anne savko O.D. OPTOMETRY

Today's Date _____ **Welcome to our office**

Title Mr. Mrs. Ms. Miss Master Rev. Dr. PhD. **Gender** M F

Last Name _____ **First Name** _____ **Initial** ____

Name you would like to be called / Nickname _____

Birthday _____**Age** _____ **Marital Status** S M D W DP **Race/ Ethnicity** _____

Street Address _____

City _____ **State** _____ **Zip** _____

Home Phone (____)_____ **Cell Phone** (_____)_____

Work Phone (_____)_____ **Email** _____

Patient's Soc. Sec # _____-_____-_____ **Patient's Driver's License #** _____

Employer (or School) _____ **Occupation (or grade)** _____

Spouse's/ Parent's Work # (____)_____

Emergency Contact Name _____ **Relation** _____ **Phone** (____) _____

Who may we thank for referring you? _____

Vision Insurance _____ **Patient relationship to Subscriber** self

Subscriber Name _____ spouse

Suscriber ID # _____ child

Subscriber Date of Birth _____ student

Subscriber Soc. Sec. # _____ partner

Primary Medical Insurance _____ **Group/ Plan #**_ _____
PPO POS HMO Medicare Part B

Subscriber Name _____ **Patient relationship to Subscriber** self

Subscriber Date of Birth _____ spouse

Subscriber Soc. Sec # _____ child

Do you have secondary Vision Insurance? Yes No _____ student

Do you have secondary Medical Insurance? Yes No _____ partner

Do you participate in a Flex Spending account? Yes No

Most Vision Insurance Plans do not pay for both examination for glasses and an evaluation for contact lenses. There will be an additional charge if you choose to have both services.

I understand and agree that I am responsible for the full amount of my fee's for any professional services rendered. Pre-authorization is not a guarantee of payment. I understand that I am financially responsible for any charges not reimbursed by my insurance company. It is possible for insurance companies to misquote benefits and coverage for optometric services.

I authorize the release of any information necessary to process insurance claims. I authorize payment of Optometric and Medical benefits to Dr. Savko for services rendered, and to deposit checks received on this account when made out to Dr. Savko. I certify that the information above is true and correct to the best of my knowledge.

Long time authorization / financial responsibility/ signature on file _____ **date** _____

Patient Health History

Patient Name _____ Occupation _____ DOB ____/____/_____

Primary Care Physician _____ Pharmacy used _____

Do you wear glasses? Yes No Are you interested in LASIK/ Refractive Surgery? Yes No

Do you wear contact lenses? Yes No
(New Patient) If yes, Name of Contact Lens _____
Right Eye Power_____Left Eye Power _____

Why have you come in today? (ex: change in vision, update glasses prescription, update contact lens prescription, floaters, red eyes, etc…)_____
_____
_____

Medical History
Please list all your current medications (include birth control, over the counter, aspirin, vitamins, etc.): □None _____
_____
_____

List all major injuries,surgeries, and/ or hospitalizations(eye surgery included): □ None _____
_____
_____

List any allergic reactions to medications or eye drops : □ None_____

Women- Are you pregnant? Yes No Are you currently breast feeding? Yes No

Please indicate if any of the conditions apply to you or a family member (blood relative).

Disease/ Condition	Yourself		Family Member	
	Yes	No	Yes	No
Cataract	□	□	□	□
Eyeturn/ strabismus	□	□	□	□
Lazy eye/ amblyopia	□	□	□	□
Glaucoma	□	□	□	□
Macular Degeneration	□	□	□	□
Retinal Detachment	□	□	□	□
Color Vision Defect	□	□	□	□
Blindness	□	□	□	□

Other _____

Review of Systems **Please indicate below if you have or ever had problems with the following conditions:**

Allergic/ Immunologic
□ None
□ Lupus- SLE
□ Rheumatoid Arthritis
□ Environmental Allergies
□ Seasonal Allergies
□ Other

Ear, Nose, Throat
□ None
□ Sinusitis
□ Upper Resp infection
□ Other

Gastrointestinal
□ None
□ Crohn's disease
□ Colitis
□ Acid Reflux/Ulcer
□ Other

Skin
□ None
□ Eczema
□ Rosacea
□ Psoriasis
□ Other

Psychiatric
□ None
□ Depression
□ Anxiety
□ Bi-polar
□ Schizophrenia
□ Other

Cardiovascular
□ None
□ High Blood Pressure
□ Heart Disease
□ Stroke
□High Cholesterol

Endocrine/ Glands
□None
□ Diabetes
□ Hormone dysfunction
□ Thyroid Dysfunction
□ Other

Respiratory
□ None
□Asthma
□ Bronchitis
□ Emphysema
□ Other

Muscle/Skeletal
□None
□ Arthritis
□ Fibromylgia
□ Ankylosing Spondylitis
□ Other

Genital/ Urinary
□None
□ Urinary Tract Infection
□ HIV positive
□ Herpes/ Chlamydia
□Other

Hematologic/ Lymphatic
□ None
□ Anemia
□ Leukemia
□ Bleeding Disorder
□ Other

Neurological
□ None
□ Multiple Sclerosis
□ Epilepsy
□ Tremors
□ Other

General Health
□ None
□ Weight loss/ gain
□ Fever
□ Trauma
□ Other

Social
□ tobacco use
current smoker former smoker
□ Non-prescription drugs/ recreational drugs
_____
□ alcohol consumption _____
□ Height _____ Weight _____

Please sign below to acknowledge that this form is current:

Signature: _____ **Date**: _____

Effective Date of Notice: June 1, 2018

Anne Savko, O.D. Optometry
1338 N. Moorpark Road, Thousand Oaks, CA 91360
Phone: 805-495-5510 Fax: 805-373-8570 Email: aesavko@gmail.com

NOTICE OF PRIVACY

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

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 how we protect your health information and what rights you have regarding it.

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.

Get an electronic or paper copy of your medical records. 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 of a summary of your health information, usually within 30 days of your request. 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).

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.

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 the number listed above. 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: 1) Share information with your family, close friends, or others involved in your care. 2) Share information in a disaster relief situation. 3) 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: 1) Marketing purposes. 2) Sale of your information. 3) 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: 1) Treat you. We can use your health information and share it with other professionals who are treating you. 2) Run our organization. We can use and share your health information to run our practice, improve our care and contact you when necessary. 3) Bill for your services. We can use and share your health information to bill and get payment from health plans and other entities.

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: 1) Preventing disease. 2) Helping with product recalls. 3) Reporting adverse reactions to medications. 4) Reporting suspected abuse, neglect, or domestic violence. 5) 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: 1) For workers' compensation claims. 2) For law enforcement purposes or with a law enforcement official. 3) With health oversight agencies for activities authorized by law. 4) 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

1) We are required by law to maintain the privacy and security of your protected health information. 2) We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 3) We must follow the duties and privacy practices described in this notice and give you a copy of it. 4) 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. 5) For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html. 6) 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.

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 call or write to notify you of other treatments or services available at our office that might help you.

OUR NOTICE OF PRIVACY PRACTICES

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 one in our office and have copies available in our office.

COMPLAINTS

If you think that 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, fax or email 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.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I reviewed and was offered/received a copy of ANNE SAVKO, O.D. OPTOMETRY Notice of Privacy Practices.

Patient name _____

Signature _____Date_____

anne savko O.D.
OPTOMETRY

1338 N. Moorpark Rd. Thousand Oaks, CA 91360
(805) 495-5510 FAX: (805)373-8570

We are proud to introduce the latest in retinal imaging, the Optomap. It is a painless and quick widefield photograph of structures inside the eye. It is the doctor's preferred method to look at the internal health of your eye. This instrument will enhance our ability to detect and monitor retinal defects associated with common systemic diseases such as hypertension, diabetes, high cholesterol, and thyroid problems. Through this digital imaging of the retina, we can observe early changes in the eye relating to glaucoma, cataracts, and macular degeneration.

This technology is now our new standard of care.

There is a **$39 co-pay** for the series of pictures and review with the doctor.
Please check one of the following:

☐ Yes, I would like to have this procedure

☐ I would like to discuss with the doctor

I certify that I do <u>not</u> have a history of Epilepsy or Seizures._____(initial)

This procedure is safe for everyone else (elderly, children, pregnant women, etc.)

Print Name:_____Date:_____

Signature:_____