HIPAA CONSENT AND PAYMENT AUTHORIZATION

I hereby authorize Benjamin Gates OD PLLC to obtain my medical information to assist in the care of my health. This information may be disclosed to and used to carry out my treatment, and for the health care corporations quality reviews. I have been offered a copy of the clinic's Privacy Notice for a more complete description of uses and disclosures before signing this consent. I understand that this clinic has the right to change their privacy practices and that I may obtain any revised notices from this clinic. I understand that I have a right to request a restriction of how my protected health information is used. I also understand that I may revoke this consent at any times, by making a request in writing, except for information already used or disclosed. If I have questions about disclosure of my health information, I can contact Benjamin Gates OD PLLC at (804)565-2020. I also authorize any necessary medical treatment by the optometrists in the practice of Benjamin Gates OD PLLC. I agree to be responsible for my bill and any necessary collection fees made necessary to collect payment of materials and/or services rendered. I authorize this office to release any information necessary to expedite insurance claims. I further authorized Benjamin Gates OD PLLC to release or obtain any required medical information from my attending physicians or any medical facility. Payment for exam fees is due at the time of service. Insurance information must be presented before services are rendered. Professional fees cannot be refunded.

Signature_____ Date_____

Membership # _____

HEALTH & VISION HISTORY *(Confidential)*

(Please print)

Today's date: ___/___/___

LAST NAME _____ FIRST NAME _____ MI ___ SEX: M / F

ADDRESS _____ CITY _____ ZIP _____

HOME PHONE: ( ) _____ WORK PHONE: ( ) _____

E-MAIL ADDRESS _____ BIRTHDATE ___/___/___ AGE ___

OCCUPATION or FIELD OF STUDY & SCHOOL? _____ EMPLOYER _____

HOBBIES, ARTISTIC INTERESTS, SPORTS _____

_____

_____

What is your reason for coming in today? _____

Age of present glasses _____ yrs. Age of present contact lenses _____ yrs.

Date of Last Eye Exam _____ Doctor's Name & City _____

Have you had your eyes dilated before? ☐ No ☐ Yes When? _____

WHAT ARE THE REASONS FOR TODAY'S VISIT? (Check all that apply)

☐ Need Updated Exam
☐ Distance blur
☐ Near/Reading blur
☐ Double vision ☐ Headaches
☐ Problems with Computer use

Glasses are:
☐ Lost
☐ Broken
☐ Scratched
☐ Not effective
☐ Never worn glasses

Contact Lenses:
☐ Never worn contacts
☐ I am interested in contacts
☐ Irritating
☐ Not effective
☐ Torn/ Damaged/ Lost ☐ Other:

_____

DO YOU OR ANY FAMILY MEMBER HAVE ANY OF THE FOLLOWING? (Check and indicate who has the condition):

☐ Diabetes _____
☐ High Blood Pressure _____
☐ Arthritis _____
☐ Thyroid problems _____
☐ Lung Disease _____
☐ Heart Disease _____
☐ Head Injury _____

☐ Eye Disease or Injury _____
☐ Eye Surgery _____
☐ Glaucoma _____
☐ Cataract _____
☐ Macular Degeneration _____
☐ Crossed/ Turned/ Lazy eye _____
☐ Retinal Detachment _____

Are you being treated for any medical conditions? (List:) _____

List any DRUGS or MEDICATIONS you are now taking _____

List any ALLERGIES you have including allergies to medications _____

Who is your Primary Care Physician? _____

WOMEN: Are you pregnant or nursing? ☐ yes ☐ no

IF YOU WEAR CONTACT LENSES, PLEASE ANSWER THE FOLLOWING:

TYPE: ☐ Soft ☐ Disposable ☐ Astigmatism ☐ Gas Permeable/Hard ☐ Monovision ☐ Tinted ☐ Bifocal

METHOD OF WEAR: ☐ Daily Wear ☐ Overnight What Contact Lens Solutions do you use? _____

Who referred you to our office: ☐ Optical Company _____ ☐ Friend _____

☐ Family Member _____ ☐ Other _____

Names of FAMILY MEMBERS who are patients of this office: _____

Please indicate method of Payment: Type: ☐ Cash ☐ Check ☐ Charge ☐ Insurance _____