855 Washington Ave. Holland, MI 49423
P 616-395-2020 F 616-396-8628

# WEST COAST | EYE CARE

Date:_____

Name:_____ Birthdate:_____ Age:_____

Cell #:_____ Home #: _____ Work #:_____

Address:_____ City:_____ State:_____ Zip:_____

Email:_____ Sex: Male Female

Employer/School: _____ Occupation/grade:_____

Spouse / Parent's Name:_____

Social Security # Patient:_____ Social Security # Spouse/Parent:_____

**How did you first hear about our office?** _____

**How would you like us to contact you for appointments, glasses/contact lens pick up etc.?**

❑ Cell Phone ❑ Home Phone ❑ E-mail ❑ Mail/Postcard

## Medical History

Do you have any allergies to medications/environmental?_____

Are you taking any medications (including oral contraceptives, aspirin, over the counter medications and vitamins)? Please list:

_____

_____

Are you using any eyedrops (prescription or over the counter)? Please list:_____

_____

Do you or a family member (parents, grandparents, siblings, children) currently have, or have you ever had any of these conditions?

| | Yes | No | Relative | If Yes: Please Explain |
|---|---|---|---|---|
| Diabetes | ☐ | ☐ | ☐ | _____ |
| High Blood Pressure | ☐ | ☐ | ☐ | _____ |
| High Cholesterol | ☐ | ☐ | ☐ | _____ |
| Vascular/Cardiovascular | ☐ | ☐ | ☐ | _____ |
| Respiratory (Asthma, Emphysema, etc.) | ☐ | ☐ | ☐ | _____ |
| Endocrine (Thyroid) | ☐ | ☐ | ☐ | _____ |
| Bones/Joints/Muscles (Arthritis, etc.) | ☐ | ☐ | ☐ | _____ |
| Ear/Nose/Throat (Sinus, Chronic Cough, etc.) | ☐ | ☐ | ☐ | _____ |
| Gastrointestinal (Diarrhea, Constipation, Ulcers, etc.) | ☐ | ☐ | ☐ | _____ |
| Genitourinary (Kidney, Bladder, Genitals, etc.) | ☐ | ☐ | ☐ | _____ |
| Blood/Lymph (Anemia, etc.) | ☐ | ☐ | ☐ | _____ |
| Skin | ☐ | ☐ | ☐ | _____ |
| Constitutional (Weight loss/gain, Fever, etc.) | ☐ | ☐ | ☐ | _____ |
| Neurological (Migraines, Headache, Multiple Sclerosis, etc.) | ☐ | ☐ | ☐ | _____ |
| Psychological (Depression, Anxiety, etc.) | ☐ | ☐ | ☐ | _____ |
| Eyes (Cataract, Glaucoma, Macular Degeneration, etc.) | ☐ | ☐ | ☐ | _____ |

Are you pregnant/nursing? No Yes

## Social History

Do you use tobacco products? No Yes If yes, type, amount, how long?_____

Do you drink alcohol? No Yes If yes, type, amount, how long?_____

Do you use illegal drugs? No Yes If yes, type, amount, how long?_____

WEST COAST | EYE CARE

**INSURANCE INFORMATION**

855 Washington Ave, Holland, MI 49423. P 616-395-2020. F 616-296-8628

Date _____ Patient Name_____ Date of Birth_____/_____/_____

Name of Insured _____ Insured Date of Birth_____/_____/_____

Insured Relationship to patient: SELF SPOUSE PARENT (circle one) Insured Social Security#_____

Vision Insurance_____Employer_____

Medical Insurance_____ Insured ID#_____

**I understand that I am responsible for any payment my insurance does not reimburse West Coast Eye Care.**

Signature_____ Date _____

WEST COAST | EYE CARE

COVID-19 Pandemic Eye Exam and Treatment Consent Form

Patient Legal Name: _____ DOB: _____ Date:_____

Patient has read and acknowledged the following statements to indicate agreement. If the patient cannot positively affirm to all these questions, the patient will be asked to postpone or reschedule their visit to a later date.

___ Patient does not currently, nor has had in the last 14 (fourteen) days COVID-19 symptoms as published by the CDC such as fever, cough, flu-like symptoms etc.

___ To the best of the patient's knowledge, the patient does not have nor has been in direct contact with someone who has confirmed diagnosis of COVID-19 or a presumptive positive COVID-19 test result in the last 14 (fourteen) days nor is Patient awaiting test results for COVID-19.

___ Patient has a temperature of less than 100.5 degrees F taken in the office by staff member.

___ Patient agrees they will not hold West Coast Eyecare or any of its doctors or staff personally responsible should the patient, or someone they come in contact with, become positive or presumptively positive diagnosed with the COVID-19 virus. There are certain inherent risks associated with an eye exam during a pandemic and the patient assumes full responsibility for personal illness that may result and further release and discharge West Coast Eyecare and its doctors and staff for injury, loss, or damage arising out of their visit.

Signature: _____ Date: _____

# ATTENTION

**Mask**

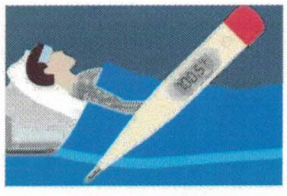
Everyone age 2 and older MUST wear a mask upon entering the office.

**6 ft**

Please maintain a social distance of 6 ft between you and other patients.

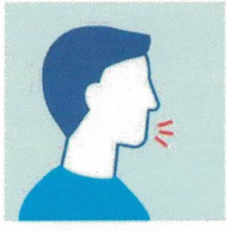

**Fever**

Anyone with a temperature of 100.5°F or higher, will be sent home and rescheduled.



**Not Well**

Anyone with symptoms of COVID-19 such as fever, cough, flu-like symptoms, etc will be sent home and rescheduled.

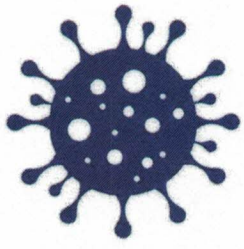


**Exam**

Only the patient is allowed in the exam room with the doctor. Only one parent/caregiver is allowed in the exam room if the patient is a minor or requires assistance.


**Exposure**

If you have been exposed to a test-positive COVID-19 patient in the past 14 days or are awaiting test results, you will be sent home and rescheduled.



Member
American Optometric Association

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY.**

Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice).

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

## *USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION*

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health 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; referring you to another doctor or clinic for eye care or 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 must carry out 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.

## *OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT*

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. 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 a 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" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA;
- [specify other uses and disclosures affected by state law].

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care.Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for heath care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

### *SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION*

The following are some specific uses and disclosures we may not make of your health information **without** your authorization:

**Marketing activities.** We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent to such payment.

**Sale of health information.** We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.

**Psychotherapy notes.** Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

### *YOUR RIGHTS TO PROVIDE AN AUTHORIZATIONFOR OTHER USES AND DISCLOSURES*

Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization.

You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.

We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.

We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

### *YOUR INDIVIDUAL RIGHTS*

You have many rights concerning the confidentiality of your health information. You have the right:

**To request restrictions on the health information we may use and disclose for treatment, payment and health care operations.** We are not required to agree to these requests. To request restrictions, please send a written request to us at the address below.

**To receive confidential communications of health information about you in any manner other than described in our authorization request form**. You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.

**To inspect or copy your health information.**You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.

**To amend health information.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:

- was not created by us, unless the person that created the information is no longer available to make the amendment,
- is not part of the health information kept by or for us,
- is not part of the information you would be permitted to inspect or copy, or
- is accurate and complete.

**To receive an accounting of disclosures of your health information.** You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).

**To designate another party to receive your health information.** If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

***Contact Person:***

Our contact person for all questions, requests or for further information related to the privacy of your health information is:

_____ _____

Name Address

***Complaints:***

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to 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, fax or E mail shown above. If you prefer, you can discuss your complaint in person or by phone.

***Changes to This Notice:***

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

Notice Revised and Effective: _____

**NF 5/2013**

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**ACKNOWLEDGEMENT OF RECEIPT**

I acknowledge that I received a copy of _____ O.D., Notice of Privacy Practices.

Date _____ Patient name _____ Signature _____