PATIENT INFORMATION

PLEASE PRINT. PLEASE DO NOT MAIL.

Montgomery Eye Care ● Eye Surgery Center of Colorado

Patient: _____ Spouse: _____
First Last M Name

SSN: _____ - _____ - _____ Birthdate: ____/____/____ Sex: _____ Race: _____
Month Day Year M/F

Permanent Address: _____
Street City State ZIP

Secondary Address: _____
Street City State ZIP

Email Address: _____

Home Phone: (_____) _____ Cell phone: (_____) _____

Employer: _____ Address: _____
Business Name Street

_____ Phone: (_____) _____
City State ZIP

IN CASE OF EMERGENCY,
PLEASE CONTACT: _____ Phone: (_____) _____
Full Name Relationship

HOW DID YOU HEAR ABOUT US? _____

WERE YOU REFERRED BY A DOCTOR? Y / N Doctor: _____
Doctor Name/Practice

Address: _____ Phone: (_____) _____
Street City ZIP

ACKNOWLEDGEMENT OF RECEIPT OF MONTGOMERY EYE CARE AND EYE SURGERY CENTER OF COLORADO NOTICE OF HEALTH INFORMATION PRACTICES: Montgomery Eye Care and Eye Surgery Center of Colorado will maintain a record of the care and services you receive. You have been given a copy of the notice and an opportunity to review the notice. As provided in the Notice, the terms of the Notice may change, and any changes will apply to all of your protected health information maintained by Montgomery Eye Care and Eye Surgery Center of Colorado. If we change the Notice, we are not required to notify you, but you may obtain a revised copy of the Notice at Montgomery Eye Care and Eye Surgery Center of Colorado and it will also be posted at the facility. I authorize disclosure of my health information contained in my medical record for the purpose of Peer Review activities.

_____
Signature of Patient or Legal Representative Print Name of Patient or Legal Representative Date

_____
Signature of Witness Print Name of Witness Date

Date: _____ **Chart #**_____

MONTGOMERY
EYE CARE

Chart No: _____

Date: _____

Technician Use Only
Reviewed By: _____ Date: _____

MEDICAL HISTORY

PLEASE PRINT. PLEASE DO NOT MAIL

Patient: _____ Age: ____ Marital Status: M S D W
Last Name First Name M

FAMILY DOCTOR: _____ Phone: (_____)_____
Name

Address: _____
Street City State Zip

Date of Last Visit: _____ Reason for Visit: _____

Tests Performed (please list): _____

PAST OCULAR HISTORY:

Previous History of Eye Treatment or Exams: _____

_____

What problems are you having with your eyes? _____

PAST/PRESENT MEDICAL HISTORY: Please check Yes or No for each of the following.

No	Yes		No	Yes		No	Yes		No	Yes	
☐	☐	Rheumatic Fever	☐	☐	Heart Disease	☐	☐	MRSA	☐	☐	Anemia
☐	☐	Pneumonia	☐	☐	Angina	☐	☐	Liver Disease/Hepatitis	☐	☐	Bleeding Problems
☐	☐	Tuberculosis	☐	☐	Irregular Heartbeat/Pacer	☐	☐	Kidney Disease	☐	☐	Blood Diseases
☐	☐	Asthma	☐	☐	Heart Attack	☐	☐	Hiatal Hernia	☐	☐	Radiation/Chemo
☐	☐	Emphysema	☐	☐	Congestive Heart Failure	☐	☐	Ulcers	☐	☐	Memory Loss
☐	☐	Bronchitis	☐	☐	Stroke	☐	☐	Diverticulosis	☐	☐	Alzheimer's
☐	☐	Carotid Artery Disease	☐	☐	Claustrophobia	☐	☐	Arthritis	☐	☐	Psychiatric Disorder
☐	☐	High Blood Pressure	☐	☐	Thyroid Disorder	☐	☐	Phlebitis	☐	☐	Seizures
									☐	☐	Diabetes
										☐	Type 1
										☐	Type 2

WOMEN: ARE YOU

No	Yes		No	Yes	
☐	☐	Pregnant/Trying to Get Pregnant	☐	☐	Nursing
☐	☐	Taking Oral Contraceptives			

Last A1C _____

HOSPITALIZATIONS: Please list the date of any relevant surgeries or hospitalizations.

No	Yes		No	Yes		No	Yes	
☐	☐	Eye Surgery _____	☐	☐	Stomach/Abdomen _____	☐	☐	Cancer _____
☐	☐	Thyroid/Neck _____	☐	☐	Gallbladder _____	☐	☐	Prostate _____
☐	☐	Heart _____	☐	☐	Appendectomy _____	☐	☐	Hysterectomy _____
☐	☐	Lungs _____	☐	☐	Hernia _____	Other _____		
☐	☐	Mastectomy _____	☐	☐	Back _____	Other _____		

Physician Use Only: Reviewed By: _____ Date: _____

Chart No: _____

Date: _____

Patient: _____
Last Name First Name M

Technician Use Only
Reviewed By: _____ Date: _____

PREFERRED PHARMACY: _____ Phone: (_____) _____

PRESENT PRESCRIPTION & NON-PRESCRIPTION MEDICATIONS:

Please list name, dose and frequency or attach a list. _____

_____

ALLERGIES TO MEDICATIONS: ☐ No Known Allergies Latex Sensitivity: No ☐ Yes ☐

Please list: _____

_____

FAMILY HISTORY:

	Living? No	Living? Yes	Medical Problems or Cause of Death
Mother	☐	☐	_____
Father	☐	☐	_____
Sister/Brother	☐	☐	_____

Please list any history of eye disease or eye surgery in your family: _____

_____

SOCIAL HISTORY: Do (Did) you:

No	Yes	Former		
☐	☐	☐	Smoke	How much per day? _____ For how many years? _____
☐	☐	☐	Drink Alcohol	How much per day? _____
☐	☐	☐	Recreational Drug Use	How much per day? _____

REVIEW OF SYSTEMS: Do you have these now? If yes, circle condition and explain.

No	Yes		
☐	☐	**Skin:** Psoriasis/Rash/Shingles	_____
☐	☐	**Head:** Headache/Migraines/Temporal Arteritis	_____
☐	☐	**Eyes:** Cataract/Glaucoma/Retina	_____
☐	☐	**Ears:** Hearing Loss/Aids	_____
☐	☐	**Nose/Mouth/Throat:** Dentures/Sinus	_____
☐	☐	**Neck:** Restriction of Movement/Difficulty swallowing	_____
☐	☐	**Pulmonary:** Cough/Shortness of Breath/Wheeze	_____
☐	☐	**CV:** Chest Pain/Palpitations	_____
☐	☐	**GI:** Ulcers/Pain	_____
☐	☐	**MS:** Leg Cramps/Swelling	_____
☐	☐	**Neuro:** Tremor/Speech Problems	_____
☐	☐	**Psych:** Anxiety/Depression/Insomnia/Panic Attacks	_____

Physician Use Only: Reviewed By: _____ Date: _____

ASSIGNMENT OF MEDICARE AND COMMERCIAL PAYER BENEFITS

PATIENT NAME: _____

I request that payment of authorized Medicare and Commercial Payer benefits be made on my behalf to: **Montgomery Eye Care ● Eye Surgery Center of Colorado**

for any service furnished to me by a physician of the group. I authorize any holder of medical information about me to release to the Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier and I am responsible for the Medicare deductible, co-insurance or the 20% Medicare does not pay, and for any non-covered services.

MEDIGAP OR OTHER SECONDARY INSURANCE

I request that the payment of authorized Medigap benefits be made either by me or on my behalf to **Montgomery Eye Care ● Eye Surgery Center of Colorado**, or any physician of that group, for services provided to me by a physician of the group. I authorize any holder of medical information about me to release it to my Medigap or Commercial insurer or any information needed to determine these benefits payable for related services.

My signature below further verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished.

This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

Patient Name	**Chart #**	
Patient Signature	**Date**	**Time**
Signature of Legal Patient Representative: ***(If patient is unable to sign)***	**Date**	**Time**
Witness Signature	**Date**	**Time**

MONTGOMERY EYE CARE ● EYE SURGERY CENTER OF COLORADO

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

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.

Montgomery Eye Care/Eye Surgery Center of Colorado is required to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices. We will not use or disclose your health information except as described in this Notice. This Notice applies to all of the medical records generated by Montgomery Eye Care/Eye Surgery Center of Colorado as well as records we receive from other providers.

USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION IN TREATMENT, PAYMENT & HEALTH CARE OPERATIONS

Treatment: **Montgomery Eye Care/Eye Surgery Center of Colorado** may use and disclose your protected health information in the course of providing or managing your health care as well as any related services. For the purpose of treatment, we may coordinate your health care with a third party. For example, we may disclose your protected health information to a pharmacy to fulfill a prescription for medication, to a radiology facility to order an X-ray, or to another physician who is assisting in your health care. In addition, we may disclose protected health information to other health care providers related to the treatment provided by those other providers.

Payment: When needed, **Montgomery Eye Care/Eye Surgery Center of Colorado** will use or disclose your protected health information to obtain payment for its services. Such uses, or disclosures may include disclosures to your health insurer to get approval for a recommended procedure or to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. When obtaining payment for your health care, we may also disclose your protected health information to your insurance company to demonstrate the medical necessity of the care or for utilization review when required to do so by your insurance company. Finally, we may also disclose your protected health information to another provider where that provider is involved in your care and requires the information to obtain payment.

Operations: **Montgomery Eye Care/Eye Surgery Center of Colorado** may use or disclose your protected health information when needed for the practice's health care operations for the purposes of management or administration of the practice and for offering quality health care services. Health care operations may include: (1) quality evaluations and improvement activities; (2) employee review activities and training programs; (3) accreditation, certification, licensing, or credentialing activities; (4) reviews and audits such as compliance reviews, medical reviews, legal services, and maintaining compliance programs; and (5) business management and general administrative activities. For instance, we may use, as needed, protected health information of patients to review their treatment course when making quality assessments regarding ophthalmologic care or treatment. In addition, we may disclose your protected health information to another provider or health plan for their health care operations.

Other Uses and Disclosures: As part of treatment, payment, and health care operations, **Montgomery Eye Care/Eye Surgery Center of Colorado** may also use or disclose your protected health information to: (1) remind you of an appointment; (2) inform you of potential treatment alternatives or options; or (3) inform you of health-related benefits or services that may be of interest to you.

USES & DISCLOSURES TO WHICH YOU MAY OBJECT

Family/Friends: Montgomery Eye Care/Eye Surgery Center of Colorado may disclose your protected health information to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose protected health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. If you have any objection to the use and disclosure of your protected health information in this manner, please tell us.

USES & DISCLOSURES THAT ARE REQUIRED OR PERMITTED WITHOUT YOUR AUTHORIZATION

Research: Under certain circumstances, Montgomery Eye Care/Eye Surgery Center of Colorado may use and disclose your protected health information to approved clinical research studies. While most clinical research studies require specific patient consent, there are some instances where a retrospective record review with no patient contact may be conducted by such researchers. For example, the research project may involve comparing the health and recovery of patients who received one medication for their medical condition to those who received a different medication for that same condition.

Regulatory Agencies: Montgomery Eye Care/Eye Surgery Center of Colorado may disclose your protected health information to government and certain private health oversight agencies, e.g., the Department of Public Health and Environment or the Board of Medical Examiners, for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary to monitor compliance with the requirements of government programs.

Law Enforcement/Litigation: Montgomery Eye Care/Eye Surgery Center of Colorado may disclose your protected health information for law enforcement purposes as required by law or in response to a court order or other process in litigation.

Public Health: As required by law, Montgomery Eye Care/Eye Surgery Center of Colorado may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. For example, we are required to report the existence of a communicable disease, such as acquired immune deficiency syndrome ("AIDS"), to the Department of Public Health and Environment to protect the health and well-being of the general public.

Workers' Compensation: Montgomery Eye Care/Eye Surgery Center of Colorado may release protected health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Military/Veterans: Montgomery Eye Care/Eye Surgery Center of Colorado may disclose your protected health information as required by military command authorities, if you are a member of the armed forces.

Organ Procurement Organizations: To the extent allowed by law, m Montgomery Eye Care/Eye Surgery Center of Colorado ay disclose your protected health information to organ procurement organizations and other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

As Otherwise Required or Permitted by Law: Montgomery Eye Care/Eye Surgery Center of Colorado will disclose your protected health information in any situation in which such disclosure is required by law (e.g., child abuse, domestic abuse) or any other use permitted under HIPAA, its amendments or regulations.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION:

Other than the circumstances described above, **Montgomery Eye Care/Eye Surgery Center of Colorado** will not disclose your protected health information unless you provide written authorization. An authorization is specifically required in most situations involving uses or disclosures of protected health information for marketing purpose, for the sale of protected health information, or for psychotherapy purposes. You may revoke your authorization in writing at any time except to the extent that we have already taken action in reliance upon the authorization.

YOUR RIGHTS RELATED TO YOUR HEALTH INFORMATION:

Although all records concerning your treatment obtained at Montgomery Eye Care/Eye Surgery Center of Colorado are the property of Montgomery Eye Care/Eye Surgery Center of Colorado you have the following rights concerning your protected health information:

- ***Right to Confidential Communications:*** You have the right to receive confidential communications of your protected health information by alternative means or at alternative locations. For example, you may request that we contact you at work or by mail.
- ***Right to Inspect and Copy:*** You generally have the right to inspect and copy your protected health information, except as restricted by your physician or by law. Further, if we maintain your health records on an electronic health records system, you have the right to request an electronic copy of your health records.
- ***Right to Amend:*** You have the right to request an amendment or correction to your protected health information. If we agree that an amendment or correction is appropriate, we will ensure that the amendment or correction is attached to your medical record.
- ***Right to an Accounting:*** You have the right to obtain a statement of the disclosures that have been made of your protected health information other than by your authorization, other than to you and other than for the purpose of treatment, payment or routine operational purposes.
- ***Right to Request Restrictions:*** You have the right to request restrictions on certain uses and disclosures of your protected health information. If we agree, we will abide by the restrictions. Additionally, if you (or anyone on your behalf besides a health plan) pay for the care or services at issue in full out of your own pocket, we are required to comply with your request not to disclose your protected health information to a health plan, unless required by law to do so.
- ***Right to Receive a Copy of this Notice:*** You have the right to receive a paper copy of this Notice, upon request, if this Notice has been provided to you electronically.
- ***Right to Revoke Authorization:*** You have the right to revoke your authorization to use or disclose your protected health information, except to the extent that action has already been taken in reliance on your authorization.
- ***Right to Notice of Breach of Security:*** You have the right to be notified in the event of a breach of unsecured protected health information occurs.
- ***Right to Opt Out:*** You may be contacted for certain fund-raising purposes and you have the right to opt out of receiving such communications.

FOR MORE INFORMATION REGARDING HOW TO EXERCISE THESE RIGHTS: If you have questions or would like more information regarding any of the rights listed above, please contact the Compliance Officer at [phone number].

IF YOU BELIEVE THAT YOUR RIGHTS HAVE BEEN VIOLATED: You may file a complaint with Montgomery Eye Care/Eye Surgery Center of Colorado or with the U.S. Secretary of Health and Human Services. To file a complaint with Montgomery Eye Care/Eye Surgery Center of Colorado please contact the Compliance Officer at (303)426-4810. All complaints must be submitted in writing. There will be no retaliation for filing a complaint.

NOTICE EFFECTIVE DATE: This Notice is effective for all protected health information created on or after September 23, 2013.

Montgomery Eye Care ● Eye Surgery Center of Colorado

Patient Right and Responsibilities

You have the RIGHT:

- To be treated with respect, consideration, and dignity.
- To be provided with personal privacy, safety and security when in our care.
- To communicate in your primary language whenever possible if you are not fluent in English.
- To be provided, to the degree known, information concerning your diagnosis, evaluation, treatment and prognosis.
- To be informed and participate in treatment decisions, know the benefits, side effects, and possible complications of treatment.
- To be provided with help that will facilitate informed healthcare decisions despite language barriers, physical or mental disability, or difficulty understanding the care plan.
- To be informed about services and related costs.
- To choose your providers and know the names and professional status of those working with you.
- To file a complaint against a provider, the facility, or healthcare personnel without fear of reprisal.
- To emergency care without waiting for authorizations or fearing financial penalty.
- To be provided reasonable access to care regardless of:
    - Ethnicity, Race, Age, Gender Identity and Expression, Disability, Culture, Different Ideas and Perspectives, First Generation Status, Marital Status, Geographic Background, Religious and Spiritual Beliefs, Sex, Sexual Orientation, Socioeconomic Status, Veteran Status, or Natural Origin.
- To privacy and confidentiality of your health information and health records.
- To read and request changes to your records if information is not correct, relevant, or complete.
- To request that uses and disclosure of protected health information be restricted.
- To consent to or refuse any care or treatment including research.
- To receive appropriate referrals to other providers and services.
- To request to a change in providers if other qualified providers are available.

You have the RESPONSIBILITY:

- To seek healthcare promptly.
- To give accurate information about your health history to the best of your ability regarding:
    - Health
    - Medications, including over-the-counter products and dietary supplements
    - Allergies or sensitivities
- To follow the treatment plan prescribed by the provider, participate in your care and to inform the provider if the treatment plan is not understood or manageable.
- To know the names, purposes, and effects of medications prescribed to you.
- To ask questions or clarification about anything you do not understand.
- To report any significant changes in symptoms or failure to improve.
- To provide a responsible adult to transport you home from the facility and remain with you for 24 hours if required by the provider.
- To understand and honor financial obligations related to your care, including understanding your insurance coverage.
- To respect and follow Montgomery Eye Care/Eye Surgery Center of Colorado Policies and Procedures.
- To treat all Montgomery Eye Care/Eye Surgery Center of Colorado staff with courtesy and respect.
- To arrive for appointments at or before scheduled appointment time, keep appointments or cancel in a timely manner.
- To provide useful feedback about our services and policies.
- To inform the provider about the existence of a living will, medical power of attorney or other advance directive that could affect your care.

Grievance Policy:

You and your representative have the right to:

- Voice a complaint to your healthcare providers and administrators without fear of reprisal.
- Contact Compliance Officer Anna Montgomery, RN at (303)426-4810 to file a formal grievance
- Contact the State of Colorado to issue a grievance at (303)894-2882 or you may go online at http://dora.state.co.us/medical/complaints.htm
- Contact Colorado Department of Health and Human Services at (303)693-2800 or (800)886-7689 Ext. 2800
- Contact the Medicare Hotline at (800)633-4227 or you may go online at https://www.medicare.gov/claims-appeals/how-to-file-a-complaint-grievance
- Receive a timely response with the results of your complaint