

PATIENT REGISTRATION

Contact Information

Today's Date: _____

First Name: _____ Last Name: _____

Street Address: _____ City/State: _____

Zip Code: _____ DOB: _____ Birth Sex: _____

Phone Number (day): _____

Email Address: _____

Emergency Contact: _____

Phone Number: _____ Relationship: _____

Ethnicity: African American Asian Caucasian Hispanic Other: _____

Preferred Pharmacy

Name: _____

Phone Number: _____

Fax Number: _____

City or Zip Code: _____

Cross streets/Intersection: _____

Referring Provider/Primary Care Provider

Name: _____

Practice Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE OR MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO ASCEND VISION PARTNERS AND OR ANY OF ITS AFFILIATED COMPANIES FOR ANY SERVICES FURNISHED TO ME BY THE PROVIDER/CLINIC. I AUTHORIZE ANY HOLDER OR MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE INSURANCE COMPANY OR TO CMS (CENTERS FOR MEDICARE AND MEDICAID SERVICES) AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO RELATED SERVICES. I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF THE MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IN THE MEDICARE ASSIGNED CASES, THE PHYSICIAN OR SUPPLIER AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGE, AND THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE ARE BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE CARRIER. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THE ASSIGNMENT IS TO BE CONSIDERED VALID AS ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY THE SAID INSURANCE COMPANY.

Patient Signature: _____ Date: _____

Print: _____

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY AND RELEASE TO PROVIDE PROTECTED HEALTH INFORMATION

If you are not covered by a health plan or fail to provide the information necessary for us to file a claim, you are expected to pay for your services at the time of your appointment or meet with our financial representative to make other arrangements. Any physician at Ascend Vision or one of its affiliated companies will need to disclose some of your Protected Health Information (PHI) to either Medicare or your insurance to obtain payment. In addition, some charges may not be covered by your insurance, including your deductible, your copayment, and any services which are not considered medically necessary (non-covered procedures such as iLux, specialty lenses, and other non-covered services deemed by the practice). You will be responsible for these charges. For each month a balance remains unresolved, you may be charged a late fee of up to 1.5%. The practice may use the services of a collection agency to pursue unresolved accounts. I have read the above policy and understand that I am responsible for paying for provided services. I also understand that my PHI may be released to Medicare or my Insurance company to obtain payment and that payment will go directly to Ascend Vision Partners or one of its affiliated practices.

PATIENT CONSENT FOR USE OF CREDIT CARD, DEBIT CARD AND FINANCING - DISCLOSURE OF PROTECTED HEALTH INFORMATION

If you pay by credit card, debit card or financing we may need to release your Protected Health Information (PHI) to credit card companies, banks, or financing companies to obtain your payment. By signing this form, you irrevocably consent to allow any provider at Ascend Vision Partners or one of its affiliated practices to disclose your PHI to any credit card company, bank, or financing company if they request this information to process your payment. If you pay with a credit card, debit card, or third-party financing, your PHI will be released to them if requested by the credit card company, bank or third-party financing company.

By signing below, it is understood that your PHI Information will be sent to your credit card company in order to settle any dispute, I understand that the physicians at Ascend Vision Partners or one of its affiliated practices encourage patient follow-up to address any issues. I also understand that this-agreement is irrevocable.

REFRACTION TEST & CONTACT LENS FITTING POLICY

A refraction is a test that measures your ability to see the eye chart with lenses of various powers. This test is done for two reasons.

- One reason is to determine your prescription in the event that you want or need an eyeglass or contact lens prescription.
- The second is to determine whether any vision problem that you may have is correctable by glasses, or is actually because of an eye disease that is not correctable by glasses. Therefore, a refraction may be required to determine if you have an eye disease.

If you want a prescription for glasses or contact lens, this test is required. If you have vision worse than 20/20 or if you feel your vision is blurry, this test is strongly advised, since your doctor may not be able to diagnose the cause of your problem without the test.

We are required to inform you that a refraction is a non-covered service by Medicare and most insurance companies. Keep in mind that if your Primary Care Physician referred you here to our office it is for medical reasons, and your insurance company will not cover this service. Some plans may offer the refraction and eyewear to you at no charge at a participating provider's (optometrist) office.

Should you choose to get a refraction and your doctor feels it is necessary to do one, payment will be expected at the time of check out. The fee for the refraction is **\$60.00**.

The fee for contact lens fitting depends on the type of fitting. Contact lens fitting includes refraction. If your current prescription for contacts is expired, it can't be refilled. Our doctors need to check the health of your eyes to ensure we can extend your prescription. The fee for **contact lens fitting will be provided to you at time of service**.

Patient Signature: _____ Date: _____

Print: _____

Explanation of terms: - "Protected Health Information" (PHI): This means your name and address. Credit card companies usually request this information to process a payment, and we cannot legally give them even your name without your permission. - "Irrevocably consent": In general, you have the right

to revoke our permission to release protected health information. e.g, if you initially wanted us to release records to another office but changed your mind. In this instance, you do not allow us to release your name to your credit card company, we cannot process your payment. This protects from patients giving us a payment by credit card, then not allowing us to process the payment.

HISTORY & INTAKE FORM

Medication

List all current medications:

_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Past Medical History

Select any of the following medical conditions you currently have:

- | | | |
|--|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Obstructive sleep apnea of adult |
| <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Radiation therapy treatment |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Graves' disease | <input type="checkbox"/> Transplantation of bone marrow |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> H/O: hypertension | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Hearing loss | _____ |
| <input type="checkbox"/> Cerebrovascular accident / Stroke | <input type="checkbox"/> HIV | _____ |
| <input type="checkbox"/> Chronic obstructive lung disease | <input type="checkbox"/> Hypercholesterolemia | _____ |
| <input type="checkbox"/> Coronary arteriosclerosis | <input type="checkbox"/> Hyperthyroidism | _____ |
| <input type="checkbox"/> Depressive disorder | <input type="checkbox"/> Hypothyroidism | _____ |
| <input type="checkbox"/> Diabetes mellitus, type: _____ | <input type="checkbox"/> Leukemia | _____ |
| <input type="checkbox"/> Disease caused by 2019-nCoV | <input type="checkbox"/> Malignant lymphoma | _____ |
| <input type="checkbox"/> End-stage renal disease | <input type="checkbox"/> Malignant tumor of colon | |

Past Surgical History

Have you had any surgeries in the past?

Past Ocular History

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> O/E - background diabetic retinopathy | <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Allergic conjunctivitis | <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Ophthalmic migraine | <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Posterior vitreous detachment | <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Corneal dystrophy | <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Proliferative retinopathy due to diabetes | <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Macular degeneration | <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Pseudoexfoliation glaucoma | <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Retinal tear without detachment | <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Elevated intraocular pressure | <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Strabismus | <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Epiretinal membrane | <input type="checkbox"/> L <input type="checkbox"/> R | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> L <input type="checkbox"/> R | _____ | <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Glaucoma suspect | <input type="checkbox"/> L <input type="checkbox"/> R | _____ | <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Keratoconus | <input type="checkbox"/> L <input type="checkbox"/> R | _____ | <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Nonproliferative retinopathy due to diabetes | <input type="checkbox"/> L <input type="checkbox"/> R | _____ | <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> Narrow angle glaucoma | <input type="checkbox"/> L <input type="checkbox"/> R | _____ | <input type="checkbox"/> L <input type="checkbox"/> R |

Past Ocular Surgery

<input type="checkbox"/> None		<input type="checkbox"/> Strabismus surgery	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Amniotic membrane graft to cornea	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Trabeculectomy	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Chalazion removal	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Vitrectomy	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Corneal collagen cross linking	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Injection of drug into vitreous	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Corneal transplant	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Insertion of punctal plug	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Descemet's membrane endothelial keratoplasty (DMEK)	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> LASIK	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Descemet's stripping endothelial keratoplasty (DSEK)	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Laser iridotomy	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Cataract extraction	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Laser therapy for retinal lesion	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Dacryocystorhinostomy	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Simple excision of pterygium	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Excision of pterygium with graft	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> YAG laser capsulotomy of lens	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Insertion of drainage tube into anterior chamber	<input type="checkbox"/> L <input type="checkbox"/> R	<input type="checkbox"/> Other:	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Laser trabeculoplasty	<input type="checkbox"/> L <input type="checkbox"/> R	_____	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Pan-retinal photocoagulation (PRP)	<input type="checkbox"/> L <input type="checkbox"/> R	_____	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Penetrating keratoplasty (PKP)	<input type="checkbox"/> L <input type="checkbox"/> R	_____	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Photorefractive keratectomy	<input type="checkbox"/> L <input type="checkbox"/> R	_____	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Repair of blepharoptosis	<input type="checkbox"/> L <input type="checkbox"/> R	_____	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Repair of eyelid	<input type="checkbox"/> L <input type="checkbox"/> R	_____	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Repair of hole of macula lutea	<input type="checkbox"/> L <input type="checkbox"/> R	_____	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Repair of retinal detachment	<input type="checkbox"/> L <input type="checkbox"/> R	_____	<input type="checkbox"/> L <input type="checkbox"/> R
<input type="checkbox"/> Repair of retina for retinal tear or defect	<input type="checkbox"/> L <input type="checkbox"/> R		

Allergies

List all allergies and reactions if known:

Social History

Smoking Status:

- Current every day smoker
- Current someday smoker
- Former smoker
- Never smoker
- Unknown if ever smoked

Alcohol Intake:

- None
 - 1 or less per day
 - 1-2 per day
 - 3 or more per day
- If you are over 65, how many times this year have you had 5 or more drinks in 24 hours? _____

Occupation and Workplace:

Family History

_____ Member: _____	_____ Member: _____
_____ Member: _____	_____ Member: _____
_____ Member: _____	_____ Member: _____

Quality Measures

- Have you received a pneumonia vaccination on or after your 60th birthday? Yes No
- Do you have a health care proxy in the event you are unable to make your own medical decisions? Yes No
- Which statement(s) best reflects your wishes on advanced care recommendations?
 - Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.
 - Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if its necessary to save my life.
 - Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Review of Systems

Are you currently experiencing any of the following? Please check Yes or No

	System	Yes	No
High Blood Pressure	Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	Endocrine	<input type="checkbox"/>	<input type="checkbox"/>

Other Symptoms: _____

Medical Alerts

Please check Yes or No

	Alerts	Yes	No
Allergy to adhesive		<input type="checkbox"/>	<input type="checkbox"/>
Allergy to lidocaine		<input type="checkbox"/>	<input type="checkbox"/>
Allergic to Sulfa Drugs		<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve		<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints within past two years		<input type="checkbox"/>	<input type="checkbox"/>
Blood thinners / aspirin		<input type="checkbox"/>	<input type="checkbox"/>
Defibrillator		<input type="checkbox"/>	<input type="checkbox"/>
Flomax		<input type="checkbox"/>	<input type="checkbox"/>
MRSA / methicillin-resistant Staphylococcus aureus		<input type="checkbox"/>	<input type="checkbox"/>
Narrow angles		<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker		<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy or planning a pregnancy		<input type="checkbox"/>	<input type="checkbox"/>
Pseudoexfoliation syndrome		<input type="checkbox"/>	<input type="checkbox"/>
Steroid responder		<input type="checkbox"/>	<input type="checkbox"/>

Notice of Privacy Policies and Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

At **Ascend Vision Partners and its affiliated practices**, we are committed to treating and using protected health information about you responsibly. This Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

UNDERSTANDING YOUR MEDICAL RECORD/HEALTH INFORMATION

Each time you visit **Ascend Vision Partners and its affiliated practices**, a record of your visit is made. Typically, this record contains information about your visit including your examination, diagnosis, test results, treatment as well as other pertinent healthcare data. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communication with other health professionals involved in your care.
- Legal document outlining and describing the care you received.
- Tools that you or another payer (your insurance co) will use to verify that services billed were actually provided.
- An education tool for medical health providers.
- A source for medical research.
- Basis for public health officials who might use this information to assess and/or improve state as well as national healthcare standards.
- A tool that we can reference to ensure the highest quality of care and patient satisfaction.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individuals.

YOUR RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.

- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

OUR RESPONSIBILITIES

Ascend Vision Partners and its affiliated practices are required to:

- Maintain the privacy of your health information.
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have regarding communication of health information via alternative means and locations.

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to procedures included in the authorization.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

We will use your health information for treatment.

Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example: results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

[We will use your information for payment.](#)

Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for the service rendered to you.

[We will use your information for regular health operations.](#)

Your health information may be used as necessary to support the day-to-day activities and management of **Ascend Vision Partners and its affiliated practices**. For example: Information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

[Business Associates.](#)

In some instances, we have contracted separate entities to provide services for us. These "associates" require your health information in order to accomplish the tasks that we ask them to provide. Some examples of these "business associates" might be a billing service, collection agency, answering services and computer software/hardware provider.

[Communication with family.](#)

Due to the nature of our field, we will use our best judgment when disclosing health information to a family member, other relatives, or any other person that is involved in your care or that you have authorized to receive this information. Please inform the practice when you do not wish a family member or other individual to have authorization to receive your information.

[Research/Teaching/Training.](#)

We may use your information for the purpose of research, teaching, and training.

[Healthcare Oversight.](#)

Federal law requires us to release your information to an appropriate health oversight agency, public health authority or attorney, or other federal/state appointee if there are circumstances that require us to do so.

[Public health reporting.](#)

Your health information may be disclosed to public health agencies as required by law.

[Law enforcement.](#)

Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

[Appointment reminders.](#)

The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are sent by mail via postcard, or a brief message may be left on your answering machine. If you don't approve of these methods, or, if you prefer alternative methods please inform the practice.

[Other uses and disclosures.](#)

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

[Office visit.](#)

We will verify your name, address, date of birth, and current health insurance carrier when you check into our office.

Please see our full version of our Privacy Practices displayed in our reception area for more detail.

[FOR MORE INFORMATION OR TO REPORT A PROBLEM](#)

If you have complaints, questions, or would like additional information regarding this Notice or the privacy practices of **Ascend Vision Partners and its affiliated practices**, please contact:

[Privacy Officer](#)

Ascend Vision Partners and its affiliated practices

Henry Victor

Henry.Victor@AscendVision.com

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Official, or, you may file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the practice's Privacy Official or with the Office for Civil Rights. The address for the Office of Civil Rights is listed below.

OFFICE FOR CIVIL RIGHTS

U.S. Department of Health and Human Services

200 Independence Avenue, S.W.

Room 509F, HHH Building

Washington, D.C. 20201

Patient Signature: _____ **Date:** _____