Office Policies

- Please be prepared to provide us with the name and address of your primary care physician and pharmacy name and phone number
- If you are coming in for an emergency exam please be sure to contact primary care physician for referral if needed
- Please bring your medical health card so that we may keep on file for emergency medical visits
- Please bring your photo ID in order to comply with the RED FLAG LAW (prevention from identity theft)
- Exam copay is payable at the time of service
- 50% deposit is required at the time of eyeglass orders and payment in full at pickup
- 50% deposit is required at the time of contact lens orders and payment in full at pickup
- Kindly give 24hr notice if appointment changes need to be made

Primary Care Physician (PCP)/Pharmacy

Name: ____ Phone Number: ____________________________

Address:____

Pharmacy Name: _______________________________________ Phone Number:_____________________

Pharmacy Address: ____

Medication Information

Please advise us of any doctors that you have seen within the past 6 months: ____________________

____

Please list all medications that you take: ____

____

____

____

____

Please list any medication allergies: ____

____

____

____

____

Today's Date________________________________

Patient Information

Name: _______________________________________ Social Security #: _______________________

Address: ____________________________ City: _______________ State: _______ Zip: ________

Birth Date: __________________ Home Number: ________________ Cell Number: ______________

Work Number: ____________________________ E-Mail Address: ____________________________

Where do you prefer to receive calls at? __________ Home __________ Work __________ Either

Whom may we thank for referring you to us? ____

Person to contact in case if emergency: ____

Brief Health History

Do you or anyone in your immediate family have a history of the following?

_______Diabetes ______Blindness _____High Blood Pressure _____Thyroid Disease
_______Cataracts ______Glaucoma _____Macular Degeneration _____Turned/Lazy Eye

Please Check Any Of The Following Conditions That Apply To You:

____Frequent Headaches ____Pregnant ____Given Birth Last 6 Months _________Eye Strain
____Allergies ____Drug Allergies (please list)____

Insurance Information Authorization

-Please give BOTH your *vision* and *medical* cards to the receptionist

Insurance Carrier: ____

Policy #: ____ Group #: _________________________

Subscriber Name: _______________________________ Date of birth: _________________________

Responsible Party's Employer: ____

Relationship to subscriber (please circle one) self spouse child life partner dependent child in college

Marital status Minor Married Divorced Single Widow **Gender** Male Female

Preferred Language: English Italian Spanish Portuguese French German **Ethnicity:** Hispanic or Latino
Not Hispanic or Latino

Race: American Indian Alaska Native Asian Black or African American Pacific Islander White

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the eye doctor to release any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance co. to pay directly to the eye doctor insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X____ **Date:** _______________________

Communication Consent

Patient Name: ____ Date: ____________________

John P. Boscia O.D.
2020 Sullivan Trail
Easton, PA 18040
610-258-6666
eye2eye2020.com

The office policy of John P. Boscia O.D. and staff is not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, and/or cell phone. Also, information will not be left with an unauthorized person who may answer the telephone.

I authorize John P. Boscia O.D. and/or his staff to leave medical information pertaining to my care by the following methods and will assume full responsibility to notify this office whenever this information changes.

Home Telephone	( ) Yes	( ) No
Answering Machine	( ) Yes	( ) No
Work Telephone	( ) Yes	( ) No
Voice Mail	( ) Yes	( ) No
Cell Phone/Voice Mail	( ) Yes	( ) No
Fax Medical Records to another Entity	( ) Yes	( ) No
Send Medical Records via secure Email	( ) Yes	( ) No
Would you like your record uploaded to Microsoft Healthvault?	( ) Yes	( ) No

If you would like to have information released to someone other than yourself please complete the following:

Spouse: ____

Parent: ____

Other: ____

AUTHORIZATION

Print Name: ____

Patient/Guardian Signature: ____

Review of Systems Form

Name: ___________________ Today's Date: _________________

DOB: _______________ Patient #: ______________________________

Instructions: *Please circle all symptoms that apply to you, or check "Negative"*

Category	**Negative**	**Symptoms**
General		Drowsiness, Insomnia, Sleep Disturbance, Restless Legs, Nightmares, Fatigue, Fever, chills, Sweats, Change in Appetite, Weight Gain/Loss
Eyes		Eye Injury, Light Sensitivity, Eye Surgery, Floaters, Flashing Lights, Pressure in Eyes, Cataracts, Double Vision, Eyes itch, Burn & Water, Eye Pain, Irritation
Ears, Nose, Mouth, Throat		Difficulty with: Hearing, Smell, Swallowing, Taste, Voice Pain: Throat, Nose, Ears, Mouth
Cardiovascular		Pain: Chest, Calf, Jaw, Lightheadedness, Ankle Edema (swelling) Chest Palpitations, Difficulty Breathing When Lying Flat, Shortness of Breath with Exertion
Respiratory		Shortness of Breath, Cough, Sputum Production, Rapid Breathing, Elevate Head to Sleep, TB Exposure, Choking
Gastrointestinal		Nausea, Vomiting, Diarrhea, Constipation, Abdominal Pain, Bloody or Black Stool, Fecal Incontinence, Pain with Swallowing
Genitourinary		Pain with Urination, Difficulty Urinating, Blood in Urine, Sexual Dysfunction, Kidney Stones, Chronic Pelvic Pain, Urgency, Frequency
Musculoskeletal		Pain: Neck, Back, Joint, Hip, Knee, Muscle Twitching, Hammertoes Swelling, Immobility, Arthritis, Muscle Cramps, Weakness
Skin		Hair Loss, Rash, Dryness, Discoloration, Itching, Eczema Bleeding Spot on Skin, Shingles, Bites, Nail Changes, Moles
Neurological		Headache, Seizure, Loss of Consciousness, Dizziness, Slurred Speech, Tremors, Weakness, Numbness, tingling, Gait Difficulty, Problem with: concentration, Memory, Word Finding
Psychiatric		Depression, Sadness, Crying Spells, Thoughts of Suicide, Paranoia, Irritability, Anxiety, Panic Attacks, Inability to Make Decisions, Visual or Auditory Hallucination, Hyperactivity, Behavioral Changes
Endocrine		Cold or Heat Intolerance, Excessive thirst, Hunger, Urination, Menstrual Irregularity, Diabetes, Thyroid Disease, Weight Gain or Loss
Hematologic/ Lymphatic		Easily Bruised, Rib Pain, Bone Pain, Enlarged Lymph Nodes, Anemia Clotting Problems, Bleeding from: Nose, Mouth, Rectum
Allergenic/ Immunologic		Hay Fever, Sneezing, Itching Eyes, Nasal Congestion, Post Nasal Drip, Sore Throat, Seasonal Allergies, Persistent Infections, Tick Bites
Smoking History		Current every day smoker, Current some day smoker, Former smoker, Never smoker, current status unknown, unknown if ever smoked

Latex Allergy ______Yes ______No

Send copies to (Please provide full name of Doctor):

PCP (Family Doctor)____________________________

Referring Doctor: _____________________________ Other: ______________________________________

Patient Signature: __________________________ Provider Signature: _________________________

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.

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. You can:

- 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, fax or E Mail shown at the beginning of this Notice.
- 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 E Mail 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, fax or E mail shown at the beginning of this Notice.
- 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 photo copies 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 photo copies if we send you a written notice of the extension. If you want to review or get photo copies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- 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, fax or E mail shown at the beginning of this Notice.
- 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, fax or E mail shown at the beginning of this Notice.
- 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, fax or E mail shown at the beginning of this Notice.

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 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, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that 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, fax or E mail 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.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of________________________________O.D., Notice of Privacy Practices. Date___________

Patient name____**Signature**____

YOUR RIGHTS TO PROVIDE AN AUTHORIZAION FOR 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:

- o was not created by us, unless the person that created the information is no longer available to make the amendment,
- o is not part of the health information kept by or for us,
- o is not part of the information you would be permitted to inspect or copy, or
- o 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:
Shelly Bobyak **2020 Sullivan Trail, Easton**

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: **9/23/13**

NF 5/2013

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of ________________________________, Notice of Privacy Practices.

Date ______________Patient name ______________Signature____________________________________