Bright Vision Center - Case History Form

Name: _____ SS#:_____ Date: _____

Address: _____ Zip Code: _____

Date of Birth: _____ Gender: ☐ M ☐ F Home Phone:_____

Cell Phone: _____ Email: _____

Dilation is part of your eye exam. If you don't want to be dilated, please sign here:_____

Medication & Allergy Information

Allergic to: ☐ Penicillin ☐ Sulfa ☐ Latex ☐ Other (Explain)_____

List all medications currently taking:_____

Do you: ☐ Smoke ☐ Drink Alcohol ☐ Use Other Drugs If female, are you: ☐ Pregnant ☐ Nursing

Please list any surgery, eye and non-eye related:_____

Please Circle if you have any of the following conditions:

ENT: Sinusitis - Dry Mouth - Loss Hearing – Laryngitis – Other:_____

Neuro: Tumor – Stoke/CVA – Epilepsy – Cerebral Palsy – Migraine – MS – Other:_____

Psych: Anxiety Disorder – Depression – Bipolar Disorder – Attention Deficit – Other:_____

Cardio: Congestive Heart Failure – Vascular Disease – Heart Disease – High Blood Pressure – Other:_____

Respiratory: Emphysema – Bronchitis – Sleep Apnea – COPD - Asthma – Other:_____

Gastro: Ulcer – Acid Reflux – Celiac Disease – Crohn's Disease – Colitis – Hepatitis - Other:_____

GU: Pregnant – Nursing - Herpes –Prostate Disease – Kidney Disease – STD – Other:_____

Musk/Skel: MD – Ankylosing Spondylitis – Osteoporosis – Gout – Arthritis – Fibromyalgia – Other:_____

Skin: Herpes Simplex (Cold Sores) – Herpes Zoster (Shingles) – Rosacea – Psoriasis – Eczema – Other:_____

Endo: Type II Diabetes – Hormonal Dysfunction – Thyroid Dysfunction – Type I Diabetes – Other:_____

Hem/Lymph: Cholesterol – Ulcer – Large Volume Blood Loss – Anemia – Cancer - Other:_____

Immune: Lupus – Rheumatoid Arthritis – HIV - Sjogren's Syndrome – Other: _____

Family History: Diabetes – Hypertension – Thyroid – Cataract – Glaucoma – Macular Degeneration – Nystagmus - Strabismus – Amblyopia – Retinal Detachment – Severe Myopia – Severe Hyperopia – Other:_____

Bright Vision Center

Dr. Rolando Ortiz, Optometrist, PLLC.

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. We are required by law to give you a copy of our privacy practices. This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payments or health care operations treatment, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information, this is information about you, including demographic information, that may identify you and that relates to your past, present or future health or condition and related health care services. We respect our legal obligation to keep health information that identifies you private.

Uses and Disclosures of Protected Health Information: Treatment, Payment and Health Care Operation

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your Protected Health Information, as necessary, to: set up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses or eye medication including faxing the to be filled; referring you to another doctor or health provider; or requesting medical information from other health provider. Your protected health information will be used, as needed, to obtain payment for your health care services. For example, to obtain approval from your vision or health insurance; processing bills and claims and collecting unpaid balances.

We may use or disclose, as-needed, your protected health information in order to support Health Care Operation activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when the doctor is ready to see you. We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment. This could include reminder postcards mailed to you, email, messages or phone calls.

Under the law, we may use or disclose your Protected Health Information into the following situations without your authorization. These situations include: Public Health issues as required by law; Communicable Diseases; Health Oversight activities such as Medicare or Medicaid Audits; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement: Coroners, Funeral Directors, and Organ Donation; Research: Criminal Activity; Military Activity and National Security; Worker's Compensation, among others. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements. Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. YOU MAY REVOKE THIS AUTHORIZATION, at any time, in writing, except to the extent that your doctor or doctor's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

You have the right to inspect your Protected Health Information and to request a restriction. This means you may ask us not to use or disclose any part of your Protected Health Information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in written and state the specific restriction requested and to whom you want the restriction to apply. We do not have to agree to your requests, but if we agree, we must honor your restrictions.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

Complaints and Contact Information

You may complain to us or to the Secretary 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 our privacy contact of your complaint. We will not retaliate against you by filing a complaint. Please contact us by mail or phone if you have questions about this notice.

This notice was published and became effective on April 26, 2012.

Patient Name: _____

Patient or Guardian Signature: _____

Date: _____

836 E Chatham St. Suite 106 Cary, NC 27511 Phone: 919-755-3444

Warranty Policies

Prescriptions for Glasses and Contact Lenses:

- Prescription will have a **complimentary re-evaluation exam up to 90 days** after the initial examination if glasses/contacts were purchased with us. After this period there will be a $65.00 charge for the visit.

Eyeglasses:

- **Frame:** Warranty up to a year on manufacturer's defect. Some with a deductible charge which depends on each frame.

- **Lenses:** Warranty only on lenses with anti-reflective (AR) coating. Scratches or peeling of the AR will be covered up to a year.

Warranty does not cover if any type of glue or tape is used or if glasses are lost or stolen

Those orders that have not been picked up in 6 months from day ordered will be canceled.

Patient Name: _____

Patient/Guardian Signature: _____

Date: _____

This warranty does not apply to glasses/contacts purchased somewhere else, re-evaluation will have a fee of $65.00 including within the 90 days.

All sales are final-Money is non-refundable.

Bright Vision Center

Today's Date: _____

Patient's Name: _____

Date of Birth: _____/_____/_____

Patient Disclosure Authorization

When stating the following persons please state the authorization you would like for them to have. If you would later like to remove a person you will have to fill this page out again. **If a patient is under 18 parent/guardian please sign.**

Parent/Guardian Name: _____

Patient/Parent/Guardian Signature: _____

Name: _____ **Relationship:** _____	Only Glasses	Only Prescription	All Records
	Yes ☐	Yes ☐	Yes ☐
Name: _____ **Relationship:** _____	Only Glasses	Only Prescription	All Records
	Yes ☐	Yes ☐	Yes ☐
Name: _____ **Relationship:** _____	Only Glasses	Only Prescription	All Records
	Yes ☐	Yes ☐	Yes ☐