtaining my signature on each and every claim to be submitted for myself and/or my dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim dated today or in the future until further notice has been expressed in writing.
• Boerne Vision Center, P.A. may use my health care information and may disclose such information to the insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services.

FINANCIAL RESPONSIBILITY

• I understand that I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES whether or not paid by insurance, and I am responsible to pay any copayments/co-insurance at the time of my visit.
• I understand that if I have a balance, I will be mailed a statement or asked to pay at subsequent visit.
• If there is an overpayment on my account, a store credit will be placed on my account. It will remain a credit for 3 years. If the credit is not used within a 3 year period it will be forfeited.
• I understand that if I do not pick up my glasses, contact lenses, or other merchandise within 90 days of the date of purchase, I will forfeit any deposits made towards the purchase, and no refunds will be given. Any amounts paid by your insurance company on your behalf will not be refunded or reversed.

REFRACTION POLICY

•Refraction is the measurement of vision performed by the doctor to determine if you need corrective lenses (glasses and/or contact lenses). If you do need glasses or contacts, you will be given a prescription.
•Most medical insurance companies (including Medicare) will cover an eye exam if you have a medical diagnosis, but do not cover refraction.
•Our fee for this procedure is $45.00 and is due at the time of the exam, if you have a separate vision plan such as VSP, Davis, Avesis, Eyemed, Human Vision, etc., please let us know before we start your exam.
•I understand that my medical insurance may not cover refraction and prescription for glasses and that I may be responsible for the $45.00 fee.

WARRANTY

• I understand Boerne Vision Center, P.A. offers a one-time, one year warranty on all frames due to manufacturer defect, at no cost. Gross negligence or loss is not covered under this warranty. Boerne Vision Center, P.A. also offers a one-time, one year warranty on all lenses that have at least a TD2 or glare coating.
• All frames have a one year, one time manufacturer defect warranty from the date of purchase. Frames with dog/human bite marks or glue will not be covered. Neglect or loss is not covered. In the event of a claim, Boerne Vision Center reserves the right to repair or replace the frame.
• Returns: There are no refunds or returns on custom-made eyeglass lenses or contact lenses. Nonprescription sunglasses or other merchandise can be exchanged or returned for store credit within 7 days of purchase. Merchandise must be in the original, unopened package. NO cash refunds.
• COSMETIC FRAME RETURNS NOT AVAILABLE. We do NOT offer a change of frame due to dislike or unhappiness with frame color, style, or otherwise. Cancelled orders are subject to a 50% restocking fee.
• I understand I have 60 days from the date of my exam to return for a glasses prescription re-check. After 60 days, I may still return; however, a new exam & refraction will be billed.

I have read and I understand the DILATION DISCLAIMER, FINANCIAL POLICY, REFRACTION POLICY and WARRANTY POLICY of Boerne Vision Center PA. I further understand that if I have any questions regarding any of these policies, I am able to speak to an associate who can answer my questions while I am in the office or by sending an email to office@boernevisioncenter.com.

_____ Date _____

Signature of Patient, Parent/Guardian (Check one): ☐**SELF** ☐**PARENT** ☐**GUARDIAN**

Boerne Vision Center
EYECARE EYEWEAR

BOERNE VISION CENTER
DR. SUSAN L. JOHNSON
124 E BANDERA RD SUITE #403
BOERNE, TX 78006

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.

Our goal is to take appropriate steps to attempt to safeguard any medical or other personal information that is provided to us. The Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires us to: (i) maintain the privacy of medical information provided to us; (ii) provide notice of our legal duties and privacy practice; and (iii) abide by the terms of our Notice of Privacy Practices currently in effect.

WHO WILL FOLLOW THIS NOTICE

- **This notice describes the practices of our employees and staff and other healthcare associates and staff regarding your health care information. This notice applies to each of these individuals, entities, sites and locations. In addition, these individuals, entities, sites and locations may share medical information with each other for treatment, payment and health care operation purposes described in this notice.**

INFORMATION COLLECTED ABOUT YOU

In the ordinary course of receiving treatment and health care services from us, you will be providing us with personal information such as:

- Your name, address, and phone number.
- Information relating to your medical history.
- Your insurance information and coverage.
- Information concerning your doctor, nurse or other medical providers.
- Any other information we need in the course of your treatment.

In addition, we will gather certain medical information about you and will create a record (PHI) of the care provided to you. Some information also may be provided to us by other individuals or organizations that are part of your "circle of care" - such as the referring physician, your other doctors, your health plan, and close friends or family members. We may use and disclose personal and identifiable health information about you for a variety of purposes. All of the types of uses and disclosures of information are described below, but not every use or disclosure in a category is listed.

MANDATORY ELEMENTS

Required Disclosures. We are required to disclose health information about you to the Secretary of Health and Human Services, upon request, to determine our compliance with HIPAA and to you, in accordance with your right to access and right to receive an accounting of disclosures, as described below.

For Treatment. We may use health information about you in your treatment. For example, we may use your medical history, such as any presence or absence of diabetes, to assess the health of your eyes.

For Payment. We may use and disclose health information about you to bill for our services and to collect payment from you or your insurance company. For example, we may need to give a payer information about your current medical condition so that it will pay us for the eye examinations or other services that we have furnished you. We may also need to inform your payer of the treatment you are going to receive in order to obtain prior approval or to determine whether the service is covered.

For Health Care Operations. We may use and disclose information about you for the general operation of our business. For example, we sometimes arrange for auditors or other consultants to review our practices, evaluate our operations, and tell us how to improve our services. Or, for example, we may use and disclose your health information to review the quality of services provided to you.

Public Policy Uses and Disclosures. There are a number of public policy reasons why we may disclose information about you which are described below.

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

We may disclose protected health information about you in connection with certain public health reporting activities.

We may disclose protected health information about you in connection with certain public health reporting activities. For instance, we may disclose such information to a public health authority authorized to collect or receive PHI for the purpose of preventing or controlling disease, injury or disability, or at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority. Public health authorities include state health departments, the Center for Disease Control, the Food and Drug Administration, the Occupational Safety and Health Administration and the Environmental Protection Agency, to name a few.

We are also permitted to disclose protected health information to a public health authority or other government authority authorized by law to receive reports of child abuse or neglect. Additionally we may disclose protected health information to a person subject to the Food and Drug Administration's power for the following activities: to report adverse events, product defects or problems, or biological product deviations; to track products; to enable product recalls, repairs or replacements; or to conduct post marketing surveillance. We may also disclose a patient's health information to a person who may have been exposed to a communicable disease or to an employer to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether an individual has a work-related illness or injury.

We may disclose a patient's health information where we reasonably believe a patient is a victim of abuse, neglect or domestic violence and the patient authorizes the disclosure or it is required or authorized by law.

We may disclose health information about you in connection with certain health oversight activities of licensing and other health oversight agencies which are authorized by law. Health oversight activities include audit, investigation, inspection, licensure or disciplinary actions, and civil, criminal, or administrative proceedings or actions or any other activity necessary for the oversight of 1) the health care system, 2) governmental benefit programs for which health information is relevant to determining beneficiary eligibility, 3) entities subject to governmental regulatory programs for which health information is necessary for determining compliance with program standards, or 4) entities subject to civil rights laws for which health information is necessary for determining compliance.

We may disclose your health information as required by law, including in response to a warrant, subpoena, or other order of court or administrative hearing body or to assist law enforcement identify or locate a suspect, fugitive, material witness or missing person. Disclosures for law enforcement purposes also permit use to make disclosures about victims of crimes and the death of an individual, among others.

We may release a patient's health information (1) to a coroner or medical examiner to identify a deceased person or determine the cause of death and (2) to funeral directors. We also may release your health information to organ procurement organizations, transplant centers, and eye or tissue banks, if you are an organ donor.
We may release your health information to workers' compensation or similar programs, which provide benefits for work-related injuries or illnesses without regard to fault.
Health information about you also may be disclosed when necessary to prevent a serious threat to your health and safety or the health and safety of others.
We may use or disclose certain health information about your condition and treatment for research purposes where an Institutional Review Board or a similar body referred to as a Privacy Board determines that your privacy interests will be adequately protected in the study. We may also use and disclose your health information to prepare or analyze a research protocol and for other research purposes.
If you are a member of the Armed Forces, we may release health information about you for activities deemed necessary by military command authorities. We may release health information about foreign military personnel to their appropriate foreign military authority.
We may disclose your protected health information for legal or administrative proceedings that involve you. We may release such information upon order of a court or administrative tribunal. We may also release protected health information in the absence of such an order and in response to a discovery or other lawful request, if efforts have been made to notify you or secure a protective order.
If you are an inmate, we may release protected health information about you to a correctional institution where you are incarcerated or to law enforcement officials in certain situations such as where the information is necessary for your treatment, health or safety, or the health or safety of others.
Finally, we may disclose protected health information for national security and intelligence activities and for the provision of protective services to the President of the United States and other officials or foreign heads of state.
Our Business Associates. We sometimes work with outside individuals and businesses that help us operate our business successfully. We may disclose your health information to these business associates so that they can perform the tasks that we hire them to do. Our business associates must promise that they will respect the confidentiality of your personal and identifiable health information.
Disclosures to Persons Assisting in Your Care or Payment for Your Care. We may disclose information to individuals involved in your care or in the payment for your care. This includes people and organizations that are part of your "circle of care" – such as your spouse, your other doctors, or an aide who may be providing services to you. We may also use and disclose health information about a patient for disaster relief efforts and to notify persons responsible for a patient's care about a patient's location, general condition or death. Generally, we will obtain your verbal agreement before using or disclosing health information in this way. However, under certain circumstances, such as in an emergency situation, we may make these uses and disclosures without your agreement.
Appointment Reminders. We may use and disclose medical information to contact you by any means including phone, mail, facsimile or email as a reminder that you have an appointment or that you should schedule an appointment.
Treatment Alternatives. We may use and disclose your personal health information in order to tell you about or recommend possible treatment options, alternatives or health-related services that may be of interest to you.
Fundraising. We may use your protected health information to contact you in an effort to raise funds for our operations.

OTHER USES AND DISCLOSURES OF PERSONAL INFORMATION

We are required to obtain written authorization from you for any other uses and disclosures of medical information other that those described above. If you provide us with such permission, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose personal information about you for the reasons covered by your written authorization, except to the extent we have already relied on your original permission.

INDIVIDUAL RIGHTS

You have the right to ask for restrictions on the ways we use and disclose your health information for treatment, payment and health care operation purposes. You may also request that we limit our disclosures to persons assisting your care or payment for your care. We will consider your request, but we are not required to accept it.
You have the right to request that you receive communication containing your protected health information from us by alternative means or at alternative locations. For example, you may ask that we only contact you at home or by mail.
Except under certain circumstances, you have the right to inspect and copy medical, billing and other records used to make decisions about you. If you ask for copies of this information, we may charge you a fee for copying and mailing.
If you believe that information in your record is incorrect or incomplete, you have the right to ask us to correct the existing information or add missing information. Under certain circumstances, we may deny your request, such as when the information is accurate and complete.
Your have the right to receive a list of certain instances when we have used or disclosed your medical information. We are not required to include in the list uses and disclosures for your treatment, payment for services furnished to you, our health care operations, disclosures to you, disclosures you give us authorization to make and uses and disclosures before Feb 1, 2018, among others. If you ask for this information from us more that once every twelve months, we may charge you a fee.
You have the right to a copy of this notice in paper form. You may ask us for a copy at any time.
To exercise any of your rights, please contact us in writing at 124 E. Bandera Rd. STE 403, Boerne, TX 78006, HIPAA Compliance Officer. When making a request for amendment, you must state a reason for making the request.

CHANGES TO THIS NOTICE

We reserve the right to make changes to this notice at any time. We reserve the right to make the revised notice effective for personal health information we have about you as well as any information we receive in the future. In the event there is a material change to this notice, the revised notice will be posted. In addition, you may request a copy of the revised notice at any time.

COMPLAINTS/COMMENTS

If you have any complaints concerning our privacy practices, you may contact A. Sauceda, 303 E. Quincy, Suite 100, San Antonio, Texas, 78215. (210) 271-7648. You may also contact the Secretary of the Department of Health and Human Services, at 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201 (e-mail: ***ocrmail@hhs.gov***).

YOU WILL NOT BE RETALIATED AGAINST OR PENALIZED BY US FOR FILING A COMPLAINT.

To obtain more information concerning this notice, you may contact our HIPAA Privacy Officer at 124 E. Bandera Rd. STE 403, Boerne, TX 78006 (830) 331-8745. This notice is effective as of Feb 1, 2018.

Signature of Patient, Parent/Guardian:_____ Date:_____