Welcome to Our Low Vision Clinic

Your low vision appointment is with ________________________________

Time ___________________    Date ___________________
LOW VISION EVALUATION CHECKLIST

Please make sure that each box is checked before you come for your evaluation.

- Please bring welcome packet filled out
  - Acknowledgement of receipt signed
  - Authorization for release of information
  - ABN (if present)

- Please bring all medical cards, primary and secondary, for billing

- Please bring all vision devices (whether they work or not) except for heavy electronic items

- If paying privately please bring form of payment (check, card or cash)

- Make sure that you are going to the correct location (Downtown or Roseville)
NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices (“Notice”) describes how we may use or disclose your health information and how you can get access to such information. Please read it carefully. Your “health information,” for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as “health information” in this Notice).

We are required by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health 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; referring you to another doctor or clinic for eye care or 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 must carry out 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.

OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. 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 a 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” and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA;
• [specify other uses and disclosures affected by state law].

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for health care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION

The following are some specific uses and disclosures we may not make of your health information without your authorization:

Marketing activities. We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent to such payment.

Sale of health information. We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.

Psychotherapy notes. Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

• Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization.
• You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.
• We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.

• We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right:

• To request restrictions on the health information we may use and disclose for treatment, payment and health care operations. We are not required to agree to these requests. To request restrictions, please send a written request to us at the address below.

• To receive confidential communications of health information about you in any manner other than described in our authorization request form. You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.

• To inspect or copy your health information. You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.

• To amend health information. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:
  • was not created by us, unless the person that created the information is no longer available to make the amendment,
  • is not part of the health information kept by or for us,
  • is not part of the information you would be permitted to inspect or copy, or
  • is accurate and complete.

• To receive an accounting of disclosures of your health information. You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).
• To designate another party to receive your health information. If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

Contact Person:
Our contact person for all questions, requests or for further information related to the privacy of your health information is:

Toni Boom
Director of Clinical Services
1238 S Street
Sacramento, CA 95811

Complaints:
If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to 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 E mail shown above. If you prefer, you can discuss your complaint in person or by phone.

Changes to This Notice:
We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

Notice Revised and Effective: August 7, 2013

ACKNOWLEDGEMENT OF RECEIPT
I acknowledge that I received a copy of Society for the Blind, Low Vision Clinic, Notice of Privacy Practices.

Date ___________ Patient Name________________________________

Signature _______________________________
BILLING POLICY

The Low Vision Clinic at Society for the Blind serves the Department of Rehabilitation and Medicare as well as many private insurance companies. Our goal is to meet or exceed your expectations when you visit our clinic without any surprises. In order to achieve this, we would like to share our billing policies with you.

If you are insured by an HMO, please make sure your primary care doctor and the Low Vision Clinic at Society for the Blind are affiliated with the same medical groups. Otherwise your insurance company will not pay for your low vision evaluation and it will become your responsibility.

If you are insured by Medicare or a PPO, please bring a current copy of your insurance card to your Low Vision Evaluation so that we can bill your insurance for you.

We will collect the fees for your Low Vision Evaluation on the day of your appointment. These fees are determined by the insurance companies and can include your Co-Pay, Refraction, or the percentage not covered by your insurance plan.

If you are currently uninsured, the entire exam fee will be collected on the day of your appointment. We accept cash, checks, VISA, MasterCard and Debit cards.

Most medical insurance companies do not cover routine eye exams. If you are being seen due to a medical condition, they typically will pay for the medical portion of the exam after you have met your annual deductible. This does not include the refraction. The refraction is the part of your Low Vision Evaluation where we determine your remaining functional vision for the evaluation of low vision aids.

We are governed by the rules and conditions set up by the insurance companies. If you have any questions about our billing policies, please contact us at 916.452.8271 x505.
AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby give my permission for Society for the Blind, Low Vision Clinic, to obtain or exchange information regarding my medical or visual treatment.

This information will be used only for Low Vision Evaluation and/or rehabilitation services.

__________________________________   _________________________  
Patient Signature    Date

__________________________________   _________________________  
Parent/Guardian Signature   Date
MEDICAL HISTORY QUESTIONNAIRE

Name: _____________________________  Today’s Date: _____ / _____ / _____
Address: ____________________________  Phone: _________________________
City: ___________________  Zip: __________  Work/Cell Phone: _______________
Guardian (If Applicable): __________________  Occupation: ______________________
Birth Date: ___ / ___ / ___  Social Security #: ___ / ___ / ___  Last Eye Exam: ___ / ___ / ___
EmailAddress: ___________________________  Last Medical Exam: ___ / ___ / ___
Are you a veteran? ____________________  Medicare ID number: ______________
Name of Medical Doctor: ___________________  Medical Dr.’s Phone: ______________
Name of eye doctor: _____________________  Eye Dr.’s Phone: ______________

Medical History
Do you have any allergies to medications? □ no  □ yes  If yes, explain: ____________________________
Do you have any immunity 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
Do you wear glasses? □ no  □ yes
If yes, how old is your present pair of lenses? ____________________________
Do you wear contact lenses? □ no  □ yes
If yes, how old is your present pair of lenses? ____________________________
Type of contact lenses: □ Rigid □ Soft □ Extended Wear □ Other
Are they comfortable? □ no  □ yes
Brand Name __________________  Power right eye __________  Power left eye __________
MEDICAL HISTORY QUESTIONNAIRE (CONTINUED)

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

☐ Yes, I would prefer to discuss my Social History directly with the doctor. (Check box)

Do you drive? ☐ no ☐ yes If yes, do you have visual difficulty when driving? ☐ no ☐ yes
If yes, please describe:
_____________________________________________________________________________

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

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

<table>
<thead>
<tr>
<th>DISEASE/CONDITION</th>
<th>NO</th>
<th>YES</th>
<th>?</th>
<th>RELATIONSHIP TO YOU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
<td>____________________</td>
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<tr>
<td>Cancer</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
<td>____________________</td>
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<tr>
<td>Diabetes mellitus</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
<td>____________________</td>
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<tr>
<td>Endocrine disease</td>
<td>☐</td>
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<td>____________________</td>
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<tr>
<td>Stroke</td>
<td>☐</td>
<td>☐</td>
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<td>____________________</td>
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<tr>
<td>Hypercholesterolemia</td>
<td>☐</td>
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<td>☒</td>
<td>____________________</td>
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<tr>
<td>Cardiovascular disease</td>
<td>☐</td>
<td>☐</td>
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<td>____________________</td>
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<tr>
<td>Hypertension</td>
<td>☐</td>
<td>☐</td>
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<td>____________________</td>
</tr>
</tbody>
</table>

MEDICAL HISTORY QUESTIONNAIRE (CONTINUED)

Social History

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

☐ Yes, I would prefer to discuss my Social History directly with the doctor. (Check box)

Do you drive? ☐ no ☐ yes If yes, do you have visual difficulty when driving? ☐ no ☐ yes
If yes, please describe:
_____________________________________________________________________________

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:

<table>
<thead>
<tr>
<th>SYSTEM</th>
<th>NO</th>
<th>YES</th>
<th>?</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONSTITUTIONAL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fever, Weight Loss/Gain</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
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<tr>
<td>CARDIOVASCULAR</td>
<td></td>
<td></td>
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<tr>
<td>Diabetes</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
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<tr>
<td>Heart Pain</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
</tr>
<tr>
<td>Vascular Disease</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
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<tr>
<td>EARS, NOSE, MOUTH, THROAT</td>
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<tr>
<td>Hay Fever</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
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<tr>
<td>Sinus Congestion</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Runny Nose</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
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<tr>
<td>Post-Nasal Drip</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
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<tr>
<td>Chronic Cough</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
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<tr>
<td>Dry Throat/Mouth</td>
<td>☐</td>
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<tr>
<td>RESPIRATORY</td>
<td></td>
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<tr>
<td>Asthma</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
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<tr>
<td>Chronic Bronchitis</td>
<td>☐</td>
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<tr>
<td>Emphysema</td>
<td>☐</td>
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<tr>
<td>GASTROINTESTINAL</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Diarrhea</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
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<tr>
<td>Constipation</td>
<td>☐</td>
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</tr>
<tr>
<td>GENITOURINARY</td>
<td></td>
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<tr>
<td>Genital/Kidney/Bladder</td>
<td>☐</td>
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<tr>
<td>MUSCULOSKELETAL</td>
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<tr>
<td>Rheumatoid Arthritis</td>
<td>☐</td>
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<tr>
<td>Muscle Pain</td>
<td>☐</td>
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<tr>
<td>Joint Pain</td>
<td>☐</td>
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<tr>
<td>INTEGUMENTARY (SKIN)</td>
<td></td>
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<tr>
<td>NEUROLOGICAL</td>
<td></td>
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<tr>
<td>Headaches</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Migraines</td>
<td>☐</td>
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<tr>
<td>Seizures</td>
<td>☐</td>
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<tr>
<td>PSYCHIATRIC</td>
<td></td>
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<tr>
<td>ENDOCRINE</td>
<td></td>
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<tr>
<td>Anemia</td>
<td>☐</td>
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<tr>
<td>BLEEDING PROBLEMS</td>
<td></td>
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<tr>
<td>Bleeding problems</td>
<td>☐</td>
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</tbody>
</table>
### Ocular History

<table>
<thead>
<tr>
<th>Condition</th>
<th>SELF</th>
<th>FAMILY (RELATIONSHIP TO YOU)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amblyopia</td>
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<tr>
<td>Blindness</td>
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<tr>
<td>Cataract</td>
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<tr>
<td>Glaucoma</td>
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<tr>
<td>Strabismus</td>
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<tr>
<td>Macular Degeneration</td>
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<tr>
<td>Crossed Eyes</td>
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<tr>
<td>Diabetic Retinopathy</td>
<td></td>
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<tr>
<td>Retinal detachment/disease</td>
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<td></td>
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<tr>
<td>Crossed Eyes</td>
<td></td>
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<tr>
<td>Lazy Eye</td>
<td></td>
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<tr>
<td>Drooping eyelid</td>
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<tr>
<td>Prominent eyes</td>
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<tr>
<td>Eye infection</td>
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</tbody>
</table>

### Functional Vision Questionnaire

Please check if you have difficulty with any of the following:

- Seeing street signs
- Watching television
- Taking medications
- Enjoying hobbies
- Operating a computer
- Reading books
- Driving
- Dialing a telephone
- Operating appliances
- Walking
- Writing
- Other ________________________________________________________________________

Please list any eye medications (drops, vitamins etc)
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Have you had any trauma to your eye or eye surgery? If so please indicate date.
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
If you answered YES to any of the above or have a condition not listed, please explain and list medications:
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
Low Vision Clinic Doctor’s Signature______________________________  Date____________