Patient History Questionnaire Date: ____/____/______ ❐New Patient ❐ Previous Patient

Salutation: ❐ Mr. ❐ Mrs. ❐ Ms. ❐ Miss ❐ Dr. Social Security # _____-_____-_______ Date of Birth ____/____/_____

Name ____ I prefer to be called-_______________
(First) (M.I.) (Last)

Mailing Address ______________________________ City ____________________ State ________ Zip ____________

Home Phone ( )_______-________ Work Phone/Cell ( )_______-________ E-Mail ______________________
Do you prefer to receive calls at: ❐Home ❐Work ❐Either
Whom may we thank for referring you to our office? ________________________________

Responsible Party / Insurance

Person responsible for Account/Payment? ❐Self ❐ Other ____________________________
Vision Insurance ____________________ Medical Insurance ____________________ Do you have Medicare ❐ No ❐ Yes
Primary Insured's Name ❐Self ❐ Other ____________________ **Please present insurance card to front desk**
If other, complete the following: Relationship to Patient ________________
Insured's Date of Birth ____/____/______ Social Security # ______-______-__________

Authorization and Release (If using Insurance)
*I hereby authorize the release of any medical or other information necessary to process my insurance claim. I authorize payment of benefits directly to Eyes on the Mountain. I understand that I am responsible for any deductible, share of cost, or uncovered service.

Signature of patient / or guardian ____ Date _____/_____/_______

Health History

Date of last exam ____________ Name of Eye Doctor ____________________ Family Doctor ____________________
List any drug allergies ____
List any medications you take ____
List any eye surgeries you have had ____
Do you wear glasses? ❐No ❐Yes If yes, how old is your current pair of glasses? ______________
Do you wear contact lenses? ❐No ❐Yes Are you interested in contact lenses today? ❐No ❐Yes

Family History

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

CONDITION	NO	YES	RELATIONSHIP	CONDITION	NO	YES	RELATIONSHIP
Blindness	❐	❐	____________	Cancer	❐	❐	____________
Cataract	❐	❐	____________	Diabetes	❐	❐	____________
Crossed Eyes	❐	❐	____________	Heart Disease	❐	❐	____________
Glaucoma	❐	❐	____________	High Blood Pressure	❐	❐	____________
Macular Degeneration	❐	❐	____________	Kidney Disease	❐	❐	____________
Retinal Detachment	❐	❐	____________	Thyroid Disease	❐	❐	____________
Retinal Disease	❐	❐	____________	Lupus	❐	❐	____________
Arthritis	❐	❐	____________	Other ____________	❐	❐	____________

Social History

For insurance purposes are you: ❐Student ❐Single ❐Married ❐Widowed
Occupation ______________________________ Your Employer ______________________________
How many hours per day do you spend on the computer? _________ hours/day
Do you use tobacco? ❐No ❐Yes If yes, type / amount / how long: ______________________
Do you drink alcohol? ❐No ❐Yes If yes, type / amount / how long: ______________________
Have you received a pneumonia vaccine? YES NO month/year ______________________
Have you received a Flu Shot? YES NO month/year ______________________

PLEASE BE SURE TO COMPLETE BOTH SIDES OF FORM

REVIEW OF SYSTEMS: Do you have a problem with…

SYSTEM	NO	YES
EYES		
Loss of Vision	❒	❒
Distorted Vision / Halos	❒	❒
Loss of Side Vision	❒	❒
Double Vision	❒	❒
Dryness	❒	❒
Tired Eyes	❒	❒
Mucous Discharge	❒	❒
Redness	❒	❒
Sandy or Gritty Feeling	❒	❒
Itching	❒	❒
Burning	❒	❒
Excess Tearing / Watering	❒	❒
Glare / Light Sensitivity	❒	❒
Eye Pain of Soreness	❒	❒
Chronic Eye Infections	❒	❒
Sties or Chalazions	❒	❒
Flashes / Floaters in Vision	❒	❒
CONSTITUTIONAL / GENERAL		
Fever	❒	❒
Weight Loss	❒	❒
Weight Gain	❒	❒
INTEGUMENTARY / SKIN		
Rashes	❒	❒
Dryness	❒	❒
Sores	❒	❒
ALLERGIC / IMMUNOLOGIC		
Hayfever	❒	❒
Medicine Allergies	❒	❒
NEUROLOGICAL		
Headaches	❒	❒
Migraines	❒	❒
Seizures	❒	❒
ENDOCRINE		
Thyroid	❒	❒
Other Glands	❒	❒

SYSTEM	NO	YES
EARS, NOSE, MOUTH, THROAT		
Allergies / Hayfever	❒	❒
Sinus Problems	❒	❒
Chronic Cough	❒	❒
Dry Throat / Mouth	❒	❒
Chronic Ear Infections	❒	❒
RESPIRATORY		
Shortness of breath	❒	❒
Asthma	❒	❒
Emphysema	❒	❒
CARDIOVASCULAR		
Diabetes	❒	❒
Heart Pain	❒	❒
High Blood Pressure	❒	❒
Vascular Disease	❒	❒
GASTROINTESTINAL		
Diarrhea	❒	❒
Constipation	❒	❒
Ulcers	❒	❒
GENITOURINARY		
Genitals	❒	❒
Kidney	❒	❒
Bladder	❒	❒
MUSCULOSKELETAL		
Rheumatoid Arthritis	❒	❒
Muscle Pain	❒	❒
Joint Pain	❒	❒
HEMATOLOGIC / LYMPHATIC		
Anemia	❒	❒
Bleeding Problems	❒	❒
Swelling	❒	❒
PSYCHIATRIC		
Nervous Disorders	❒	❒
Depression	❒	❒
Compulsive Behavior	❒	❒

*Doctor's Notes and Initials	*For Future Visits History Reviewed by Patient Date and Patient's Initials

Dilation Today

- ❒ Yes, I would like to be dilated today.
- ❒ I am unsure about being dilated today. I would like more information please.
- ❒ No, I would not like to be dilated today. I understand the importance of a dilated eye exam.

HIPAA Acknowledgement

I am aware that Eyes on the Mountain abides by the HIPAA privacy Policy thereby keeping my personal and medical information confidential.

Patient / Guardian Signature ______________________ Date: __________

Eyes on the Mountain
1807 Taft Highway, Suite 9
Signal Mountain, TN 37377
P. 423-886-7252 F. 423-886-9551

We at Eyes on the Mountain are committed to providing you the best eye care possible. In order to accomplish this, we find it necessary to implement the following financial policies.

Insurance Authorization and Assignment: I request the payment of authorized private insurance company benefits, Medicare and Medicaid services, or any other applicable benefits be paid on my behalf to Dr. Hale of Eyes on the Mountain for any furnished service. I authorize Eyes on the Mountain to release any medical or other information about me to any private insurance company, Medicare and Medicaid, any other company and its agents which might provide coverage to me.

All Services are the Responsibility of the Patient: Eyes on the Mountain will gladly bill your primary insurance. I understand that insurance benefits must be determined prior to my exam. If I become aware of insurance coverage after services have been rendered, I agree to personally submit the claim to my insurance company for reimbursement. I understand that if my insurance company requires a referral from my primary-care physician, and I do not furnish the correct referral at the time of service, I will be responsible for payment if my insurance company refuses my claim. I also understand that I am financially responsible for non-covered services and any unpaid insurance balance over sixty days past due.

Payments, Co-Pays, Deductibles, and Non Covered Services: I understand that not all services and meters may be covered by my insurance or may exceed benefits or coverage. I agree to pay all payments, co-pays, deductibles, and non-covered services at the time of service for medical care, and at the time of delivery for materials. If I have no vision coverage, I understand that a deposit of one half the total payment is due at the time of order. Any materials ordered that have not been picked up within six months will be returned, and any deposit will be forfeit.

Returned Checks: There is a $15.00 fee for any check returned by the bank. This will be added to the unpaid balance and must be paid by cash or credit card.

Print Patient Name: ____

Responsible Party (if not the patient): ________________________________

Signature: ______________________________ Date: ________________

ACKNOWLEDGEMENT RECEIPT:

By initialing below, I acknowledge I was offered a copy of Eyes on the Mountain's Notice of Privacy Practices,

______ Yes, I would like to receive a copy of Eyes on the Mountain's Notice of Privacy Practices.

______ No, I do not wish to receive a copy of Eyes on the Mountain's Notice of Privacy Practices.

Eyes on the Mountain | Notice of Privacy Practices

Effective 09/11/2021

Your Information. Your Rights. Our Responsibilities.
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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. You can get an electronic or paper copy of your medical record:

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information. We may charge a reasonable, cost-based fee.

ASK US TO CORRECT YOUR MEDICAL RECORD

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days

REQUEST CONFIDENTIAL COMMUNICATIONS

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

ASK US TO LIMIT WHAT WE USE OR SHARE

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

GET A LIST OF THOSE WITH WHOM WE'VE SHARED INFORMATION

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

GET A COPY OF THIS PRIVACY NOTICE

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

CHOOSE SOMEONE TO ACT FOR YOU

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

FILE A COMPLAINT IF YOU FEEL YOUR RIGHTS ARE VIOLATED

- You can complain if you feel we have violated your rights by contacting us at 423-886-7252.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

HOW DO WE TYPICALLY USE OR SHARE YOUR HEALTH INFORMATION?

We typically use or share your health information in the following ways:

TREAT YOU

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

RUN OUR ORGANIZATION

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

BILL FOR YOUR SERVICES

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

HELP WITH PUBLIC HEALTH AND SAFETY ISSUES

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

DO RESEARCH

We can use or share your information for health research.

COMPLY WITH THE LAW

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

RESPOND TO ORGAN AND TISSUE DONATION REQUESTS

We can share health information about you with organ procurement organizations.

WORK WITH A MEDICAL EXAMINER OR FUNERAL DIRECTOR

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

ADDRESS WORKERS' COMPENSATION, LAW ENFORCEMENT, AND OTHER GOVERNMENT REQUESTS

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

RESPOND TO LAWSUITS AND LEGAL ACTIONS

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

FOR MORE INFORMATION SEE:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.