DANIEL & DAVIS OPTOMETRY

Susan L. Daniel, O.D. · Christopher Davis, O.D. · Camilla E. Dukes, O.D., F.C.O.V.D. · Karen E. Love, O.D., F.C.O.V.D.

Thank you for choosing Daniel and Davis Optometry for your child's eye health needs.We ask that you review and complete the following items in preparation for your child's evaluation.

Welcome to Our Office – This is a general form that gives us basic information about your child. The form requires two signatures – one signature that allows us to assist you in obtaining payment from your insurance, and the second signature acknowledges the validity of the information that you have provided on the form.

Children's Vision Questionnaire – This form provides us with more detailed information regarding your child's history and health. Please take your time when completing this form so you may be as thorough as possible.

Notice of Developmental Evaluation Procedures and *Test for Developmental Visual Services* – These items detail the procedures that will be involved in your child's vision evaluation. The notice requires your signature to acknowledge that you agree to these services, and the detailed descriptions are for your information and records.

Office Policies – This form explains our office policies in detail, including our policies on payments, contact lens evaluations, vision insurances, and medical insurances. Please sign the bottom of this form to acknowledge that you understand these policies.

Notice of Privacy Practices and *Acknowledgement of Receipt* – The HIPAA Notice of Privacy Practices details our office's privacy policy and discusses how we make use of your personal health information. The federal government requires that we give this notice to you, and that you verify that you have received this notice by signing the Acknowledgement of Receipt. Please keep the notice for your records, return to us the signed acknowledgment.

Also enclosed are driving directions should you need assistance in finding our facility.

Please bring the completed paperwork, along with any eyeglasses, contact lenses and visual aids that are currently used, with you to your child's exam. Do not hesitate to contact us should you have any questions regarding this material. We look forward to seeing you and your child.

3144 El Camino Real, Suite 202 · Carlsbad, CA 92008 · (760) 434-3314 · (760) 434-5624 Fax

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WELCOME TO OUR OFFICE

Today's Date: ______________________

Name ______________________

Preferred name / nickname: ______________________

Date of birth ________ Age: ______ Sex: ❒ M ❒ F

Race __________ Ethnicity__________

Street Address ______________________

City ______________________ Zip: ______

Home/Daytime phone ______________________

Cell phone ______________________

Email address ______________________

Preferred method of communication:

❒ Home phone ❒ Daytime phone ❒ Cell phone ❒ Email

Employer ______________________

Occupation ______________________

Hobbies/Sports ______________________

Special Needs ______________________

Spouse (or parent) name ______________________

Spouse (or parent) daytime phone ______________________

Vision Insurance ❒ VSP ❒ MESC ❒ CompBenefits/Humana ❒ UFCW

Medical Insurance __________ ❒ HMO ❒ PPO ❒ POS

Patient's Social Security Number ______________________

Insured's Social Security Number ______________________

Pharmacy Preference______________________

How did you hear about our office?

❒ Friend or relative. Who? ______________________

❒ Another health care practitioner. Who? ______________________

❒ School District. Which one? ______________________

❒ Previous patient. Who? ______________________

❒ Participating eye care plan. Which one? ______________________

❒ Walk in ❒ Internet ❒ Other ______________________

Method of payment:

❒ Check ❒ Cash ❒ Visa / MC / Discover / AMEX

❒ Insurance – Please specify type: ______________________

❒ School District Contract – Which one? ______________________

Insurance Authorization

I certify that the information given by me in applying for insurance and/or Medicare payments is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Daniel and Davis Optometry on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature below authorizes the release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

______________________ ____________
Signature Date

Please tell us why you are here today: ______________________

____

Do you currently wear glasses? ❒ Yes ❒ No

Do you currently wear contact lenses? ❒ Yes ❒ No If yes, contact lens type: __________ Brand: __________

How often do you wear your contacts? __________ For how many hours/day? ______ Contact lens solution: __________

Are you interested in laser vision correction? ❒ Yes ❒ No

Please check any/all of the following symptoms that you experience:

❒ Eye discomfort ❒ Loss of vision ❒ Dryness ❒ Tired eyes
❒ Sensitivity to sunlight ❒ Blurred vision ❒ Redness ❒ Floaters or spots
❒ Sandy or gritty feeling ❒ Distorted vision ❒ Itching ❒ Flashes of light
❒ Sties or chalazions ❒ Halos ❒ Burning ❒ Problems with glare or reflection

PERSONAL Ocular History Please check all of the following eye conditions that apply to you:

❒ Blindness	❒ Eye injury	❒ Eye turn / lazy eye	❒ Retinal disease
❒ Cataracts	❒ Eye Surgery	❒ Glaucoma	❒ Vision training / eye exercises
❒ Color blindness/deficiency	❒ Other ____________		

PERSONAL Medical History Please check all of the following medical conditions that apply to you; elaborate if necessary:

❒ Arthritis / Rheumatoid	❒ Developmental delay	❒ Head injury	❒ Stroke
❒ Asthma	❒ Diabetes	❒ Headaches	❒ Seizures
❒ Brain injury	❒ Dizziness	❒ High/low blood pressure	❒ STDs
❒ Bronchitis	❒ Fainting	❒ Migraines	❒ Other ____________

❒ Allergies: ____________ ❒ Lung disorders: ____________

❒ Cancers/tumors: ____________ ❒ Neuro-developmental disorders: ____________

❒ Heart/vascular disorders: ____________ ❒ Surgery: ____________

❒ Kidney disorders: ____________ ❒ Psychiatric disorders: ____________

❒ Liver disorders: ____________ ❒ Thyroid disorders: ____________

Do you currently: ❒ Smoke? ❒ Drink? ❒ Use narcotics? If so, how often? ____________

Are you currently under the care of a physician? ❒ Yes ❒ No

Primary care physician: ____________ City: ____________ Date of last physical: ____________

List all of your current medications:

Medication	Dosage	What is it for?

Medication **allergies**: ____________

FAMILY Ocular and Medical History Please check all of the following conditions that apply to your family members. Please identify the specific family member(s) with each condition. Use 'M' to designate maternal relatives and 'P' to designate paternal relatives (e.g. M-grandmother, P-uncle, etc.)

❒ Blindness: ____________ ❒ Glaucoma: ____________

❒ Cataracts: ____________ ❒ Retinal disease: ____________

❒ Color blindness/deficiency: ____________ ❒ Vision training / Eye exercises: ____________

❒ Eye turn / Lazy eye: ____________ ❒ Other: ____________

❒ Arthritis: ____________ ❒ Kidney disorders: ____________

❒ Asthma: ____________ ❒ Liver disorders: ____________

❒ Bronchitis: ____________ ❒ Lung disorders: ____________

❒ Cancers/tumors: ____________ ❒ Neuro-developemental disorders: ____________

❒ Developmental delay: ____________ ❒ Psychiatric disorders: ____________

❒ Diabetes: ____________ ❒ Stroke: ____________

❒ Dizziness/fainting: ____________ ❒ Seizures: ____________

❒ Headaches/Migraines: ____________ ❒ Thyroid disorders: ____________

❒ Heart/Vascular disorders: ____________ ❒ Other: ____________

The information I have provided on this form is true and complete to the best of my knowledge.

____________________ Signature ____________ Date

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CHILDREN'S VISION QUESTIONNAIRE

*Please fill out this questionnaire **carefully** and return it to our office **prior** to your appointment. Thank you.*

General Information

Child's full name: ________________ ❒ Male ❒ Female

Birth date: ________ Age (years): ______(months): ________

School name and address: ________________

Grade: ______ Teacher: __________ Principal: __________

Is your child especially afraid of doctors? ❒ No ❒ Yes

Child's dominant hand: ❒ Right ❒ Left Has guidance been given in use of hand? ❒ No ❒ Yes

Please list the names and birth dates of your family:

	Name	Birth date
Mother / Caretaker		
Father / Caretaker		
Sibling		
Sibling		
Sibling		
Sibling		

Were you referred to our office? ❒ No ❒ Yes

If yes, whom may we thank for this referral? ________________ Phone: __________

Address: ________________ City: __________ Zip: __________

Responsible Person Information

Home address: ________________ City: __________ Zip: __________

Home phone: ________________

Father / Caregiver occupation: ________________ Business phone: __________

Business address: ________________ City: __________ Zip: __________

Mother / Caregiver occupation: ________________ Business phone: __________

Business address: ________________ City: __________ Zip: __________

Do you have major medical insurance? ❒ No ❒ Yes If yes, which? ❒ HMO ❒ PPO ❒ POS

Primary carrier: ________________ Policy #: __________

Secondary carrier: ________________ Policy #: __________

Name of insured: ________________ Insured's Social Security Number: __________

Do you have vision insurance? ❒ No ❒ Yes

Carrier: ________________ Policy #: __________

Name of insured: ________________ Insured's Social Security Number: __________

Medical History

Pediatrician's name: ______________________ Date of last evaluation: ______________

For what reason?____

Results and recommendations: ______________________________________

Child's current state of health: ______________________________________

List any medications used at the current time (prescription, over-the-counter, herbs, vitamins, supplements, etc.):

Medication For what condition(s)?

____

____

____

____

Any reactions to immunization(s)? ❒ No ❒ Yes

If yes, please explain:____

____

List hospitalizations, illnesses, bad falls, high fevers, etc.:

Age Severe Mild Complications

____

____

____

____

Is your child generally healthy? ❒ No ❒ Yes

If no, please explain:____

Are there any chronic problems (i.e. ear infections, asthma, hay fever, allergies)? ❒ No ❒ Yes

If yes, please list:____

Has a neurological evaluation been performed? ❒ No ❒ Yes

If yes, by whom? ______________________

Results and recommendations: ______________________________________

____

Has a psychological evaluation been performed? ❒ No ❒ Yes

If yes, by whom? ______________________

Results and recommendations: ______________________________________

____

Has an occupational evaluation been performed? ❒ No ❒ Yes

If yes, by whom? ______________________

Results and recommendations: ______________________________________

____

Is there any history of the following? (check all that apply)

	Patient	Family	Who?		Patient	Family	Who?
Diabetes	❒	❒	________	High blood pressure	❒	❒	________
"Cross" or "Wall" Eye	❒	❒	________	Learning disability	❒	❒	________
Chromosomal imbalance	❒	❒	________	Amblyopia (lazy eye)	❒	❒	________
Glaucoma	❒	❒	________	Multiple Sclerosis	❒	❒	________
Epilepsy or seizures	❒	❒	________				

Other (please explain): ____

Nutritional Information

Current Diet: ❒ Excellent ❒ Good ❒ Fair ❒ Poor

Does your child: ❒ Like sweets ❒ Crave sweets

What types? ____

Is your child active? ❒ No ❒ Yes Moderately? ❒ No ❒ Yes Extremely? ❒ No ❒ Yes

Are there periods of: Very high energy? ❒ No ❒ Yes Very low energy? ❒ No ❒ Yes

Please explain: ____

Developmental History

Full-term pregnancy? ❒ No ❒ Yes

Did the mother experience any health problems during the pregnancy? ❒ No ❒ Yes

If yes, please explain:____

Normal birth? ❒ No ❒ Yes

Any complications before, during, or immediately following delivery? ❒ No ❒ Yes

If yes, please explain:____

Birth weight: ____________ Apgar scores at birth: ____________________ After 10 minutes: ____________________

Were forceps used? ❒ No ❒ Yes

Was there ever any reason for concern over your child's general growth or development? ❒No ❒Yes

If yes, please explain: ____

Did your child crawl (stomach on floor)? ❒ No ❒ Yes At what age? ____________

Did your child creep (on all fours)? ❒ No ❒ Yes At what age? ____________

If not, please describe: ____

At what age did your child walk? __________

Was your child active? ❒ No ❒ Yes

Speech: First words: ______________________________ At what age? ____________

Was early speech clear to others? ❒ No ❒ Yes

Is speech clear now? ❒ No ❒ Yes

Visual History

Has your child's vision been previously evaluated? ❒ No ❒ Yes

If yes, Doctor's name: ______________________________ Date of last evaluation: ____________________

Reason for examination: ____

Results and recommendations: ____

Were glasses, contact lenses, or other optical devices recommended? ❒ No ❒ Yes

If yes, what? ____

Are they used? ❒ No ❒ Yes If yes, when? ____

If no, why not?____

Members of the family of have had visual attention and the reason:

Name	Age	Visual Situation

Present Situation

Why do you feel your child needs a vision evaluation? ______________________________

____

____

How long has this problem/difficulty been observed? ______________________________

Is there any evidence from the school, psychological, or other tests that indicates some visual malfunction may be present?

❒ No ❒ Yes

If yes, what? ______________________________

____

Does your child report any of the following?

	No	Yes	If yes, when?
Headaches	❒	❒	______
Blurred vision / focus goes in and out	❒	❒	______
Double vision	❒	❒	______
Eyes hurt	❒	❒	______
Eyes tired	❒	❒	______
Words move around on the page	❒	❒	______
Motion sickness / car sickness	❒	❒	______
Dizziness	❒	❒	______

List any other complaints your child makes concerning his/her vision: ______________________________

____

Have you or anyone else ever noticed the following?

	No	Yes	If yes, when?
Eyes frequently reddened	❒	❒	______
Frequent eye rubbing	❒	❒	______
Frequent sties	❒	❒	______
Frowning	❒	❒	______
Bothered by light	❒	❒	______
Frequent blinking	❒	❒	______
Closing or covering one eye	❒	❒	______
Difficulty seeing distant objects	❒	❒	______
Head close to paper when reading or writing	❒	❒	______
Avoids reading	❒	❒	______
Prefers being read to	❒	❒	______
Tilts head when reading	❒	❒	______
Tilts head when writing	❒	❒	______
Moves head when reading	❒	❒	______
Confuses letters or words	❒	❒	______
Reverses letters or words	❒	❒	______
Confuses right and left	❒	❒	______
Skips, rereads, or omits words	❒	❒	______

	No	Yes	If yes, when?
Loses place while reading	❒	❒	______
Vocalizes when reading silently	❒	❒	______
Reads slowly	❒	❒	______
Uses finger as marker	❒	❒	______
Poor reading comprehension	❒	❒	______
Comprehension decreases over time	❒	❒	______
Writes or prints poorly	❒	❒	______
Writes neatly but slowly	❒	❒	______
Does not support paper when writing	❒	❒	______
Awkward or immature pencil grip	❒	❒	______
Frequent erasures	❒	❒	______
Tires easily	❒	❒	______
Difficulty copying from chalkboard	❒	❒	______
Difficulty recognizing same word on different page	❒	❒	______
Poor word attack skills	❒	❒	______
Difficulty with memory	❒	❒	______
Remembers better what he/she hears than sees	❒	❒	______
Responds better orally than by writing	❒	❒	______
Seems to know material, but does poorly on tests	❒	❒	______
Dislikes/avoids near tasks	❒	❒	______
Short attention span / loses interest	❒	❒	______
Poor large motor coordination	❒	❒	______
Poor fine motor coordination	❒	❒	______
Difficulty with scissors / small hand tools	❒	❒	______
Dislikes/avoids sports	❒	❒	______
Difficulty catching/hitting a ball	❒	❒	______

Television Viewing / Leisure Time Activities

Does your child watch television? ❒ No ❒ Yes

If yes, how much?__________ How often? __________ Viewing distance? __________

Does your child spend time using computer/video games? ❒ No ❒ Yes

If yes, how much?__________ How often? __________ Viewing distance? __________

What other activities occupy your child's leisure time? __________

Are there any activities your child would like to participate in, but doesn't? Please explain: __________

____

School

Age at time of entrance to Preschool: __________ Kindergarten: ___________ First Grade: ________

Does your child like school? ❒ No ❒ Yes

Specifically describe any school difficulties: ____

____

Has your child changed schools often? ❒ No ❒ Yes

If yes, when? ____

Has a grade been repeated? ❒ No ❒ Yes

If yes, which and why? ____

Does your child seem to be under tension or extreme pressure when doing schoolwork? ❒ No ❒ Yes

Has your child had any special tutoring, therapy and/or remedial assistance? ❒ No ❒ Yes

If yes, when? ____

Where and from whom? ____

How long? ____

Results: ____

Does your child like to read? ❒ No ❒ Yes

Voluntarily? ❒ No ❒ Yes

Does your child read for pleasure? ❒ No ❒ Yes What? ______________________________

What is your child's attitude towards reading, school, his/her teachers, other youngsters? ________________

____

Overall, school work is: ❒ Above average ❒Average ❒Below average

Which subjects are:

Above average?____

Average?____

Below average?____

Does your child need to spend a lot of time/effort to maintain this level of performance? ❒ No ❒ Yes

How much time on average does your child spend each day on homework assignments? ________________

To what extent do you assist your child with homework? _______________________________

Do you feel your child is achieving up to his/her potential? ❒ No ❒ Yes

Does the teacher feel your child is achieving up to his/her potential? ❒ No ❒ Yes

General Behavior

Are there any behavior problems at school? ❒No ❒Yes

If yes, what? ____

Are there any behavior problems at home? ❒ No ❒ Yes

If yes, what? ____

What causes these problems? ____

Child's reaction to fatigue: ❒ sad ❒ irritable ❒ other: _______________________________

Child's reaction to tension: ❒ avoidance ❒ irritable ❒ other: ____________________________

Does your child say and/or do things impulsively? ❒ No ❒ Yes

Is your child in constant motion? ❒ No ❒ Yes

Can your child sit still for long periods? ❒ No ❒ Yes

Family and Home

Please indicate which adult(s) he/she lives with? ❒ Mother ❒ Father ❒ Stepmother ❒ Stepfather

❒ Foster Parents ❒ Adoptive parents ❒ Grandmother ❒ Grandfather ❒ Aunt ❒ Uncle

❒ Other caretaker (please specify): ______________________________

Does your child spend time with any other person, not in the home? ❒ No ❒ Yes

If yes, please explain: ______________________________

Has your child ever been through a traumatic family situation (such as divorce, parental loss, separation, severe parental illness)? ❒ No ❒ Yes

If yes, at what age? ______________________________

Does your child seem to have adjusted? ❒ No ❒ Yes

Was counseling/therapy undertaken? ❒ No ❒ Yes

If yes, is it on-going? ❒ No ❒ Yes

Is your family life stable at this time? ❒ No ❒ Yes

If no, please explain: ______________________________

How does your child get along with:

Parents / other caretakers? ______________________________

Silbings?______________________________

Classmates in school?______________________________

Playmates at home?______________________________

Did father or anyone in father's family have a learning problem? ❒ No ❒ Yes

If yes, who? ______________________________

Did mother or anyone in mother's family have a learning problem? ❒ No ❒ Yes

If yes, who? ______________________________

Do any, or did any, of the other children in the family have learning problems? ❒ No ❒ Yes

If yes, who? ______________________________

To what extent?______________________________

____

____

____

Give a brief description of your child as a person:

Is there any other information you feel would be helpful or important in our treatment of your child?

Release of Information and Insurance Filing

It is often beneficial to us to discuss examination results and to exchange information with your child's school and/or other professionals involved in your child's care. Please sign below to authorize this exchange of information.

I agree to permit information from, or copies of, my child's examination records to be forwarded to my child's school, other health care providers, or insurance carriers upon their written request, or upon the recommendation of DRS. DANIEL AND DAVIS OPTOMETRY when it is necessary for the treatment of my child's visual condition, or for the processing of insurance claims. I authorize DRS. DANIEL AND DAVIS OPTOMETRY to exchange information with my child's school and other professionals involved in my child's care, by means of my signature below. This authorization shall be considered valid for the duration of my child's treatment.

____ ______________________
Signature Date

____
Relationship to patient

I hereby give my permission to DRS. DANIEL AND DAVIS OPTOMETRY to treat ______________________
(child's name)

____ ______________________
Parent's or Guardian's Signature Date

Thank you for carefully completing this questionnaire. The information supplied will allow for a more efficient use of time, enabling us to perform a comprehensive evaluation of your child and better meet your child's specific visual needs.

If at any time you have questions or concerns regarding your child's vision or treatment, please do not hesitate to contact us. You may leave a message for us 24 hours a day, seven days a week.

Please arrive on time for your evaluation so that we may have the maximum opportunity to evaluate your child's visual status. We request a minimum of 24 hours notice if you are unable to keep your appointment.

Thank you for your cooperation.

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NOTICE OF DEVELOPMENTAL EVALUATION PROCEDURES

Your evaluation will include any or all of the following procedures:

Comprehensive Eye Exam with Refraction	$169
Optomap Retinal Examination	$39
Visual Efficiency Exam	$125
Visual Perceptual Exam	$175
Specialized Written Report	$100

A detailed description of these procedures and the services they include may be found on the following *Test for Developmental Visual Services.*

Vision insurance may provide coverage for the *comprehensive eye examination only.* We are a provider for Vision Service Plan (VSP) and Medical Eye Services (MESC).

The remaining services may qualify for reimbursement by your medical insurance. **We do not belong to any network of medical insurance providers except Medicare. Therefore, besides Medicare, we do not accept payments from any medical insurances**. We may still request a copy of your medical insurance card so that we may be able to assist you as much as possible in submitting a claim to your own insurance for reimbursement.

I understand that the any or all of the above procedures will be part of my evaluation at Daniel and Davis Optometry. I understand that payment for these services is expected at the time services are rendered.

Patient (or Responsible Party) Signature: ______________________________________

Printed Name: ________________________ Relationship to Patient: ________________

Date: ______________________________

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OFFICE POLICIES

We are committed to offering the best and most thorough care possible. Please review policies listed below, as they are important to understanding the services offered at our office, how your payments are processed and how your insurance is billed.

Professional fees are due at the time services are rendered. Full payment is required when an order for glasses or contacts is placed. Professional fees are non-refundable. We accept Visa, MasterCard, Discover, American Express, and checks with valid identification. We also accept assignment on many types of vision insurance. There is a 25% service charge on all cancelled orders once the job has been started.

CONTACT LENS POLICIES

Contact lenses are medical devices that require a comprehensive vision and eye health evaluation before they are prescribed. If contact lenses are appropriate for you, follow-up medical management is required. We will release your prescription to you after the doctor has determined that the contact lenses meet all the criteria for proper eye health and visual acuity specific to your case. Continued use of contact lenses requires a yearly comprehensive eye exam and contact lens medical management to ensure that contact lens wear is still appropriate based on the health of your eyes.

If you are unable to adapt to your contact lenses, you have within 90 days the option to: (1) change to a different type of contact lens and pay the difference should there be any, or (2) apply the amounts paid less the professional fees toward the purchase of glasses. No cash refunds will be given, only office credit with the return of contact lenses in good condition.

RETURNED CHECK POLICY

Any check returned to us as insufficient funds shall be charged a $25 service fee in addition to the value of the check. Additional fees as high as three times the amount of the check as well as collection fees may be charged if prompt payment of the returned check is not made.

VISION SERVICES AND VISION INSURANCE

Drs. Daniel and Davis Optometry accepts plans from four vision insurance providers: **Vision Service Plan (VSP), Medical Eye Services (MESC), CompBenefits/Humana, and United Food and Commercial Workers (UFCW).** Vision insurance generally provides coverage for your yearly eye exam, which includes the comprehensive screening of your eyes' health, and prescription of corrective glasses (if necessary).

Your vision insurance plan may also provide nominal coverage for frames, spectacle lenses, and/or contact lens evaluations and supply.

We do our best to verify insurance eligibility prior to any rendered services, so that we are able to notify you of any areas of concern prior to your appointment. Vision insurances have a large number of different vision plans with varying copays, exam coverage, material coverage, fee schedules, and eligibility dates.

If you have any questions regarding your eligibility for any services or materials, we will assist you as much as possible and provide as much information as we are able to attain. However, we strongly encourage you to research your insurance coverage thoroughly – both VSP and MESC provide member information that can be accessed on their respective websites or by calling their member information phone lines. If your insurance is provided to you as a benefit of your employment, your Human Resources or Insurance Benefits contact may also be a good resource for determining the details of your eligibility.

In some cases, the doctor may request a follow-up evaluation to your comprehensive eye exam based on a particular diagnosis or prescription that is slightly more involved. These visits are not covered by vision insurance, and payment for these services is expected at the time services are rendered. You may ask the doctor if you have questions regarding the cost for this follow-up care.

MEDICAL SERVICES AND MEDICAL INSURANCE

In the event of a medical visit, **Drs. Daniel and Davis Optometry does not belong to any network of medical insurance providers except Medicare. Therefore, besides Medicare, we do not accept payments from any medical insurances**. We may still request a copy of your medical insurance card so that we may be able to assist you as much as possible in submitting a claim to your own insurance for reimbursement.

Medical visits may include, but are not limited to, eye infections, eye-related emergencies, eye-related allergic reactions, and foreign body removal. The cost for these services, and any subsequent follow-up appointments, can often only be determined after the patient is evaluated by the doctor. For such visits and follow-up appointments, payment is expected at the time services are rendered.

We encourage you to call our office or come in immediately when such medical conditions or emergencies arise, as we are often able to treat you in a timelier manner than your primary healthcare provider or any urgent care or emergency room. After your initial evaluation and diagnosis, you may elect to continue follow-up care with your primary healthcare physician, who may be able to bill your insurance directly should this be your preference.

In addition, many vision therapy services that are not typically covered by standard vision insurances such as VSP or MESC may qualify for reimbursement by your medical insurance. Again, we encourage you to research your insurance thoroughly to determine what services may or may not be covered. Our office will assist you as much as possible with the procedure codes and diagnosis codes that medical insurances use to determine coverage and payment.

If you have any further questions regarding our office policies, your payments or insurance, our doctors and staff will assist you as much as possible.

I have read and understand the above office policies regarding services rendered at Daniel and Davis Optometry.

____ ____________________
Signature Date

____
Printed Name

The Health Insurance Portability and Accountability Act ("HIPAA")
NOTICE OF PRIVACY PRACTICES

DANIEL & DAVIS OPTOMETRY

3144 El Camino Real, Suite 202, Carlsbad, CA 92008
(760) 434-3314 | (760) 434-5624 Fax
Office Contact Person: Alice Amaro

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.

Drs. Daniel and Davis Optometry will ask you to sign an Acknowledgment that you have received this Notice of Privacy Practices. We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes, in accordance with the HIPAA Privacy regulation, how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment, or health care operations.

Examples of how we use or disclose 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 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 have to do 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.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. 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 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" who perform health care operations for us and who commit to respect the privacy of your health information.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES
We will not make any other uses or disclosures of your health information unless you sign a written “authorization form.” The content of an “authorization form” is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes you may initiate the process if it‟ s your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION
The law gives you many rights regarding your health information.

RESTRICTION REQUESTS. You have the right to ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.

ALTERNATIVE MEANS OF COMMUNICATION. You have the right to ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using email to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.

ACCESS. You have the right to ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.

HEALTH CARE INFORMATION AMENDMENTS. You have the right to ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address or fax shown at the beginning of this Notice.

ACCOUNTING. You have the right to get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.

NOTICE OF PRIVACY PRACTICES. You have the right to get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address or fax shown at the beginning of this Notice.

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office and have copies available in our office.

COMPLAINTS
If you think we have not properly respected the privacy of your health information, you are free to complain to us or 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 or fax shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION
If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

EFFECTIVE DATE
This Notice of Privacy Practices is effective as of April 14, 2003.

DANIEL & DAVIS
OPTOMETRY
3144 El Camino Real, Suite 202, Carlsbad, CA 92008
(760) 434-3314 | (760) 434-5624 Fax

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

____
Patient Name (please print)

____
Signature

____
Date

The above patient has refused to sign this “Acknowledgement of Receipt” when asked on this date.

____
Employee Name (please print)

____
Signature

____
Date

DANIEL & DAVIS
OPTOMETRY

DRIVING DIRECTIONS

3144 El Camino Real, Suite 202
Carlsbad, CA 92008
(760) 434-3314

From North:
- Interstate 5S
- Freeway 78E
- Exit El Camino Real
- Turn right onto El Camino Real
- Make a u-turn at Carlsbad Village Drive
- Turn right at first driveway

From East:
- Freeway 78W
- Exit El Camino Real
- Turn left onto El Camino Real
- Make a u-turn at Carlsbad Village Drive
- Turn right at first driveway

From South:
- Interstate 5N
- Exit Carlsbad Village Drive
- Turn right onto Carlsbad Village Drive
- Turn left on El Camino Real
- Turn right at first driveway

Carlsbad Medical Dental Plaza – 3144 El Camino Real
Take elevator to 2nd Floor
Suite 202 is to the right as you exit the elevator