Dear Patient:

Welcome to Hade Eye Care. Our mission is to provide you with the highest level of medical care. The doctor is an ophthalmologist who is trained in the diagnosis and treatment of diseases of the eye. If possible, all evaluation and testing will completed on your initial visit. Patients should realize that a complete eye exam with or without testing, could last anywhere from one hour to one and a half hours.

First time patients must provide a thorough medical history, including all medications. Enclosed is a form to aid in obtaining your medical history. Also enclosed you will find our patient demographic sheet, financial policy, and HIPPA Notice of Privacy Practice. Please complete ALL forms and bring them with you to your office visit.

At your visit, a vision test and measurement of intraocular pressure will be performed, and either dilation of your pupils using eyedrops or a broad view picture of the back of your eye will be done. If drops are used, approximately 15 minutes later, the physician will complete the examination. Depending on the physician’s findings, additional testing may be performed. Full eye exams (both for medical and routine reasons) usually require a refraction (examination to determine if glasses need to be prescribed or updated). Some insurance companies DO NOT cover this, which may require an additional fee of $45.00.

Dilating drops will cause your vision to be blurry (especially up close) for a length of time that varies from person to person and bright light may be bothersome. It is impossible for the doctor to predict how long your vision will be affected. Sunglasses may be helpful in reducing the glare. You may want to make arrangements for someone to drive you home. As an alternative, our office offers Optos wide field fundus imaging which will allow the necessary examination of your eye without the use of dilating eye drops. However, insurance will not cover this and the fee is $45.00.

If you wear contact lenses and need a renewal on your prescription, you will need to have a contact lens evaluation. This is not covered by insurance companies and will require an additional fee.

What you need to bring:

- Your insurance cards
- Referral from you primary care provider, if your insurance plan requires it
- Eyeglasses
- Contact lenses with packaging or contact lens prescription
- List of current medications
- List of allergies
- Optional: Past medical records and diagnostic testing from prior eye doctors

If your visit is for routine eye care-examination of eyes, vision, contact lenses, please be aware that not all insurance plans cover some or all of these benefits. Please check with your insurance company to see if these benefits are covered under your plan.

If you have further questions, please contact the office.

Sincerely,
The Office of Hade Eye Care, LLC
## Registration Form

### Patient Information:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Social Security #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td>Age:</td>
</tr>
<tr>
<td>Address: (street) (city) (state) (Zip)</td>
<td></td>
</tr>
<tr>
<td>Home Phone #:</td>
<td>Cell Phone #:</td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
</tbody>
</table>

### Marital Status:
- Married
- Single
- Widowed
- Divorced

| Pharmacy: (include town) | Primary care physician: (phone #) |

### Race/Ethnicity:
- Caucasian
- African American
- Asian/Pacific Islander
- Hispanic
- Native American
- Other

### Primary Language: ________________

### Responsible Party: (please check)  
- Self
- Other (please fill out requested information below)

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship: (circle one) Parent Spouse Other</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td>Phone #:</td>
</tr>
</tbody>
</table>

### Insurance:

<table>
<thead>
<tr>
<th>Carrier:</th>
<th>Policy #:</th>
<th>Group #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Holder:</td>
<td>Date of Birth:</td>
<td>Social Security #:</td>
</tr>
</tbody>
</table>

| Relationship: (circle one) Self Parent Spouse Other | |

Does your insurance require a referral?  
- YES  
- NO

Does your MAJOR MEDICAL HEALTH INSURANCE allow one “routine” visit per year?  
- YES  
- NO

Do you have a SEPARATE vision plan?  
- YES  
- NO  
If YES, what is the name of the plan?

### Secondary Insurance:

<table>
<thead>
<tr>
<th>Carrier:</th>
<th>Policy #:</th>
<th>Group #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Holder:</td>
<td>Date of Birth:</td>
<td>Social Security #:</td>
</tr>
</tbody>
</table>

| Relationship: (circle one) Self Parent Spouse Other | |

### Emergency Contact:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Relationship:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Phone #:</td>
</tr>
</tbody>
</table>
Medical vs Wellness/Routine Eye Exams

You may be presenting here for what your insurance considers a “Wellness” or “Routine” eye exam—many insurance companies provide for a yearly exam to make sure your eyes are healthy. This will not cover treatment of eye problems other than prescribing of contacts or glasses. Furthermore, if in the course of a wellness eye exam a medical condition is found, you may need another appointment to deal with this; this further exam may be covered by your medical insurance. Understand that many Medical insurance plans require a copay as contracted by you with your insurance company. Wellness Exams may not have a copay.

We have contracted with VSP (Vision Service Plan) to provide routine eye exams. If a medical condition is also found, the refraction will be billed to VSP and the medical portion will be billed to your primary medical insurance.

Refraction policy: (Please initial both)

_____ Refraction is the measurement of the lens power necessary to prescribe or change your glasses (give an eyeglass prescription) or contact lenses.
   A contact lens prescription cannot be given without yearly checks on the contacts.

_____ Most Medical insurance plans, including Medicare, do not cover the refraction fee. If your examination includes a refraction and your insurance does not cover, the charge is $45.00.

Today I am here for (initial ONE choice)

_____ Wellness/Routine/annual preventative exam

_____ Medical Eye Exam. I am here today for this because of complaints such as diabetes, dry eye symptoms (burning/irritation, redness/tearing/itching), “pink eye”, sudden loss of vision, glaucoma, cataracts, macular degeneration, painful eye, etc.

Our staff is here to try to help you make these decisions. You must understand that we cannot resubmit bills after the insurance company processes your claim. It is your responsibility to know the benefits of your plan. Be aware that if you are not sure if your plan covers a yearly “Wellness” or “Routine” exam and we submit it as such, it will not be paid and you will be responsible for the full balance. Every insurance company has a myriad of plans within it, and we cannot possibly know the details of all these plans. It is the patient’s responsibility to do so, and to contact the insurance company prior to the exam.

Finally, a word from the doctor: I am as unhappy (and at times confused) as you are by these roadblocks put in our way by the insurance industry, but like you, I have to abide by them. In the care of Medicare, we have no such distinctions between Routine and Medical Eye Exams. We can all understand what drives the private insurance industry to establish these rules. We will try to get past these annoyances and make your visit a rewarding and pleasant experience.

____________________________________  ______________________
Patient Signature (or Guardian)            Date
HADE EYE CARE FINANCIAL POLICY

We dedicated to providing you with the best possible care. If you have medical insurance, we are committed to helping you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy. Ultimately, any and all financial liability rests with the patient.

If you have no insurance or are a member of insurance plans that we don’t participate in, FULL PAYMENT OF SERVICES IS DUE AT THE TIME THEY ARE Rendered. We accept cash, personal checks and credit cards.

- **HMO and Managed Care Plans**: Co-payment is due at the time of appointment. If a referral is required from your primary care physician, you are responsible for obtaining it prior to your appointments; in the absence of a referral, you will need to reschedule your visit.

- **Medicare**: You are responsible for your annual deductible and 20% co-insurance payment. In addition, you are generally responsible for durable equipment and non-covered services. Please note that refraction is a non-covered service according to Medicare regulations. For any questions about the non-covered refraction, please call Medicare.

- **Workers’ Compensation**: You are responsible for submitting bills to your insurance company. You are responsible for any bills not paid in full within thirty (30) days.

- **Motor Vehicle Accidents**: We are not responsible for submitting bills to your insurance company. You are responsible for any deductibles or co-payments, and will be fully responsible for any bills not paid in full within thirty (30) days. We will gladly provide you with a receipt that you can submit for reimbursement.

- **Hospitalization**: Physician fees for hospital visits, including surgery, will be billed directly to your insurance company. You are responsible for any non-covered fees. Our fees do not include charges for the hospital or hospital dispensed medications, or another physician’s fees.

- **Responsible Parent**: In case of divorced or separated parents, our policy is that the parent bringing the child into our office is responsible for the full payment of out of pocket fees at the time of service.

- **Contact Lenses**: Payment or credit card information is required at the time an order is placed.

- **Returned Checks**: Any check payments that do not clear the bank will be subject to a $45.00 returned check fee.

We will gladly discuss your proposed treatment and answer any questions related to our fees. We will also be happy to discuss general questions concerning insurance; however please understand that we cannot be familiar with the specific terms of every insurance issued. That is between you and the insurance company with whom you have contracted. Therefore, for specific answers to questions, you may need to call your insurance company directly.

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to my provider at Hade Eye Care for any services furnished by them. I authorize any holder of medical information about me to release to my Insurance Company, its agents, or any other carrier that I may have, any information needed to determine these benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing.

I understand and agree that, regardless of my insurance status, I am ultimately responsible for all charges for professional services rendered to me, or my dependents. I agree to reimburse Hade Eye Care the fees of any collection agency, which may be based on a percentage at maximum 25% of the debt, and all costs, and expenses, including reasonable attorney’s fees we incur in such collection efforts. As well, a 1.5% monthly interest associated with the collection of this account until the balance has been satisfied.

I have read and understand the information in this financial policy and assignment of benefits.

Signature ___________________________ Date ________________

Parent’s Signature (if minor) ___________________________ Date ________________
HADE EYE CARE

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Date ____________________

Name ____________________ ____________________ ____________________
Last First Middle

Address ____________________________________________________________
Street

City ____________________ State _______________ Zip Code ______________

Home Phone # _______________ Cell Phone # _______________ Date of Birth _______________

With my consent, Hade Eye Care may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Hade Eye Care Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Hade Eye Care reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to Hade Eye Care, 1 Indian Road, Suite 9, Denville, NJ 07834.

With my consent, Hade Eye Care may call, e-mail, or mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and to receive free health resources and periodic special offers from our office. Hade Eye Care may also leave messages on my voicemail.

By signing this form, I am consenting Hade Eye Care’s use and disclosure of my protected health information (PHI) to carry out treatment, payment, and healthcare operations (TPO).

I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Hade Eye Care may decline to provide treatment to me.

Is there a person that you authorize to receive/discuss your PHI?  □ YES  □ NO

If yes, please indicate name and relationship: ______________________________________________________

Special instructions: ________________________________________________________________________________

______________________________________________________________________________________________

Patient Name (print) ____________________ Date ____________________

Parent/Legal Guardian Name ____________________ Signature of Patient or Legal Guardian ____________________
INFORMATION AND CONSENT FOR FUNDUS EYE EXAM

It may be important to your care today to examine the back of your eyes today. To perform a complete, evaluation of the retina, optic nerve and adjacent structures is necessary. This may reveal the presence of a serious systemic condition as well as eye conditions.

Dilating eye drops are used to enlarge the pupil of the eye to allow the physician to obtain a better view of the inside of your eyes. The dilation eye drops generally take about 15 minutes to work adequately.

Dilation frequently changes vision for a length of time, which varies from person to person and may make bright lights bothersome. It is not possible for us to predict what degree your vision will be affected. Driving may be difficult immediately after the examination. If you are concerned about these problems, you may wish to make alternative transportation arrangements, although it may be possible to drive with the aid of sunglasses.

Adverse reactions, such as acute angle closure glaucoma, may be triggered from dilating eye drops. This is extremely rare and treatable with immediate medical attention.

As an alternative, we also offer the Optos fundus examination in which a specialized camera is able to obtain a wide field view of the inside of your eye without the use of dilating eye drops. The Optos is a digital camera capable of recording the inside appearance of the eye in a single panoramic image. This technology also allow the doctor to analyze the anatomy of the inner eye and the images can be isolated, enlarged, studied and compared to previous images. Comparison is valuable in detecting and tracking disease. The Optos is usually not covered by insurance providers and if you elect this option, your out of pocket fee on the day of service is $45. There are some conditions that warrant the Optos and can be submitted to your insurance. Examples of such conditions are diabetes and high blood pressure which have produced retinal complications, plaquenil therapy, glaucoma, macular degeneration, and other previously identified retinal disorders.

For a yearly complete eye exam, “routine eye exam” and any eye conditions affecting the back part of your eye, you must choose either dilation or the Optos fundus examination. Without being able to examine you in one of these ways, we cannot provide you with a thorough exam and be able to care for you properly.

□ I want to have the Optos fundus examination. The out of pocket expense of $45 and will not be submitted to any insurance plan.

□ I decline the Optos fundus examination and opt for dilation. I hereby authorize the physician and/or such assistants as may be designated by him to administer dilating eye drops. You understand that dilation will require more time for your examination due to the time they take to work adequately. You further understand and acknowledge that you have been warned of the potential risks that dilating drops may have on your ability to drive and will take appropriate steps to reduce this risk by not driving immediately after your eyes have been dilated.

______________________________  _________________________
Patient Signature                     Date
INFORMATION AND CONSENT FOR REFRACTION

We may need to perform a vision test called “refraction” (description to follow) to check your vision today.

A refraction is a diagnostic test used to determine the patient’s best ability to see. A refraction is the specific measurements of the refractive state of the eye. A series of lenses are presented to you to determine which lens provides you with the sharpest and clearest possible vision. This is an essential part of most ophthalmologic evaluations. As an ophthalmologist, I must be able to differentiate visual complaints that are medical from those that are isolated to the need for eyewear. It is usual, therefore, to perform refraction on any exam where vision is a complaint. This test is performed during your annual eye exam or if there has been a decrease in your vision since your last visit. This test is necessary to perform in order for your physician to determine the best visual acuity which is needed to evaluate for possible eye diseases. A refraction is also used as the basis for prescribing glasses, contacts or other optical devices.

SOME INSURANCE COMPANIES INCLUDING MEDICARE DO NOT COVER THE REFRACTION MEASUREMENT.

Our office fee for refraction is $45. We will submit for this service (if you have insurance other than solely Medicare which we know does not cover refraction) and if it is not paid by your insurance as a covered service, you will be billed accordingly. If you check with other ophthalmology practices, you will find the same policy is being followed as industry standard. My own feeling is that refraction is medically necessary even when new glasses are not being prescribed to evaluate the proper functioning of the eye. Unfortunately, Medicare and many major medical plans do not agree.

This fee is collected in addition to any co-payments, coinsurance, or deductible payments.

☐ I accept responsibility for the cost of this service.

________________________________________  _______________________
Patient/Guardian Signature                Date
CONTACT LENS AGREEMENT/CONSENT

The contact lens evaluation applies to anyone either wearing or wanting to wear contact lenses. This evaluation involves checking vision with current lenses, and possibly presenting a series of alternate lenses to determine which prescription provides the sharpest and clearest vision. It also involves an evaluation of the fit and centration of the lenses by the physician using the microscope. This testing is needed to insure that the lenses are not adversely affecting your eyes.

On the day of your examination you will be instructed on insertion and removal of the contact lenses (if needed) and give you instruction on contact lens care regimens. After receiving these instructions, you will wear the lenses for one to two weeks, which is the “trial” period, and return for a follow-up examination to evaluate the fit and prescription. If you are a previous wearer and no changes have been made to your contact lens prescription or contact lens brand/type, the fitting fee is still required; but you are not required to return back for contact lens related follow up visits. Contact lenses are medical devices that are worn on the eye and are required by law that patients’ return yearly to renew your contact lens prescription so that the doctor can assess the health of your eyes.

If you decide or need to “up-grade” to a different category (spherical to toric, spherical to multifocal, etc) after the initial visit, additional fees will be added. Contact lens fitting fees do not include the price of contact lenses.

NOTICE:
Fitting fees cover up to 60 days of follow-up care. Follow-up care is vital to determine your fit of the lens to protect the health of your eyes. If you elect to forgo the follow-up care and return beyond the initial 60 days period, you will be responsible for a contact lens refit fee.

CONTACT LENS FITTING FEES WILL NOT BE REFUNDED OR CREDITED.______ (initial)

Fairness to Contact Lens Consumer Act:
This act went into effect February 4, 2004. As stated by this Act, you are entitled to a copy of your contact lens prescription once the prescription is finalized by the examining doctor. Receiving a trial lens IS NOT a finalized prescription. A finalized prescription is determined at the follow-up appointment after you have been wearing the trial lenses.

Contact lens prescriptions are valid for one year.

I have read and understand the above information and agree to the terms set forth in this agreement. I also acknowledge that I have had all my questions answered.

________________________  ______________________
Signature of patient or legal guardian  Date
<table>
<thead>
<tr>
<th>CURRENT CONTACT LENS WEARER</th>
<th>Contact lens evaluation (spherical and toric lenses)</th>
<th>$40</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Assessment to determine if current contacts continue to fit well, not injuring eyes and includes any necessary adjustment to strength of prescription</td>
<td></td>
</tr>
<tr>
<td>STAYING IN SAME LENSES</td>
<td>- Contact lens evaluation for multifocal with <em>minor</em> change to prescription</td>
<td>$45</td>
</tr>
<tr>
<td></td>
<td>- Contact lens evaluation of monovision</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assessment to determine if current contacts continue to fit well, not injuring eyes and includes any necessary adjustment to strength of prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contact lens evaluation of multifocal with <em>major</em> change to prescription</td>
<td>$60</td>
</tr>
<tr>
<td></td>
<td>Assessment to determine if current contacts continue to fit well, not injuring eyes and includes necessary adjustment to strength of prescription</td>
<td></td>
</tr>
<tr>
<td>CURRENT CONTACT LENS WEARER</td>
<td>Refit of spherical contact lens</td>
<td>$70</td>
</tr>
<tr>
<td>CHANGING BRAND OR TYPE TO DIFFERENT CONTACT LENSES</td>
<td>(Examples: change due to discomfort of current lenses, change to or from daily disposable, old lenses discontinued, etc)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Refit of toric contact lens</td>
<td>$85</td>
</tr>
<tr>
<td></td>
<td>(Examples: change due to discomfort of current lenses, change to or from daily disposable, change from spherical to toric lens, old lenses discontinued, etc)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Refit of multifocal contact lens</td>
<td>$150</td>
</tr>
<tr>
<td></td>
<td>(Examples: changing from wearing spherical or toric contacts, doesn’t like comfort of current contacts, doesn’t like vision in current brand of contacts, wants to change to or from daily disposable multifocal contacts, old contacts discontinued.)</td>
<td></td>
</tr>
<tr>
<td>NEW CONTACT LENS WEARER</td>
<td>New spherical contact lens fitting</td>
<td>$125</td>
</tr>
<tr>
<td></td>
<td>Contacts for patients who have little or no astigmatism. Includes training and instruction.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>New toric contact lens fitting</td>
<td>$150</td>
</tr>
<tr>
<td></td>
<td>Contacts for patients who have more than a minimal amount of astigmatism. Includes training and instruction.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>New multifocal or monovision contact lens fitting</td>
<td>$225</td>
</tr>
<tr>
<td></td>
<td>Contacts for patients who need different prescription needs to correct distance and near vision. Includes training and instruction.</td>
<td></td>
</tr>
</tbody>
</table>
If you present to the office as a new patient but do not have complete information regarding the type and brand of contact lenses that you are currently wearing, you will be considered as a refit and be charged accordingly.

The evaluation fees DO NOT include the cost of the annual supply of contact lenses. Except where noted, the fees include the trial lenses, your contact lens-related follow up visits for 60 days, and a contact lens solution starter kit. You have 60 days of contact lens-related follow-up visits included in the contact lens evaluation fee to come back and have the doctor check the contacts if you are having any problems at all. For any visits following the 60 days evaluation there will be a fit charge.

The prescription expires in ONE YEAR, after which you will be unable to order or receive any contact lenses. It is very important to schedule your annual examination prior to your prescription expiring, in order for the doctor to assess the health of your eyes. These fees are collected in addition to any co-payments, coinsurance or deductible payments at the time of service. I have read and understand the above fees:

Sign:_______________________________  Date:_____________
(Patient/Guardian)
NAME ___________________________ DATE OF BIRTH ___________________________

PRIMARY CARE PHYSICIAN ______________________________

ALLERGIES __________________________________________

<table>
<thead>
<tr>
<th>Medical History</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Cancer (If yes, of what? ____________)</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>Thyroid dysfunction</td>
</tr>
<tr>
<td>Heart disease</td>
<td>Stroke</td>
</tr>
<tr>
<td>High cholesterol</td>
<td>Rheumatoid arthritis</td>
</tr>
<tr>
<td>Asthma</td>
<td>HIV</td>
</tr>
<tr>
<td>Emphysema</td>
<td>Seasonal allergies</td>
</tr>
<tr>
<td>Pregnant (Currently)</td>
<td></td>
</tr>
</tbody>
</table>

OTHER(S): ____________________________________________

Please circle if you are experiencing the any following symptoms:

<table>
<thead>
<tr>
<th>Constitutional</th>
<th>None</th>
<th>Fever</th>
<th>Chills</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurologic</td>
<td>None</td>
<td>Dizziness</td>
<td>Headache</td>
<td>Numbness</td>
</tr>
<tr>
<td>Heme/Lymph</td>
<td>None</td>
<td>Swollen glands</td>
<td>Clotting problem</td>
<td>Blood transfusion</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>None</td>
<td>Joint pain</td>
<td>Neck pain</td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>None</td>
<td>Stomach pain</td>
<td>Nausea</td>
<td>Vomiting</td>
</tr>
<tr>
<td>Psychological</td>
<td>None</td>
<td>Depression</td>
<td>Anxiety</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>None</td>
<td>Chest pain</td>
<td>Heart attack</td>
<td>Heart murmur</td>
</tr>
<tr>
<td>Endocrine</td>
<td>None</td>
<td>Excess thirst</td>
<td>Excessive fatigue</td>
<td>Excessively hot/cold</td>
</tr>
<tr>
<td>Respiratory</td>
<td>None</td>
<td>Short of breath</td>
<td>Wheezing</td>
<td>Cough</td>
</tr>
<tr>
<td>Skin</td>
<td>None</td>
<td>Rash</td>
<td>Itch</td>
<td></td>
</tr>
<tr>
<td>Genitourinary</td>
<td>None</td>
<td>Blood in urine</td>
<td>Pain with urination</td>
<td></td>
</tr>
</tbody>
</table>

MEDICATIONS

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>Times a day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1 2 3 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 2 3 4</td>
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<tr>
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<td>1 2 3 4</td>
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<td></td>
<td>1 2 3 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 2 3 4</td>
</tr>
</tbody>
</table>

Do you smoke? __________ If yes, how many cigarettes _____ or packs _____ a day?

Do you drink alcohol? __________ If yes, how many drinks a day? _____ week? _______

Occupation ____________________________________
**CONTACT LENSES**

DO YOU WEAR CONTACT LENSES? □ Yes □ No

If you do, please supply the following: (this information can be found on your current CL box or blister pack)

**RIGHT EYE:** Brand:________________________ Base Curve (or B.C)_________ Power (+, -) __________

**LEFT EYE:** Brand:________________________ Base Curve (or B.C)_________ Power (+, -) __________

---

**EYE DROPS**

<table>
<thead>
<tr>
<th>Name</th>
<th>Times a day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Right/Left/Both</td>
</tr>
</tbody>
</table>

---

**CURRENT EYE PROBLEMS OR SYMPTOMS**

- Blurred distance vision
- Blurred reading vision
- Double vision
- Flashing lights/floaters
- Glare/Halos around lights
- Itching or burning
- Tearing
- Foreign body sensation
- Red eye
- Dry eye

---

**YOUR PREVIOUS EYE HISTORY**

- Cataract
- Glaucoma
- Macular degeneration
- Retinal detachment
- Lazy eye/amblyopia
- Iritis/Uveitis
- Eye injury
- Other __________________________

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**FAMILY HISTORY OF EYE DISEASES/PROBLEMS**

(limited to: father, mother, sister, brother, grandparents)

- Cataract
- Glaucoma
- Macular degeneration
- Retinal detachment
- Blindness
- Iritis/Uveitis
- Crossed eyes
- Other __________________________

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**PREVIOUS EYE SURGERIES**

<table>
<thead>
<tr>
<th>Type</th>
<th>Eye</th>
<th>Year</th>
<th>Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Right/Left</td>
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This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e. name, address, phone, etc.) that may identify you and related to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

**YOUR RIGHTS UNDER THE PRIVACY RULE**

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

**You have the right to receive, and we are required to provide you with a copy of this Notice of Privacy Practices.** We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on its website.

**You have the right to authorize other use and disclosure.** This means you have the right to authorize any use or disclosure of PHI that is not specified in this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to see your PHI. You may revoke an authorization at any time in writing, except to the extent that your healthcare provider or our practice has taken an action in reliance on the use or disclosure indication in the authorization.

**You have the right to request an alternative means of confidential communication.** This means you have the right to ask us to contact you about medical matters using an alternative method (i.e. email, telephone) and to a destination (i.e. cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

**You have the right to inspect and copy your PHI.** This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by state or federal guidelines.

**You have the right to request a restriction of you PHI.** This means you may ask us, in writing, not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out of pocket. We are not permitted to deny this specific type of requested restriction.

**You may have the right to request an amendment to you protected health information.** This means you may request an amendment of you PHI for as long as we maintain this information. In certain cases, we may deny your request.

**You have the right to request a disclosure accountability.** This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside this office.

**You have the right to receive a privacy breach notice.** You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact the office. Contact information is provided on the following page under Privacy Complaints.
HOW WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

**Treatment**- We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

**Special Notices**- we may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide you information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan to disclose information to the health plan sponsor. You will have the right to opt out of such special notices and each such notice will include instructions for opting out.

**Payment**- Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as making a determination of eligibility or coverage for insurance benefits.

**Healthcare Operations**- We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions, and patient safety activities.

**Health Information Organization**- The practice may elect to use a health information organization or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment or healthcare operations.

**To Others Involved in Your Healthcare**- Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person’s involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgement, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

**Other Permitted and Required Uses and Disclosures**- We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities, health oversight activities, in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker’s compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

**Privacy Complaints**

You have the right to complain to us or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying us at:

Hade Eye Care, LLC, 1 Indian Road, Suite 9, Denville, NJ 07834

We will not retaliate against you for filing a complaint.