15651 Sheridan Street/ Suite 1000
Davie, FL 33331
Phone: (954) 252-8885 Fax (954) 252-8882

Welcome!

How did you hear about us? (Check all that may apply)

- ❑ Walking/Passing By
- ❑ From a Friend or Family Member. Please give their name(s)_____
- ❑ Mailing and/or other announcement
- ❑ Other source. Please list_____

Name_____ Date of birth: _____ Age: _____

Address_____ Sex *(Circle One)* M F

City_____ Zip Code_____

Home Phone_____ Work Phone_____

Cell Phone_____ E-mail_____

Vision Insurance Plan_____ Social Security #_____

Occupation_____ Last eye exam_____

Current Medications_____

Allergies_____ Name of Physician_____

Have you ever worn contact lenses? *(Circle One)* Yes No

Are you interested in wearing contact lenses? *(Circle One)* Yes No

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By signing below, I affirm that I have read and understand the Privacy Policy for Sheridan Eye Care that is attached on Pages 2 and 3, as well as agreeing to the Optical Policies section on Page 3.

Signature_____ **Date**_____

As a policy, payment is due at time of services rendered.

Privacy Policy

Notice Of Privacy Practices For Protected Health Information

This notice is being provided to you as a requirement of the federal Health Insurance Portability and Accountability Act (HIPAA). This notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created in or received by your health care provider, and that relates to your past, present or future physical health or condition. Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment and a plan for future care or treatment. Understanding what is in your medical record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

1 - How Medical Information About You May Be Used And Disclosed

We may use and disclose protected health information about you to provide you with medical treatment or services. We may disclose this information to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you. For example, we may disclose information to people outside of our office when scheduling tests, arranging consultations with other physicians, phoning in prescriptions, etc.

1.1 - For Treatment

We may use and disclose protected health information about you to provide you with medical treatment or services. We may disclose this information to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you. For example, we may disclose information to people outside of our office when scheduling tests, arranging consultations with other physicians, phoning in prescriptions, etc.

1.2 - For Payment

We may use and disclose protected health information to obtain reimbursement for the health care provided to you. We may also use this information to obtain prior authorization for proposed treatment or to determine whether your plan will cover the treatment. We will also share this information with our billing service as needed to facilitate their efforts towards reimbursement from you or your insurance company.

1.3 - For Healthcare Operations

We may use and disclose protected health information to support functions of our practice related to treatment and payment such as case management and quality assurance. In addition, we may use your health information to evaluate staff performance, to help us decide what additional services we offer, and other management and administrative activities.

1.4 - Appointment Reminders

We may contact you to remind you that you have an appointment or need a referral for an appointment.

1.5 - Treatment Issues

We may call you with test results, to tell you about treatment options or alternatives, or to respond to your phone call and answer questions about your treatment.

1.6 - Health-Related Benefits and Services

We may use and disclose medical information to tell you about health-related benefits, services or medical education classes that may be of interest to you.

1.7 - Individuals Involved in Your Care or Payment for Your Care

Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care.

1.8 - Emergencies

We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably possible after the delivery of your treatment.

1.9 - Communication Barriers

We may use or disclose your protected health information if we have attempted to
obtain consent from you but are unable to do so due to substantial communication barriers and we determine that your consent to receive treatment is clearly inferred from the circumstances.

1.10 - Required by Law

We may use or disclose your protected health information when required by federal, state or local law. The disclosure will be limited to the relevant requirements of the law.

1.11 - Public Health Risks

We may use or disclose your protected health information for public health reasons in order to prevent or control disease, injury or disability; or to report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

1.12 - Communicable Diseases

We may disclose your protected health information, if required by law, to a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading the disease or condition.

1.13 - Health Oversight Activities

We may disclose protected health information to federal or state agencies that oversee our activities.

1.14 - Legal Proceedings

We may disclose protected health information in response to a court or administrative order or in response to a subpoena, discovery request or other lawful process.

1.15 - Law Enforcement

We may release protected health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process subject to all applicable legal requirements.

1.16 - Workers Compensation

We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

1.17 - Military Activity and National Security

If you are, or were, a member of the armed forces or part of the National

Security and Intelligence communities we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

1.18 - Business Associates

There may be some services provided in our organization through contracts with Business Associates. Examples include our billing services, answering services, web services, etc. When these services are contracted, we may disclose some of your protected health information to our Business Associate so that they can perform their job. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

1.19 - Other Uses and Disclosures of Health Information

Other uses and disclosures of your protected health information will be made only with your written authorization unless otherwise permitted or required by law as described above. You may revoke this authorization at any time in writing, except to the extent that action has already been taken in reliance on the use or disclosure indicated on the authorization.

2 - Your Health Information Rights

You have the right to inspect and obtain a copy of your protected health information. This means you may inspect and obtain a copy of your medical and billing records. A reasonable copying charge may apply. This request must be made in writing.

2.1 - Right To Inspect And Copy Your Protected Health Information

You have the right to inspect and obtain a copy of your protected health information. This means you may inspect and obtain a copy of your medical and billing records. A reasonable copying charge may apply. This request must be made in writing.

2.2 - Right To Request A Restriction On Uses And Disclosures Of Your Protected Health Information

You have the right to request a restriction on your protected health information. This means you may ask us to restrict or limit disclosure of any part of your protected health information. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or payment for your care. You must state the specific restriction requested and to whom you want the restriction to apply. However, this request is subject to our approval. If the physician believes it is in your best interest to permit use and disclosure of your information, it will not be restricted. If the physician does agree to the requested restriction, we may not use or disclose your protected health information unless it is needed to provide emergency treatment.

2.3 - Right To Request To Receive Confidential Communications

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. You must make this request in writing and your request must specify how or where you wish to be contacted. We will not ask you the reason for your request.

2.4 - Right To Request Amendments To Your Protected Health Information

You have the right to request a correction to your protected health information. This means you may request an amendment of your medical record if you believe the health information we have about you is incorrect or incomplete. You must make this request in writing. Forms are available for this purpose and can be obtained from us. We may deny your request for an amendment if we feel it is inaccurate, or if the amendment you are requesting is part of the record that was not created by us. If we deny your request for amendment, you have the right to have your request and our denial added to your medical record.

2.5 - Right To Receive An Accounting

You have the right to receive an accounting of disclosures of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operation, or for disclosures that occurred prior to April 14, 2003. You must make this request in writing and this request must include a time frame, which may not be longer than 6 years or may not include dates prior to April 14, 2003.

2.6 - Right To Obtain A Paper Copy Of This Notice

You have the right to obtain a paper copy of this notice from us.

2.7 - Right To Register A Complaint

You have the right to register a complaint if you feel your privacy rights have been violated. If you believe your privacy rights have been violated, you may file a complaint with our office. You may also file a complaint with the Secretary of the Department of Health & Human Services. You will not be penalized for filing a complaint.

3 - Changes To This Notice

We reserve the right to change this notice and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date at the top. You are entitled to a copy of the notice currently in effect. This notice will be posted on our website.

4 - Contacting Our Privacy Officer:

Amandip Sappal, O.D.
15651 Sheridan St
Suite 1000
Davie,FL 33331
Tel (954) 252-8885
Fax (954) 252-8882

5 - Effective Date

This notice is effective June 27, 2005.

Optical Policies

Ophthalmic Frames = Ophthalmic frames may be returned within 30 days if they are in "re-sellable" condition. "Re-sellable" means that they are free of any defects, scratches, blemishes, hairs, oils, breaks, deformities, or chips. It is the patient's responsibility to ask about a frame's warranty. Discount frames have a maximum 60 day warranty. Sheridan Eye Care ultimately reserves the right to determine if a partial or full refund is given or not.

Opthalmic Lenses = Ophthalmic lenses are considered custom orders made by an outside lab; therefore, they can not be refunded. If there is a prescription error, lens performance issue, or progressive non-adapt, every appropriate measure will be taken by Sheridan Eye Care to remedy the problem at no cost to the patient.

Services = All fees for services are due at the time services are rendered.

Sunglasses = No refunds are allowed on non-prescription sunglasses. All sales are considered final.

Name_____ Date_____

Instructions: Please answer the following questions about how your eyes feel when reading or doing close work. Check the appropriate column below.

		Never	Infrequently	Sometimes	Fairly/Often	Always
1	Do your eyes feel tired when reading, using a computer or doing close work?					
2	Do your eyes feel uncomfortable when reading, using a computer or doing close work?					
3	Do you have headaches when reading, using a computer or doing close work?					
4	Do you feel sleepy when reading, using a computer or doing close work?					
5	Do you lose concentration when reading, using a computer or doing close work?					
6	Do you have trouble remembering what you have read?					
7	Do you have double vision when reading, using a computer or doing close work?					
8	Do you see the words move, jump, swim, or appear to float on the page when reading, using a computer or doing close work?					
9	Do you feel like you read slowly?					
10	Do your eyes ever hurt when reading, using a computer or doing close work?					
11	Do your eyes ever feel sore when reading, using a computer or doing close work?					
12	Do you feel a “pulling” feeling around your eyes when reading, using a computer or doing close work?					
13	Do you notice the words blurring or coming in and out of focus when reading, using a computer or doing close work?					
14	Do you lose your place while reading, using a computer or doing close work?					
15	Do you have to re-read the same line of words when reading?					
	Total Xs in each column	x0	x1	x2	x3	x4

Score_____

SHERIDAN EYE CARE

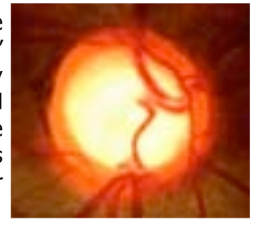
SPECIAL TESTING FORM

Visual Field Screening Test

The Visual Field is a special computerized test done to assess central and peripheral vision, as well as detect certain neurological defects. Our screening test can provide an early diagnosis for many eye diseases long before they become clinically detectable. These diseases include glaucoma, macular degeneration, and cataracts. It can also detect neurological conditions such as strokes, tumors, and other diseases.

Sheridan Eye Care offers a Visual Field screening for those patients who would like the added security of knowing that their visual and neurological systems are working properly and are healthy.

Optic Nerve Photos



The optic nerve is the "phone cable" or "USB Port" of our eye. It continually sends "pictures" of the world to our brains, just like the way today's digital cameras transmit pictures to our computers.

Diseases such as glaucoma and other optic neuropathies destroy the optic nerve over time. This can lead to decreased vision or even blindness.

Sheridan Eye Care offers a high-quality digital photograph of your optic nerve for those patients who want to record the appearance of this vital structure today before disease occurs. This will aid us, or other eye doctors, in diagnosing glaucoma or other eye diseases in the future by having a baseline comparison.

Please indicate your preference:

☐ I would only like to have a Visual Field Screening Test done to aid the doctor in possibly detecting early changes in my visual/neurological system. I understand that there is an additional $20 fee in having this test done.

☐ I would only like to have Optic Nerve Photos taken to have a permanent record that may aid the diagnosis and treatment of many eye diseases in the future. I understand that there is an additional $25 fee in having this test done.

BEST VALUE!

☐ I would like to have both the Visual Field Screening Test done and the Optic Nerve Photos taken to have a permanent record that may aid in the diagnosis and treatment of many eye diseases in the future. I understand that there is in an additional $40 fee in having these tests done.

☐ I decline having a Visual Field Screening Test and Optic Nerve Photos against Sheridan Eye Care's advice, and understand that early manifestations of some major visual/neurological conditions may go undetected, misdiagnosed, and/or untreated in a timely manner either today or in the future.

Signature_____ Date_____

Print Name_____

Dilation Consent

Pupillary dilation is a safe and routine part of a comprehensive eye examination. However, this procedure does require the instillation of prescription eye drops that may keep your vision blurry and/or dilated for up to 24 hours. Your consent is required –and driving is not recommended for 3 hours after the exam. Pupillary dilation is strongly recommended to ensure ocular health as it allows the doctor to gather a complete set of information about your eyes.

___ **Yes, I wish to have my pupils dilated.** (Please note that on some extremely busy days such as Saturday, we may not have time to dilate the eyes –therefore, it may be necessary to reschedule it for a weekday at no additional charge to you.)

___ **No, I do not wish to be dilated at this time.** I understand that this may keep the doctor from making a full assessment of my ocular health.

Signature:_____Date:_____
(Patient Signature, Parent or Guardian if patient is a minor)