TORRINGTON VISION SOURCE
Dr. Grant Jones **Dr. Lynda** Jones

Patient Information

Today's Date: .....
Sex: O Male O Female
Patient's Legal Name: .....
Age: ..... Date of Birth: ..... Social Security Number: .....
Home Address: .....
City/State/Zip Code.....
Mailing Address (if different): .....
City/State/Zip Code.....
Home Phone: ..... (Leave Message? Y / N) Cell Phone: ..... (Leave Message? Y / N)
Work Phone: ..... (Leave Message? Y / N) Email Address: .....
Is it okay to contact you via Email? O Yes O No Is it okay to contact you via text message? O Yes O No
Are you: O Single O Married O Divorced O Widowed
Spouse Name ..... Home Phone .....
Spouse Address (if different) ..... Cell Phone .....
Is any other family member a patient in this office? .....
Your Occupation: .....
Employer's Name: ..... Employer's Phone:.....
Patient's Emergency Contact:..... D.O.B. ..... Phone .....
Emergency Contact Relation to Patient .....
Patient's Pharmacy / Location: .....
Patient's Primary Care Physician: .....Patient's referring Doctor: .....
Whom may we thank for your referral? .....

PARENT INFORMATION IF PATIENT IS UNDER 18 YEARS OF AGE:

Father's Name: ..... Father's Employer: .....
Father's Social Security Number ..... Father's Work Phone: .....
Father's address if different from above: .....
Mother's Name: ..... Mother's Employer: .....
Mother's Social Security Number ..... Mother's Work Phone: .....
Mother's address if different from above: .....

Who is responsible for payment of services? .....

Please list payer's contact information if different from the patient:

Mailing Address: .....
.....
Residence Phone: ..... Cell Phone: ..... Work Phone: .....
DO YOU HAVE INSURANCE Yes ..... No ..... If yes, Name of Carrier: .....ID # .....
Insurance Card Holder Name ..... Social # of Card Holder .....
Home Phone ..... DOB ..... Relation to Patient .....
Home Address .....

Previous Eye Care Professional: ..... Date of Last Exam: .....

The reason for visit today is: .....

Are you interested in: O Glasses O Contact Lenses O Laser Vision Correction O Other

Or, please specify: .....

Type of Contact Lenses worn: O Soft O Rigid O Other *Are they comfortable?* .....

Circle any eye conditions that apply to you:

Burning	Itching	Sandy/gritty feeling	Mucous discharge	Foreign body sensation		Pain
Tearing	Blur	Double vision	Redness	Loss of Side vision	Flashes	Styes
Tired eyes	Dryness	Light sensitivity	Distorted vision	Loss of vision		Floaters

What are your current eye problems or concerns? .....

Are you currently pregnant? O yes O no Are you currently nursing? O yes O no

List all major surgeries, injuries a/o hospitalizations.....

Please list medication currently taken: .....

.....

ALLERGY

Do you have any allergies to medication? O yes O no If yes, explain: .....

.....

.....

.....

Do you have any other allergies (i.e. environmental/seasonal)? O yes O no If yes, explain: .....

.....

OCULAR HISTORY (personal & family)

				Maternal	Paternal
Crossed Eyes	O self	O family	Relationship to you:	O	O
Lazy Eye	O self	O family	Relationship to you:	O	O
Cataract	O self	O family	Relationship to you:	O	O
Glaucoma	O self	O family	Relationship to you:	O	O
Macular Degeneration	O self	O family	Relationship to you:	O	O
Other:	O self	O family	Relationship to you:	O	O

Have you ever had any type of eye injury or surgery? O yes O no If yes, explain: .....

.....

Do you use tobacco products?

O Never Smoked

O Former Smoker

O Current everday Smoker

O Current Someday Smoker

O Current Smokeless Tobacco User

Do you drink alcohol? O yes O no If yes, occasional.....one/day.....2-3/day.....4+/day

Do you have a sexually transmitted disease? O yes O no

Have you had a blood transfusion? O yes O no

Do you use illegal drugs? O yes O no

				Maternal	Paternal
CARDIOVASCULAR	O none				
Heart Disease	O self	O family	Relationship to you:	O	O
High Blood Pressure	O self	O family	Relationship to you:	O	O
Stroke	O self	O family	Relationship to you:	O	O
Heart Attack	O self	O family	Relationship to you	O	O
CONSTITUTIONAL	O none				
Appetite Excess/Loss	O self	O family	Relationship to you:	O	O
Anemia	O self	O family	Relationship to you:	O	O
Dizziness	O self	O family	Relationship to you:	O	O
ENDOCRINE	O none				
High Cholesterol	O self	O family	Relationship to you:	O	O
Crohn's Disease	O self	O family	Relationship to you:	O	O
Diabetes	O self	O family	Relationship to you:	O	O
RenalDisease	O self	O family	Relationship to you:	O	O
Thyroid Disease	O self	O family	Relationship to you:	O	O
GASTROINTESTINAL	O none				
Acid Reflux Disease	O self	O family	Relationship to you:	O	O
Diverticulosis	O self	O family	Relationship to you:	O	O
Hepatic Disease	O self	O family	Relationship to you:	O	O
GENITOURINARY	O none				
Kidney Stones	O self	O family	Relationship to you:	O	O
Bladder Infections	O self	O family	Relationship to you:	O	O
Other	O self	O family	Relationship to you:	O	O
EARS, NOSE, MOUTH, THROAT	O none				
Meniere's Syndrome	O self	O family	Relationship to you:	O	O
Sinusitis	O self	O family	Relationship to you:	O	O
HEMATOLOGICAL / LYMPHATIC	O none				
Anemia	O self	O family	Relationship to you:	O	O
Hematologic Disorder	O self	O family	Relationship to you:	O	O
Sickle Cell	O self	O family	Relationship to you:	O	O
IMMUNOLOGIC	O none				
Herpes Simplex (oral)	O self	O family	Relationship to you:	O	O
Herpes Zoster (Shingles)	O self	O family	Relationship to you:	O	O
HIV/AIDS	O self	O family	Relationship to you:	O	O
Sarcoidosis	O self	O family	Relationship to you:	O	O
Sjogren's Syndrome	O self	O family	Relationship to you:	O	O

SKIN	O none				
Rosacea	O self	O family	Relationship to you:	O	O
Albinism	O self	O family	Relationship to you:	O	O
Lupus	O self	O family	Relationship to you:	O	O
MUSCULOSKELETAL	O none				
Arthritis	O self	O family	Relationship to you:	O	O
Ankylosing Spondylitis	O self	O family	Relationship to you:	O	O
Myasthenia Gravis	O self	O family	Relationship to you:	O	O
NEUROLOGICAL	O none				
Seizure Disorder	O self	O family	Relationship to you:	O	O
Headaches/Migraines	O self	O family	Relationship to you:	O	O
Acquired Brain Injury	O self	O family	Relationship to you:	O	O
Multiple Sclerosis	O self	O family	Relationship to you:	O	O
Traumatic Brain Injury	O self	O family	Relationship to you:	O	O
PSYCHIATRIC	O none				
Attention Disorder	O self	O family	Relationship to you:	O	O
Alzheimer's	O self	O family	Relationship to you:	O	O
Depression	O self	O family	Relationship to you:	O	O
RESPIRATORY	O none				
Asthma	O self	O family	Relationship to you:	O	O
Bronchitis	O self	O family	Relationship to you:	O	O
Emphysema	O self	O family	Relationship to you:	O	O
Respiratory Dysfunction	O self	O family	Relationship to you:	O	O

Please list any other condition(s) not found above: .....

.....

.....

.....

Torrington Vision Source is committed to providing the best treatment possible for our patients at rates that are usual and customary for our area. You are responsible for payment in full regardless of the interpretation of what is "usual and customary" by a given insurance company.

I understand that payment is due when services are rendered.

PATIENT SIGNATURE: ..... DATE: .....

CONSENT TO ASSIGNMENT OF BENEFITS AND PROMISE TO PAY

Benefits to Physicians:
I hereby assign all of my rights to insurance benefits and instruct my insurance company to make payments directly to Torrington Vision Source and/or its physicians for the benefits provided.

Promise to Pay:
I understand and agree that I am responsible to pay for all services provided to me by Torrington Vision Source and its staff. If I fail to pay for the services when they are rendered, I will be responsible for all costs of collection, including but not limited to, interest at the rate of one and a half percent (1.5%) per month or eighteen percent (18%) per year, court costs and fees, attorney fees, and a collection fee of thirty five percent (35%) of the unpaid balance assigned for collection.

....
Date , Patient Signature

....
Signature of the patient Representative Relationship
(Required if the patient is a minor or an adult unable to sign)

WRITTEN AUTHORIZATION FOR RELEASE OF PHI

I hereby authorize Torrington Vision Source to discuss my Protected Health Information (PHI) with the following person. Should I wish to revoke this authorization, I understand I must do so in **WRITING.**

Name ..... Phone .....

Relationship .....

Date ..... Patient's Signature .....

....
Signature of Patient Representative Relationship
(Required if the patient is a minor or an adult unable to sign)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a Notice of Privacy Practices of Torrington Vision Source. I understand that my Protected Health information (PHI) may be used and disclosed for the purposes of TREATMENT, PAYMENT and HEALTH-CARE OPERATION of the practice.

Date ..... Patient Signature .....

....
Signature of Patient Representative Relationship
(Required if the patient is a minor or an adult unable to sign)

Notice of Privacy Practices

Torrington Vision Source!
Grant W. Jones, O.D. Lynda L. Jones, O.D.
1418 East M St, Torrington, WY 82240
Phone: 307-532-4114 Fax: 307-532-7658

Patient Signature_____ **Date**_____

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.
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, 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). 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 file a complaint if you feel we have violated your rights by contacting ????
- 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.

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 and 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.

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, on our web site, and we will mail a copy to you.

Effective Date of this Notice: January 1, 2015