TORRINGTON VISION SOURCE
Dr. Grant Jones **Dr. Lynda** Jones

Patient Information

Today's Date: .....

Patient's Legal Name: .....

Age: ..... Date of Birth: ..... Social Security Number: .....

Home Address: .....

City/State/Zip Code.....

Mailing Address (if different): .....

City/State/Zip Code.....

Home Phone: ..... (Leave Message? **Y / N**) Cell Phone: ..... (Leave Message? **Y / N**)

Work Phone: ..... (Leave Message? **Y / N**) Email Address: .....

Is it okay to contact you via Email? O Yes O No Is it okay to contact you via text message? O Yes O No

Are you: O Single O Married O Divorced O Widowed

Spouse Name ..... Home Phone .....

Spouse Address (if different) ..... Cell Phone .....

Is any other family member a patient in this office? .....

Your Occupation: .....

Employer's Name: ..... Employer's Phone:.....

Patient's Emergency Contact:..... D.O.B. ..... Phone .....

Emergency Contact Relation to Patient .....

Patient's Pharmacy / Location: .....

Patient's Primary Care Physician: .....Patient's referring Doctor: .....

Whom may we thank for your referral? .....

PARENT INFORMATION IF PATIENT IS UNDER 18 YEARS OF AGE:

Father's Name: ..... Father's Employer: .....

Father's Social Security Number ..... Father's Work Phone: .....

Father's address if different from above: .....

Mother's Name: ..... Mother's Employer: .....

Mother's Social Security Number ..... Mother's Work Phone: .....

Mother's address if different from above: .....

Who is responsible for payment of services? .....

Please list payer's contact information if different from the patient:

Mailing Address: .....

.....

Residence Phone: ..... Cell Phone: ..... Work Phone: .....

DO YOU HAVE INSURANCE Yes ..... No ..... If yes, Name of Carrier: .....ID # .....

Insurance Card Holder Name ..... Social # of Card Holder .....

Home Phone ..... DOB ..... Relation to Patient .....

Home Address .....

Previous Eye Care Professional: ..... Date of Last Exam: .....

The reason for visit today is: .....

Are you interested in: O Glasses O Contact Lenses O Laser Vision Correction O Other

Or, please specify: .....

Type of Contact Lenses worn: O Soft O Rigid O Other *Are they comfortable?* .....

Circle any eye conditions that apply to you:

Burning	Itching	Sandy/gritty feeling	Mucous discharge	Foreign body sensation		Pain
Tearing	Blur	Double vision	Redness	Loss of Side vision	Flashes	Styes
Tired eyes	Dryness	Light sensitivity	Distorted vision	Loss of vision		Floaters

What are your current eye problems or concerns? .....

Are you currently pregnant? O yes O no Are you currently nursing? O yes O no

List all major surgeries, injuries a/o hospitalizations.....

Please list medication currently taken: .....

.....

ALLERGY

Do you have any allergies to medication? O yes O no If yes, explain: .....

.....

.....

.....

Do you have any other allergies (i.e. environmental/seasonal)? O yes O no If yes, explain: .....

.....

OCULAR HISTORY (personal & family)				**Maternal**	**Paternal**
Crossed Eyes	O self	O family	Relationship to you:	O	O
Lazy Eye	O self	O family	Relationship to you:	O	O
Cataract	O self	O family	Relationship to you:	O	O
Glaucoma	O self	O family	Relationship to you:	O	O
Macular Degeneration	O self	O family	Relationship to you:	O	O
Other:	O self	O family	Relationship to you:	O	O

Have you ever had any type of eye injury or surgery? O yes O no If yes, explain: .....

.....

Do you use tobacco products?

O Never Smoked

O Former Smoker

O Current everday Smoker

O Current Someday Smoker

O Current Smokeless Tobacco User

Do you drink alcohol? O yes O no If yes, occasional.....one/day.....2-3/day.....4+/day

Do you have a sexually transmitted disease? O yes O no

Have you had a blood transfusion? O yes O no

Do you use illegal drugs? O yes O no

				Maternal	Paternal
CARDIOVASCULAR	○ none				
Heart Disease	○ self	○ family	Relationship to you:	○	○
High Blood Pressure	○ self	○ family	Relationship to you:	○	○
Stroke	○ self	○ family	Relationship to you:	○	○
Heart Attack	○ self	○ family	Relationship to you	○	○
CONSTITUTIONAL	○ none				
Appetite Excess/Loss	○ self	○ family	Relationship to you:	○	○
Anemia	○ self	○ family	Relationship to you:	○	○
Dizziness	○ self	○ family	Relationship to you:	○	○
ENDOCRINE	○ none				
High Cholesterol	○ self	○ family	Relationship to you:	○	○
Crohn's Disease	○ self	○ family	Relationship to you:	○	○
Diabetes	○ self	○ family	Relationship to you:	○	○
RenalDisease	○ self	○ family	Relationship to you:	○	○
Thyroid Disease	○ self	○ family	Relationship to you:	○	○
GASTROINTESTINAL	○ none				
Acid Reflux Disease	○ self	○ family	Relationship to you:	○	○
Diverticulosis	○ self	○ family	Relationship to you:	○	○
Hepatic Disease	○ self	○ family	Relationship to you:	○	○
GENITOURINARY	○ none				
Kidney Stones	○ self	○ family	Relationship to you:	○	○
Bladder Infections	○ self	○ family	Relationship to you:	○	○
Other	○ self	○ family	Relationship to you:	○	○
EARS, NOSE, MOUTH, THROAT	○ none				
Meniere's Syndrome	○ self	○ family	Relationship to you:	○	○
Sinusitis	○ self	○ family	Relationship to you:	○	○
HEMATOLOGICAL / LYMPHATIC	○ none				
Anemia	○ self	○ family	Relationship to you:	○	○
Hematologic Disorder	○ self	○ family	Relationship to you:	○	○
Sickle Cell	○ self	○ family	Relationship to you:	○	○
IMMUNOLOGIC	○ none				
Herpes Simplex (oral)	○ self	○ family	Relationship to you:	○	○
Herpes Zoster (Shingles)	○ self	○ family	Relationship to you:	○	○
HIV/AIDS	○ self	○ family	Relationship to you:	○	○
Sarcoidosis	○ self	○ family	Relationship to you:	○	○
Sjogren's Syndrome	○ self	○ family	Relationship to you:	○	○

SKIN	○ none				
Rosacea	○ self	○ family	Relationship to you:	○	○
Albinism	○ self	○ family	Relationship to you:	○	○
Lupus	○ self	○ family	Relationship to you:	○	○
MUSCULOSKELETAL	○ none				
Arthritis	○ self	○ family	Relationship to you:	○	○
Ankylosing Spondylitis	○ self	○ family	Relationship to you:	○	○
Myasthenia Gravis	○ self	○ family	Relationship to you:	○	○
NEUROLOGICAL	○ none				
Seizure Disorder	○ self	○ family	Relationship to you:	○	○
Headaches/Migraines	○ self	○ family	Relationship to you:	○	○
Acquired Brain Injury	○ self	○ family	Relationship to you:	○	○
Multiple Sclerosis	○ self	○ family	Relationship to you:	○	○
Traumatic Brain Injury	○ self	○ family	Relationship to you:	○	○
PSYCHIATRIC	○ none				
Attention Disorder	○ self	○ family	Relationship to you:	○	○
Alzheimer's	○ self	○ family	Relationship to you:	○	○
Depression	○ self	○ family	Relationship to you:	○	○
RESPIRATORY	○ none				
Asthma	○ self	○ family	Relationship to you:	○	○
Bronchitis	○ self	○ family	Relationship to you:	○	○
Emphysema	○ self	○ family	Relationship to you:	○	○
Respiratory Dysfunction	○ self	○ family	Relationship to you:	○	○

Please list any other condition(s) not found above: .....

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.....

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Torrington Vision Source is committed to providing the best treatment possible for our patients at rates that are usual and customary for our area. You are responsible for payment in full regardless of the interpretation of what is "usual and customary" by a given insurance company.

I understand that payment is due when services are rendered.

PATIENT SIGNATURE: ..... DATE: .....

CONSENT TO ASSIGNMENT OF BENEFITS AND PROMISE TO PAY

Benefits to Physicians:
I hereby assign all of my rights to insurance benefits and instruct my insurance company to make payments directly to Torrington Vision Source and/or its physicians for the benefits provided.

Promise to Pay:
I understand and agree that I am responsible to pay for all services provided to me by Torrington Vision Source and its staff. If I fail to pay for the services when they are rendered, I will be responsible for all costs of collection, including but not limited to, interest at the rate of one and a half percent (1.5%) per month or eighteen percent (18%) per year, court costs and fees, attorney fees, and a collection fee of thirty five percent (35%) of the unpaid balance assigned for collection.

....
Date Patient Signature

....
Signature of the patient Representative Relationship
(Required if the patient is a minor or an adult unable to sign)

WRITTEN AUTHORIZATION FOR RELEASE OF PHI

I hereby authorize Torrington Vision Source to discuss my Protected Health Information (PHI) with the following person. Should I wish to revoke this authorization, I understand I must do so in **WRITING.**

Name ..... Phone .....

Relationship .....

Date ..... Patient's Signature .....

....
Signature of Patient Representative Relationship
(Required if the patient is a minor or an adult unable to sign)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a Notice of Privacy Practices of Torrington Vision Source. I understand that my Protected Health information (PHI) may be used and disclosed for the purposes of TREATMENT, PAYMENT and HEALTH-CARE OPERATION of the practice.

Date ..... Patient Signature .....

....
Signature of Patient Representative Relationship
(Required if the patient is a minor or an adult unable to sign)

TORRINGTON VISION SOURCE!

Grant W. Jones, O.D. Lynda L. Jones, O.D.
1418 East M Street
Torrington, WY 82240
Phone: 307-532-4114 Fax: 307-532-7658

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 respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice briefly describes how we protect your health information and what rights you have regarding it.

The most common reason why we use or disclose your health information is for treatment, physician referral, payment or health care operations. Examples of how we use or disclose information are: setting up an appointment, testing or examining your eyes, asking about your health or vision care plans, preparing and sending bills or claims, and collecting unpaid amounts.

In some limited situations, the law requires us to use or disclose your health information without your permission. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose; i.e. FDA investigations, suspected abuse or neglect, subpoenas, criminal investigations, workers compensations claims, Medicaid and Medicare audits;
- Incidental disclosures that are an unavoidable by-product of permitted uses;
- Disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we may share information about your care with your family who are helping you with your eye care.

We will not make any other disclosures of your health information unless you sign a written "authorization form".

APPOINTMENT REMINDERS
We may call, write, or e-mail to remind you of scheduled appointments or recall notices. We may also call, write, or e-mail to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we may e-mail or 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.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION ALLOW YOU TO:

- Ask us to restrict our disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We have the right not to agree to this, but if we agree, we must honor the restrictions that you request.
- Ask us to communicate with you in a more confidential way. We will accommodate these requests if they are reasonable and you accept responsibility for any additional costs.
- Ask to view or obtain photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. Aside from these situations, we can assist you within 30 days of your request.
- Ask us to amend health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from date of request.
- Obtain a list of the disclosures that we have made of your health information. 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 other limited disclosures as mentioned above. You are entitled to one such list per year without charge.
- Get additional paper copies of the Notice of Privacy Practices upon request.

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 nay time as allowed by law.

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 at the address 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 at the address or phone number shown at the beginning of this notice.