

Is there anything else you would like your doctor to know about your health? _____

Social History

Do you participate in any sport, hobby, professional activities that may require special protection or correction (for example: squash/handball, scuba, reading music, carpentry)?

Do you use tobacco? Yes No What type/Amount/How long? _____

Do you drink alcohol? Yes No What type/Quantity/Frequency? _____

PAYMENT POLICY

Payment for services is requested at the time services are rendered. For materials ordered, a 50% deposit is required at the time of ordering, with the balance due on delivery. If our policies pose an financial burden, please ask to speak privately with the Office Manager.

I acknowledge that it is my responsibility to know and understand my vision insurance benefits. I agree to be responsible for all fees not covered by my vision insurance plan.

Signature

Date



CONSENT TO USE OR DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

First Name	Last Name	M.I
Street Address	City	State
Zip		
()	()	
Evening phone	Day Phone	

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office.

We have a comprehensive Notice of Privacy Practices that describes these uses and disclosures in detail. You are free to refer to this Notice at any time before you sign this consent document. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes submission of your health information to third-party payers or insurers for claims review, determination of benefits and payment; our submission of your health information to auditors hired by third-party payers and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you authorize us to use and disclose your health information to treat you, to obtain payment for our services, and to perform health care operations. You can revoke this consent in writing at any time, unless we have already treated you, sought payment for our services, or performed health care operations in reliance upon our ability to use or disclose your health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or health care operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I HAVE READ THIS CONSENT AND UNDERSTAND IT. I CONSENT TO THE USE AND DISCLOSURE OF MY HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

Signature	Date
-----------	------

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Name	Relationship to patient
------	-------------------------

Source of Authority
