ROCKRIMMON VISION SOURCE

Welcome To Our Office!!

Full Legal Name:		
I prefer to be called:	Sex:	☐Male ☐Female
Street Address:		
City:	State:	Zip:
Date of Birth:	Social Security #:	
Home Phone:	Daytime Phone:	
Cell Phone:	Email Address:	
Preferred Language:		
Ethnicity:	Communication Preference: Telephone Email Text	
Employer Name: Employer Address:		
Please list other family members in your household:		

Guarantor and Insurance Information

(Please list the person who is responsible for your bill)

Guarantor's Name:	Guarantor Home Phone:
Guarantor's Address:	Guarantor's Employer:
Guarantor SS#:	Patient's Relationship to Guarantor: (circle one) Self Spouse Child Other
Guarantor Date of Birth:	
Insurance Company:	
Who may we thank for referring you to our office? How did you hear about us?	
Please list someone outside your household to contact in case of an emergency: Name: Phone:	

Explanation of Practice Financial Policy: Payment is expected at the time of service. Insurance billing and insurance payment is based upon individual insurance guidelines. I hereby authorize payment of vision, medical and surgical benefits directly to Rockrimmon Vision Source. I have read and understand that all vision, medical and surgical charges incurred by myself, or my dependents for services rendered by Rockrimmon Vision Source are my financial responsibility. All court, attorney, or other fees necessary to collect this account are payable by me.

Patient/Guardian Signature:_____Date:_____

WELCOME TO ROCKRIMMON VISION SOURCE

Name:		Nickname:
Today's Date:	Age:	Date of Birth:
Approx date of last eye exam:	Name of previous eye doctor or clinic:	
Occupation:	Number of hours on computer per day:	
Hobbies/Sports:		
What is the reason for today's visit? What visual/ocular problems are you having? ☐Routine only, no problems.		
Any current or past medical conditions that we should be aware of?		
Females, are you pregnant and/or nursing? No Yes		
What medications are you taking?		
What are you allergic to (including medications)?		
Have you ever had any eye injuries or surgeries? What/when?		
If the doctor finds that you are a good candidate for refractive surgery, would you perhaps be interested?		

I AM CURRENTLY HAVING PROBLEMS WITH: (PLEASE CHECK APPROPRIATE BOXES BELOW)

	Blurred vision at distance		Eye strain
	Blurred vision at near		Itchy eyes
	Dry eyes		Watery eyes
	Headaches (often or severe)		Floaters/Flashes of light

Other:

DO YOU OR ANY OF YOUR BLOOD RELATIVES HAVE OR HAVE HAD ANY OF THE FOLLOWING?

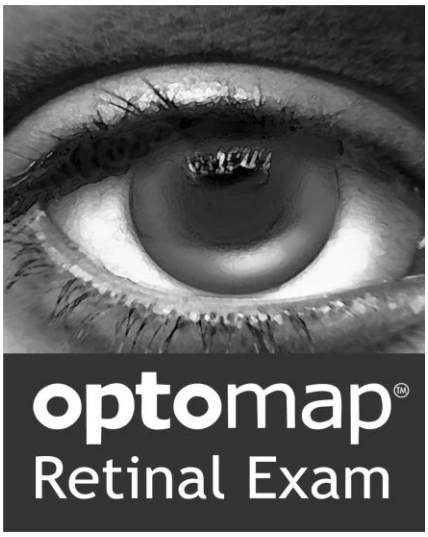
		Who? Self/Family	
Glaucoma	Y N		Comments
Cataracts	Y N		
Macular Degeneration	Y N		
Diabetes	Y N		
Seasonal allergies	Y N		Does it affect your eyes?
Multiple Sclerosis	Y N		
Thyroid conditions	Y N		
Lazy eye/crossed eye	Y N		
Heart problems	Y N		
Blindness	Y N		
High blood pressure	Y N		

Other:

CONTACT LENS WEARERS ONLY:

What type of contacts do you wear?	
How old are your current contacts?	
How many hours a day do you wear contacts?	
Do you ever sleep in your lenses?	How often?
How often do you replace your lenses?	
What solutions do you use?	

Rockrimmon Vision Source



The doctors at Rockrimmon Vision Source recommend all patients, including children, receive an Optomap Retinal Examination as part of your annual eye health evaluation. This incredible technology provides early detection of diseases that affect not only your eyes, but also your overall health. The Optomap Retinal Examination is quick, easy, comfortable, and comprehensive.

No dilating eyedrops are required for Optomap.

During your eye examination, your doctor will thoroughly evaluate the health of your eyes. The retina, which is the back-interior surface of the eye, acts as the film of your "camera." The retina is susceptible to a variety of diseases and conditions that may lead to vision loss and/or blindness.

Early detection of retinal problems is critical to protecting your long-term vision.

A dilated eye examination has become the standard of care to evaluate the interior health of the eye. The Optomap utilizes state-of-the-art technology to capture a digital image of the retina **without the inconvenience of dilation --** yet provides comparable, if not superior, results. In addition, the Optomap provides a permanent record to compare and track retinal diseases and conditions. If you ever move, the images can be e-mailed to your future eye doctor. Upon completion of the imaging today, your doctor will review the results of the examination with you.

The fee for this service is $39.00. Insurance plans do not cover the cost of this advanced diagnostic screening. **Our doctors strongly believe in this phenomenal technology and recommend that all their patients have this done.** Patients with diabetes, glaucoma, cataracts, and other conditions may benefit from both dilation and Optomap imaging.

Please check one:

	I agree to have the Optomap Retinal Exam.
	I prefer to have my eyes dilated if indicated.
	I would like more information.

Patient Name (printed):_____

Patient/Guardian Signature:_____ Date:_____

NOTICE OF PRIVACY PRACTICES

Effective date of notice: July 12, 2010

Reviewed: October 19, 2020

Rockrimmon Vision Source **Jerry Hendricks, OD | Keely Knoche, OD | Brenda Begin, OD**

6005 Delmonico Drive, Suite 140, Colorado Springs, CO Ph: 719-522-9393 | Fax: 719-532-1114

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

General Rule: We respect our legal obligation to keep health information that identifies you private. The law obligates us to give you notice of our privacy practices. Generally, we can only use your health information in our office or disclose it outside of our office, without your written permission, for purposes of treatment, payment, or healthcare operations. In most other situations, we will not use or disclose your health information unless you sign a written authorization form. In some limited situations, the law allows or requires us to disclose your health information without written authorization.

Uses or Disclosures of Health Information

Examples of how we use information for treatment purposes: When we set up an appointment for you; when our technician or doctor tests your eyes; when the doctor prescribes glasses or contact lenses; when the doctor prescribes medication; when our staff helps you select and order glasses or contact lenses.

We may disclose your health information outside of our office for treatment purposes, for example: If we refer you to another doctor or clinic for eye care or low vision aids or services; if we send a prescription for glasses or contacts to another professional to be filled; when we provide a prescription for medication to a pharmacist; when we phone to let you know that your glasses or contact lenses are ready to be picked up. If no answer, we may leave a message on your answering machine. Sometimes we may ask for copies of your health information from another professional that you may have seen before.

We may use your health information within our office or disclose your health information outside of our office for payment purposes. Some examples are: when our staff asks you about health or vision care plans that you may belong to, or about other sources of payment for our services; when we prepare bills to send to you or your health or vision care plan; when we process payment by credit card and when we try to collect unpaid amounts due; when bills or claims for payment are mailed, faxed, or sent by computer to you or your health or vision plan; when we occasionally have to ask a collection agency or attorney to help us with unpaid amounts due.

We use and disclose your health information for healthcare operations in several ways. Health care operations means those administrative and managerial functions that we must do in order to run our office. We may use or disclose your health information, for example, for financial or billing audits, for internal quality assurance, for personnel decisions, to enable our doctors to participate in managed care plans, for the defense of legal matters, to develop business plans, and for outside storage of our records.

Appointment Reminders: We may call to remind you of scheduled appointments. If no answer, we may leave a message on your answering machine. We may also call to notify you of other treatments or services available at our office that might help you.

Uses & Disclosures without an Authorization

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all these situations will apply to us; some may never happen at our office at all. Such uses or disclosures are:

- A state or federal law that mandates certain health information be reported for a specific purpose.
- Public health purposes, such as contagious disease reporting, investigation, or surveillance; and notices to and from the 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, audits by Medicare or Medicaid, or investigation of possible violations of healthcare 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 relating to workers' compensation programs.
- Disclosures to business associates who perform healthcare operations for us and who agree to keep your health information private.

Other Disclosures: We will not make any other uses or disclosures of your health information unless you sign a written authorization form. You do not have to sign such a form. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it.

Your Rights Regarding Your Health Information

The law gives you many rights regarding your health information:

You can ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or healthcare 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 Rockrimmon Vision Source at the address or fax shown.

You can 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 e-mail 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 Rockrimmon Vision Source at the address or fax shown.

You can 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. Primarily, however, you will be able to review or have a copy of your health information within 30 days of asking us. 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 required. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we sent you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to Rockrimmon Vision Source at the address or fax shown.

You can 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 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 Rockrimmon Vision Source at the address or fax shown.

You can 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), except disclosures for purposes of treatment, payment or health care operations, disclosures made in accordance with an authorization signed by you, 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 Rockrimmon Vision Source at the address or fax shown.

Our Notice of Privacy Practices: 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 in compliance with and 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 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 Rockrimmon Vision Source at the address or fax shown. If you prefer, you can discuss your complaint in person or by phone.

ROCKRIMMON VISION SOURCE™

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the ***Notice of Privacy Practices*** from Rockrimmon Vision Source. I have read the document and I understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations.

Patient Name:_____

Signature:_____ Date:_____

***If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:**

Relationship to Patient:_____ Print Name:_____

Source of Authority: _____

AUTHORIZATION TO RELEASE PERSONAL INFORMATION

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures, and financial information. Under the requirements of our Privacy Practices, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Rockrimmon Vision Source to release my records and any information requested to the following individuals.

1. _____ Relation to Patient:_____
2. _____ Relation to Patient:_____
3. _____ Relation to Patient:_____
4. _____ Relation to Patient:_____

Authorization Regarding Messages (please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments

____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

____ I authorize you to leave a message with anyone who answers the phone

____ Messages may only be left with:_____

Signature:_____ Date:_____

***Note: this does not replace a Medical Release Form. A Medical Release Form will still need to be filled out to send or receive any medical exams, procedures, tests, etc. to/from other medical offices.**