



Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

			<u>Yourself</u> / <u>Your Family</u>				
<b>I experience this on a REGULAR basis: YES NO</b>			<b>YES</b>	<b>NO</b>	<b>YES</b>	<b>NO</b>	
Blurry Vision ( D or N ) w/o glasses	<input type="checkbox"/>	<input type="checkbox"/>	AIDS / HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis / Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Color Vision (Poor)	<input type="checkbox"/>	<input type="checkbox"/>	Asthma / Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crossed eyes	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discharge from Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Cancer ( _____ )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (Type ____ )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Infection	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	-Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Itch	<input type="checkbox"/>	<input type="checkbox"/>	-Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Strain	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (Type ____ )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Turn or Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Floaters or Spots	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Halos	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches / Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light Sensitive	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Red Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Other medical problems:				
Temporary Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Current medications including eye drops:				
Water Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____				
<b>I have been diagnosed with the following:</b>			_____				
Blindness / Permanent Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____				
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	Drug allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes _____				
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____				
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Chemical dependency? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				
Retinitis Pigmentosa	<input type="checkbox"/>	<input type="checkbox"/>	Frequent alcohol use? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	Frequent tobacco use? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				
Other:			Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				

# InFocus Vision Optometric Center

## Acknowledgement of Receipt of Notice of Privacy Practices

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Privacy Notice on the date indicated below.

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Patient's Signature

or

\_\_\_\_\_  
Parent or Legal Guardian's Signature

### FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because of the following:

- The patient refused to sign.
- Due to an emergency situation, it was impossible to obtain a signature.
- We were not able to communicate with the patient.
- Other Reason: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

## InFocus Vision Optometric Center's Notice of 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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

### Overview

The law requires us to keep your protected health information ("PHI") private in accordance with this Notice of Privacy Practices ("Notice"), as long as this Notice remains in effect. We are also required to provide you with a paper copy of this Notice, which contains our privacy practices, our legal duties, and your rights concerning your PHI. From time to time, we may revise our privacy practices and the terms of our Notice at any time, as permitted or required by applicable law. Such revisions to our privacy practices and our Notice may be retroactive. Our Notice will be updated and made available to our patients prior to any significant revisions of our privacy practices and policies.

**Organizations Covered by this Notice:** This Notice contains the privacy practices for types of organizations listed below affiliated with InFocus Vision Optometric Center for delivery of health care services. Each of these organizations participates in an organized health care arrangement and may use and disclose your PHI among themselves as they shall deem appropriate for your treatment, payment or health care operations.

### Our Privacy Practices

**Use and Disclosure.** We may use or disclose your PHI for treatment, payment, or health care operations. For your convenience, we have provided the following examples of such potential uses or disclosures:

*Treatment.* Your PHI may be used by or disclosed to any physicians or other health care providers involved with the medical services provided to you.

*Payment.* Your PHI may be used or disclosed in order to collect payment for the medical services provided to you.

*Health Care Operations.* Your PHI may be used or disclosed as part of our internal health care operations. Such health care operations may include, among other things, quality of care audits of our staff and affiliates, conducting training programs, accreditation, certification, licensing, or credentialing activities.

**Authorizations.** We will not use or disclose your medical information for any reason except those described in this Notice, unless you provide us with a written authorization to do so. We may request such an authorization to use or disclose your PHI for any purpose, but you are not required to give us such authorization as a condition of your treatment. Any written authorization from you may be revoked by you in writing at any time, but such revocation will not affect any prior authorized uses or disclosures.

**Patient Access.** We will provide you with access to your PHI, as described below in the Individual Rights section of this Notice. With your permission, or in some emergencies, we may disclose your PHI to your family members, friends, or other people to aid in your treatment or the collection of payment. A disclosure of your PHI may also be made if we determine it is reasonably necessary or in your best interests for such purposes as allowing a person acting on your behalf to receive filled prescriptions, medical supplies, etc.

**Facility Directories.** Our facility directory may list the following information about you: (1) your name, (2) your location in our facility, (3) your general condition without reference to specific medical information, e.g., stable, serious, fair, etc. You may restrict or prohibit the release of the above information.

**Locating Responsible Parties.** Your PHI may be disclosed in order to locate, identify or notify a family member, your personal representative, or other person responsible for your care. If we determine in our reasonable professional judgment that you are capable of doing so, you will be given the opportunity to consent to or to prohibit or restrict the extent or recipients of such disclosure. If we determine that you are unable to provide such consent, we will limit the PHI disclosed to the minimum necessary.

**Continuing Care.** Based upon your PHI, we may provide you with appointment reminders or information concerning health issues, benefits and services, or treatment alternatives that we believe may be of interest to you.

**Disasters.** We may use or disclose your PHI to any public or private entity authorized by law or by its charter to assist in disaster relief efforts.

**Required by Law.** We may use or disclose your medical information when we are required to do so by law. For example, your PHI may be released when required by privacy laws, workers' compensation or similar laws, public health laws, court or administrative orders, subpoenas, certain discovery requests, or other laws, regulations or legal processes. Under certain circumstances, we may make limited disclosures of PHI directly to law enforcement officials or correctional institutions regarding an inmate, lawful detainee, suspect, fugitive, material witness, missing person, or a victim or suspected victim of abuse, neglect, domestic violence or other crimes. We may disclose your PHI to the extent reasonably necessary to avert a serious threat to your health or safety or the health or safety of others. We may disclose your PHI when necessary to assist law enforcement officials to capture a third party who has admitted to a crime against you or who has escaped from lawful custody.

**Deceased Persons.** We may disclose your PHI to a coroner, medical examiner, funeral director, or organ procurement organization in limited circumstances.

**Research.** Your PHI may also be used or disclosed for research purposes only in those limited circumstances not requiring your written authorization, such as those which have been approved by an institutional review board that has established procedures for ensuring the privacy of your PHI.

**Military and National Security.** We may disclose to military authorities the medical information of Armed Forces personnel under certain circumstances. When required by law, we may disclose your PHI for intelligence, counterintelligence, and other national security activities.

### Your Individual Rights

**Access and Copies.** In most cases, you have the right to review or to purchase copies of your PHI by requesting access or copies in writing to our Privacy Officer. Please contact our Privacy Officer regarding our copying fees.

**Disclosure Accounting.** You have the right to receive an accounting of the instances, if any, in which your PHI was disclosed for purposes other than those described in the following sections above: Use and Disclosures, Facility Directories, Patient Access, and Locating Responsible Parties. For each 12-month period, you have the right to receive one free copy of an accounting certain details surrounding such disclosures that occurred after April 13, 2003. If you request a disclosure accounting more than once in a 12-month period, we will charge you a reasonable, cost-based fee for each additional request. Please contact our Privacy Officer regarding these fees.

**Additional Restrictions.** You have the right to request that we place additional restrictions on our use or disclosure of your PHI, but we are not required to honor such a request. We will be bound by such restrictions only if we agree to do so in writing signed by our Privacy Officer.

**Alternate Communications.** You have the right to request that we communicate with you about your PHI by alternative means or in alternative locations. We will accommodate any reasonable request if it specifies in writing the alternative means or location, and provides a satisfactory explanation of how future payments will be handled.

**Amendments to PHI.** You have the right to request that we amend your PHI. Any such request must be in writing and contain a detailed explanation for the requested amendment. Under certain circumstances, we may deny your request but will provide you a written explanation of the denial. You have the right to send us a statement of disagreement to which we may prepare a rebuttal, a copy of which will be provided to you at no cost. Please contact our Privacy Officer with any further questions about amending your medical record.

### Complaints

If you believe we have violated your privacy rights, you may complain to us or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with us by notifying our Privacy Officer. We support your right to protect the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**Contact Us:** InFocus Vision Optometric Center, Inc.  
Rosie, Privacy Officer  
29 E. Huntington Dr., Ste. B, Arcadia, CA 91006  
Tel: (626) 303-1888