KAUFFMAN
EYE CARE

CHART #: FOR PRACTICE USE **PROVIDER:** Dr. Kauffman

PATIENT INFORMATION

PATIENT NAME: ____
LAST FIRST MIDDLE

ADDRESS: ____

ZIP CODE: ______________ **CITY:** ____________________ **STATE:** ______________

HOME PHONE #: ____________________ **WORK PHONE #:** ____________________

CELL PHONE #: ________________ **PREFERRED #: HOME** ☐ **WORK** ☐ **CELL** ☐

EMAIL ADDRESS: ______________________________ **SEX:** (circle one) FEMALE MALE

DATE OF BIRTH: ______________ **SOCIAL SECURITY NUMBER:** ____________________

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY: (circle one) SELF SPOUSE CHILD OTHER

PRIMARY CARE PHYSICIAN: ________________ **REFERRED BY:** ____________________

PATIENT'S EMPLOYER: ______________________ **EMPLOYER PHONE:** ________________

ACCIDENT INFORMATION: DATE OF ACCIDENT: ________ **WORK RELATED? Y N AUTO? Y N OTHER:** ________

RESPONSIBLE (OR INSURED) PARTY INFORMATION

RESP. PARTY NAME: ____
LAST FIRST MIDDLE

ADDRESS: ______________________ **CITY:** ______________ **STATE:** ______ **ZIP:** ________

DATE OF BIRTH: ______________________ **SEX:** (circle one) FEMALE MALE

HOME PHONE #: ______________________ **WORK PHONE #:** ______________________

CELL PHONE #: ______________________**SOCIAL SECURITY #:** ______________________

RESPONSIBLE PARTY'S EMPLOYER: ______________________ **PHONE #:** ________________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: ______________________ **PHONE #:** ________________

ADDRESS: ______________________ **CITY:** ______________ **STATE:** ______ **ZIP:** ________

CONTRACT (ID#) NUMBER: ________________**SUBSCRIBER'S NAME:** ______________________

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: ______________________ **GROUP NUMBER:** ______________________

COPAYMENT AMOUNT: $ ______________ **INSURED'S DATE OF BIRTH:** ______________________

SECONDARY INSURANCE COMPANY: ______________________ **PHONE #:** ________________

ADDRESS: ______________________ **CITY:** ______________ **STATE:** ______ **ZIP:** ________

CONTRACT (ID#) NUMBER: ________________**SUBSCRIBER'S NAME:** ______________________
PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: ______________________ **GROUP NUMBER:** ______________________

COPAYMENT AMOUNT: $ ______________ **INSURED'S DATE OF BIRTH:** ______________________

PATIENT/PARENT SIGNATURE:______________________________ **DATE:** ________________

KAUFFMAN
EYE CARE

Patient Health History Form

Name:________________________________ DOB:____________ Today's Date:__________________________

Reason For Visit Today:____

Past Medical History:
Do you have?

☐ None
☐ Diabetes
☐ Heart Disease
☐ High Cholesterol
☐ Osteoporosis
☐ Arthritis
☐ Other____
☐ Cancer
☐ Depression
☐ Multiple Sclerosis
☐ Kidney Disease
☐ Asthma
☐ Gout
☐ GERD/Reflux
☐ COPD/Emphysema
☐ Allergy/Hay Fever
☐ Lupus
☐ High Blood Pressure
☐ Thyroid Disease

Past Surgical History:____

Past Eye History:
Have you had?

☐ None
☐ Cataract Surgery
☐ Glaucoma Surgery
☐ Retina Surgery
☐ Other

Eye Diseases (*list below*)
____
____

Family History & Relationship:

☐ Glaucoma_____________________
☐ Cataracts_____________________
☐ Macular Degeneration_____________
____
☐ Blindness_____________________
☐ Other________________________
____

Eye Trauma:____
____

Social History:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Tobacco Use: ☐ Never ☐ Current ☐ Former

Alcohol Use: ☐ None ☐ Occasional ☐ 1-2 drink/day ☐ 3-4 drink/day

Medications: (*list drug name, dosage & how often taken or provide list. Include over-the-counter meds*) ☐ None
____
____

Medication Allergies (*list med and reaction*): ☐ None
____

Review of Systems: (*Please Circle Any That Apply To You Now Or In The Recent Past*)

Chest Pain, Shortness of Breath, Shortness of Breath When Lying Flat, Irregular Heart Beat
Fever, Weight Loss, Fatigue, Chills, Night Sweats
Excessive Thirst, Excessive Urination, Heat Intolerance, Cold Intolerance, Hair Loss
Abdominal Pain, Nausea, Diarrhea, Bloody Stools, Stomach Ulcers
Kidney Problems
Easy Bruising, Prolonged Bleeding
Hearing Loss, Dry Mouth, Jaw Pain with Chewing
Skin Rash, Skin Cancer
Muscle Aches, Joint Pain, Difficulty Lying Flat Due To Musculoskeletal Problems
Weakness, Headaches, Scalp Tenderness, Dizziness, Paralysis, Tremor, Stroke, Numbness
Wheezing, Cough, Difficulty Breathing

Are you experiencing any of the following? (*If yes, please circle*)

Blurred Vision Eye Pain / Irritation Floaters / Flashes Gritty / Dry Eyes Glare / Halos Around Lights

Water Eyes Mattering / Crusting Trouble: Reading Seeing Computer Watching TV Driving

If you wear contacts, list brand and power: ______________________________________

Please list any eye drops you currently use, including how often:____________________________

Appointment Policy, Financial Responsibility and Consent to Treat

Appointments

1) We value the time you/we have set aside to take care of your eyes. If you are not able to keep an appointment, we would appreciate at least 24-hour notice. Patients who do not show up for 3 appointments without notifying us in advance may be released from our practice.
2) If you are late for your appointment (>15 minutes), we will do our best to accommodate you. Please understand that on certain days it may be necessary to reschedule your appointment.
3) We strive to minimize any wait time. We work patients into our schedule on a regular basis for urgent or emergent needs. Please understand that this may affect scheduled visit times.

Insurance Plans

1) It is your responsibility to keep us updated with your correct insurance information by bringing your card to every visit. If the insurance company you designate is incorrect, you may be responsible for payment of the visit.
2) It is your responsibility to understand your benefit plan with regards to copays, deductibles, covered services, and eligibility.
3) We are a specialist's office. If your insurance requires referrals, you must come with the appropriate referral or have contacted your PCP to generate an electronic referral. Otherwise, your insurance cannot be billed. It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered. If you arrive without your referral, your appointment may be rescheduled.

Financial Responsibility

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, coinsurances.
2) **Co-payments are due at the time of service. A $20 service fee will be charged in addition to your copayment if the co-payment is not paid by the end of that business day.**
3) If you participate with a high-deductible health plan, payment is required the day of service. We will always provide you with a receipt so you can be reimbursed according to your health plan.
4) You, the patient, are responsible for non-covered services (services not covered by your insurance plan). For example, a refraction test to check for glasses is a non-covered service with medical insurance. You will be expected to pay for the refraction on the day the service is performed.
5) Self-pay patients are expected to pay for services at the time of the visit.
6) If we do not participate with your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
7) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill.

8) Any balance outstanding longer than 90 days may be forwarded to a collection agency.
9) **For scheduled appointments, prior balances must be paid prior to the visit.**
10) We accept cash, checks, and Visa, Discover, and MasterCard.
11) A $25 fee will be charged for any checks returned for insufficient funds.
12) I understand that as the parent/guardian accompanying the patient, I will be fully responsible for payment of services rendered.
13) I authorize my insurer to pay any benefits directly to Kauffman Eye Care, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Contact Lenses

There is a separate charge for contact lens fittings and evaluations in addition to the ophthalmic exam charge. The charge varies depending on the complexity of the fitting.

New contact lens wearers	Fitting fee	$60 - $100
Established contact lens wears with a lens change	Refitting fee	$40 - $80
Established contact lens wears without a lens change	Evaluation fee	$40

Consent to Treat

1) I hereby authorize Kauffman Eye Care, through its appropriate personnel, to perform or have performed upon me, or the patient named below, appropriate assessment and treatment procedures.
2) I further authorize Kauffman Eye Care to release to appropriate agencies any information acquired in the course of my care or the patient's care named below to support billing or continued care and treatment.

I have read and understand the policies, responsibilities and consents for Kauffman Eye Care I agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name: ______________________________________

Patient's Signature: ___________________________________ Date ___________________________

Responsible Person's Signature: _________________________ Relationship______________________

Signature of person authorized to give consent

On completion, we will provide you with a copy for your records. Any questions should be directed to our front desk staff, or call the 317-870-1851.

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.

Uses and Disclosures
Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Kauffman Eye Care. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information
Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you..

Individual Rights
You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Kauffman Eye Care Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may request access to your records by Dr. Kauffman. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Dr. Chad Kauffman
Kauffman Eye Care
1821 North Shadeland
Indianapolis, IN 46219

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices is:

[Same as Above]

This notice is effective on or after March 25, 2016.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Kauffman Eye Care's Notice of Privacy Practices effective March 1, 2016.

Name (please print): ___________________________________
Signature: ____________________________________
Date: ______________________________

I am a parent or legal guardian of ______________________ (patient name). I have received a copy of [Practice's] Notice of Privacy Practices effective [Date].

Name (please print): ___________________________________
Relationship to Patient: ☐ Parent ☐ Legal Guardian
Signature: ____________________________________
Date: ______________________________

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective March 1, 2016 given to individual on _______________ (date)

☐ In Person ☐ Mailing ☐ Email ☐ Other ______________________

Reason individual or parent/legal guardian did not sign this form:

☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other _______________________________________

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

☐ In person conversation ____
☐ Telephone contact ____
☐ Mailing ____
☐ Email ____
☐ Other _______________________________________

Staff Name (please print): _________________________________ Title: ______________

Signature: ____________________________________ Date: ______________________

PATIENT CONFIDENTIALITY

It is the policy of Kauffman Eye Care not to release confidential and/or unauthorized information to unauthorized people by telephone, voice messages, cell phone/pager or email without patient consent.

I, ___________________________________ (DOB:________________) grant permission for the disclosure of my Protected Health Information to the following individuals (Protected Health Information includes your name, diagnosis, test results, dates of services, treatment plan, etc.).

Please check all that apply:

☐ You may disclose my Protected Health Information to the individuals listed below.

Name	Phone Number	Relationship

Additional names may be listed on the back of this form with the patient signature.

☐ You may leave Protected Health Information on my answering machine or voicemail of phone numbers listed above. You may also send unsecured email to the email addresses listed below which may contain Protected Health Information.

☐ Email addresses:

☐ Other:

_________________________________ _________________________________

Patient's Printed Name Patient's Date of Birth

_________________________________ _________________________________

Patient's Signature (or Parent of Minor) Date

_________________________________ _________________________________

Witness Date