Poplar Spectacles Optometry
215 Alamo Plaza Suite D
Alamo CA 94507,
TEL: (925) 202-2846 • FAX: (844) 242-1243
www.poplarspecs.com
info@poplarspecs.com

WELCOME LETTER

Patient Name:	
Account No:	

Dear patient:

We welcome you to our practice and ask that you kindly complete or correct all information on this form.

PATIENT INFORMATION

PATIENT NAME:		SEX:	LAST FOUR SOCIAL SECURITY NUMBER:
ADDRESS:		DATE OF BIRTH:	MARITAL STATUS:
CITY, STATE & ZIP:		EMAIL:	
HOME PHONE:	WORK PHONE:	MOBILE PHONE:	
EMPLOYER:		OCCUPATION:	
EMPLOYER'S ADDRESS:		PRIMARY CARE PHYSICIAN:	
EMPLOYER'S CITY, STATE & ZIP:		PRIMARY CARE PHYSICIAN'S PHONE:	
EMERGENCY CONTACT NAME:	RELATIONSHIP:	EMERGENCY CONTACT PHONE:	

Do you or your family have any history of the following conditions (check all that apply)?:

Self	Family	
_____	_____	Glaucoma
_____	_____	Cataracts
_____	_____	Diabetes
_____	_____	High Blood Pressure
_____	_____	Macular Degeneration
_____	_____	Heart Problems
_____	_____	Retinal Degeneration
_____	_____	Stroke
_____	_____	Thyroid Condition
_____	_____	Crossed/Lazy Eyes
_____	_____	Asthma/ Allergies
_____	_____	Color Blindness
_____	_____	Arthritis
_____	_____	Tuberculosis
_____	_____	HIV/Hepatitis
_____	_____	Cancer
_____	_____	Neuromuscular
_____	_____	Blindness

Other:

_____

_____

Do you currently have any of the following symptoms (check all that apply)?:

_____Blurry distance vision
_____Poor night vision
_____Eye Strain
_____Blurry Near Vision
_____Trouble Reading
_____Itchy Eyes
_____Discharge
_____Watering
_____Pain in the eye
_____Burning eyes
_____Sandy/dry eyes
_____Red Eyes
_____Glare/reflections
_____Discomfort in sunlight
_____Double vision
_____Floaters or spots in vision
_____Flashes of light
_____Eye injury
_____History of wearing an eye patch
_____History of eye surgery
_____Headaches
_____Dental Abscess

Are you interested in any of the following (check all that apply)?:

_____New spectacles
_____A new prescription
_____Light weight glasses
_____Anti-reflective lens
_____Ortho K
_____Colored contact lens
_____Sunglasses
_____Clip-ons
_____Safety glasses
_____Lasik
_____Contact lenses
_____Dry eye therapy
_____Myopia control

How were you referred to us?

_____Family doctor
_____Social Media
_____Insurance company
_____Another patient
_____
_____Other
_____

MEDICATIONS:

ALLERGIES:

SOCIAL HISTORY:

_____Alcohol abuse
_____Drug use
_____Tobacco use
_____Other:

_____
_____
_____

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INSURANCE INFORMATION

Patient Name:	
Account No.:	

Please select one and fill in necessary information: Guardian / Primary Insured / SELF		
GUARDIAN PRIMARY INSURED'S NAME:	GENDER:	LAST FOUR SOCIAL SECURITY NUMBER:
ADDRESS:	DATE OF BIRTH:	
CITY, STATE, ZIP:	PATIENT'S RELATIONSHIP TO GUARANTOR:	
HOME PHONE:	WORK PHONE:	

PRIMARY VISION INSURANCE	**SECONDARY VISION INSURANCE**
COMPANY NAME:	COMPANY NAME:
POLICY ID NO.:	POLICY ID NO.:
POLICY GROUP:	POLICY GROUP:
INSURED PARTY:	

PRIMARY MEDICAL INSURANCE	**SECONDARY MEDICAL INSURANCE**
COMPANY NAME:	COMPANY NAME:
POLICY ID NO.:	POLICY ID NO.:
POLICY GROUP:	POLICY GROUP:
INSURED PARTY:	INSURED PARTY:

MEDICAL INSURANCE POLICY: As part of our services at this practice we are happy to assist you in determining the benefits of your individual policy and in collecting your reimbursement of insurance benefits for medical services. To avoid any misunderstandings please read the following statements carefully:

1. The legal obligations of your insurance provider are between yourself and your provider, not between this practice and your provider.
2. When your insurance provider (s) has settled your plan's covered items, you will be notified by a monthly statement if there were any unpaid balances. Unpaid balances can include non-covered items or services, co-pays, deductibles, lapses, ineligibility or termination of coverage's. Unpaid balances are the sole responsibility of the patient.
3. To keep the cost of records and collections down any patient portion amounts on your order will be due at the time of service.
4. I authorize the use of this form on all insurance submissions as well as authorizing the release of information to all my insurance companies as well as allowing the doctor to act as my agent to help me in obtaining payment from my insurance companies.
5. I authorize payment to be made directly to the provider and permit a copy of this authorization to be used in place of the original.

CONSENT FOR TREATMENT: I hereby authorize Poplar Spectacles Optometry to administer diagnostic and medical procedures as may be necessary for proper health care.

_____ _____

Signature of patient or authorized representative — Date

Name of Patient:

_____

Authorized representative's name

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HIPAA CONSENT

Patient Name:	
Account No.:	

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Permission to Use and Disclose My Health Information: By signing this form, I give Poplar Spectacles Optometry permission to use and/or disclose my health information to provide treatment, obtain payment, and/or conduct health care operations.

Right to Refuse: I have the right not to sign this consent. If I refuse to sign this consent, Poplar Spectacles Optometry has the right to refuse to treat me. However, treatment required by law –such as emergency care– can be provided to me whether or not I sign this consent.

Right to Review Notice of Privacy Practices: I have been provided with a copy of the Notice of Privacy Practices for Poplar Spectacles Optometry which describes how Poplar Spectacles Optometry may use and disclose my health information. I have the right to review this Notice before signing this consent.

Changes to the Notice of Privacy Practices: Poplar Spectacles Optometry may change the Notice of Privacy Practices as needed. I may obtain a current copy of the Notice of Privacy Practices for Poplar Spectacles Optometry by contacting Poplar Spectacles Optometry.

Right to Request Restrictions on Use/Disclosure: I have the right to request that the usage of my protected health information by Poplar Spectacles Optometry be restricted in how it is used and/or disclosed for the purpose of providing treatment, obtaining payment, and/or conducting health care operations. However Poplar Spectacles Optometry is not required to agree to any restriction that I request. If Poplar Spectacles Optometry does decide to agree to my request, the use and/or disclosure of my health information by Poplar Spectacles Optometry must be restricted as I requested. If I wish to request restrictions I can contact Poplar Spectacles Optometry. Poplar Spectacles Optometry will notify me on whether my restrictions have been accepted or declined.

Right to Withdraw Consent: I have the right to withdraw this consent at any time. I must do so in writing by contacting Poplar Spectacles Optometry at 215 Alamo Plaza Suite D, Alamo, CA 94507. My withdrawal of this consent will not be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then Poplar Spectacles Optometry may refuse to provide to me further treatment or follow-up, other than required emergency services.

Effective Period: This consent is good unless and until I withdraw it in writing.

References to "I" or "me": References to "I" or "me" in this Consent include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, it is because I am that person's parent, legal guardian, or agent under an active Power of Attorney for Health Care; and I am legally authorized to sign this Consent on behalf of that person.

_____ _____

Signature of patient or authorized representative Date

Name of Patient:

_____

Authorized representative's name

FOR OFFICE USE ONLY

Complete this section if this form is not signed and dated by the patient or an authorized representative for the patient.

I have made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices for Poplar Spectacles Optometry but was unable to for the following reason:

- ❑ Patient refused to sign
- ❑ Patient is unable to sign
- ❑ Other _____

_____ _____

Signature of employee Date

_____

Employee's name

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COMMUNICATION CONSENT

Patient Name:	
Account No:	

ELECTRONIC COMMUNICATION CONSENT

In respect of your privacy Poplar Spectacles Optometry would like to request permission in regards to how to best communicate with you. The information that was provided on the first page can be used to contact you through traditional office to patient communication, but in an effort to reduce paper waste we acknowledge that there may be more efficient ways to contact you. In attempt to make all communication as convenient for you as please select which method(s) are best to reaching you. Such things may not be in place currently and may be discontinued at any point after initiation at the discretion of the practice management and owners.

_____ Email. I would like to be reached by email in regards to all appointment reminder, future appointment set up, and personalized promotional offers. I can be contacted by email at:
_____@_____.com

_____ Texts. I would like to receive text notifications of any appointment reminders, future appointment set up, and personalized promotional offers. I can be texted at:
(_____)_____-_____

_____ Automated Calls. I would like to be contacted with automated calls for appointment reminders and future appointment reminders. I can be called at:
(_____)_____-_____

_____ Mail. I would like to receive physical copies by mail of any appointment reminder (within one week), future appointment set up (within one to two months), and personal promotional offers.

_____ I do <u>not</u> wish to be contacted through Electronic and Automated communication.
If you do not wish to be entered into any current or future databases for Electronic and Automated communication, please understand that any already given information can and will be used to contact you in tradition methods such as live calls for appointment reminders and future appointment set up.

_____ _____
Patient Signature/ Legal Representative Date

*(If at any point after this form is completed and you wish to begin, cancel, or change the information provided you may do so, but another form must be completed. We are more than willing to mail, fax, or email a copy of this form to you to have it updated.)

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RELEASE CONSENT

Patient Name:	
Account No.:	

AUTHORIZED CONSENT RELEASE

In direct relation to the *Notice of Privacy Practices* we are unable to release any personal medical information to anyone without written given consent by the patient or patient's guardian. Should you call and ask to have someone pick up, receive a fax of, or have mailed to them, any information in regards to your medical records no information can be given without otherwise consented or without a Third Party Release Consent form.

If there are members of your family with whom we are allowed to share information with please list their information below.* Requested information will be used to verify identity.

Name:
_____
Relation: _____
Phone: _____ Date of Birth:_____

Name: _____
Relation: _____
Phone: _____ Date of Birth:_____

Name: _____
Relation: _____
Phone: _____ Date of Birth:_____

Name:
_____
Relation: _____
Phone: _____ Date of Birth:_____

Name: _____
Relation: _____
Phone: _____ Date of Birth:_____

Name: _____
Relation: _____
Phone: _____ Date of Birth:_____

_____I do not authorize anyone to receive information in regards to my health and medical records.

By signing you understand that any of the above may contact us for your medical and health records and receive them.

_____
Print Name

_____ _____
Signature of Patient/ Legal Representative Date

*(In the event that one of these persons in no longer someone you wish to have access to your information we must have an updated version of this form. We are more than willing to mail, fax, or email a copy of this form to you to have it updated.)