169 CHRISTIANA ROAD
NEW CASTLE, DE 19720
302.322.4444 FAX: 302.322.0875

EPSTEIN EYE associates

DR. MATT J. EPSTEIN
DR. ANNY KIM
DR. LINEN J. POK

Patient Name: _____ Home Phone: _____
Address: _____ Work Phone: _____
City: _____ State: _____ Zip: _____ Cell Phone: _____
Email: _____ Date of Birth: _____ ☐Male or ☐Female
Occupation: *(If student, indicate grade)* _____ Social Security #:: _____
Employer: _____ Referred By: _____

Do you have **VISION** insurance? ☐Yes ☐No If yes, what kind? ☐EyeMed ☐NVA ☐VBA ☐VSP ☐Other: _____
Name of Insured: _____ Relation to Patient: ☐Self ☐Spouse ☐Parent/Guardian
Insured's Date of Birth: _____ Policy #: _____ Insured's SS Number: _____

Do you have **MEDICAL** insurance? ☐Yes ☐No If yes, what kind? ☐Aetna ☐BC/BS ☐Medicare ☐Other: _____
Name of Insured: _____ Relation to Patient: ☐Self ☐Spouse ☐Parent/Guardian
Insured's Date of Birth: _____ Policy #: _____ Insured's SS Number::_____

What is the reason for today's exam? _____

VISION HISTORY

Do you wear eyeglasses? ☐YES ☐NO

If YES: Are you: ☐Nearsighted/Can't see far ☐Farsighted/Can't see near Do you wear them: ☐At all times ☐Occasionally
How old are they? _____

If NO: Did you ever have glasses prescribed? ☐Yes ☐No

Do you wear contact lenses? ☐Yes ☐No

If YES: What kind? :☐Soft/Disposable ☐Gas Permeable
Do you sleep in them?: ☐Yes (extended wear) ☐No
Replaced: :☐Daily ☐Weekly:☐2-Week ☐Monthly

If NO: Have you *ever* worn contact lenses? ☐Yes ☐No

When was your last eye exam? _____

Name of previous doctor:_____

Do you use any eye drops? ☐Yes ☐No
If YES, for what? _____

Have you or a close relative had any of the following:

	Self		Relative		Relationship
Blindness	Y	N	Y	N	_____
Cataracts	Y	N	Y	N	_____
Cross Eye	Y	N	Y	N	_____
Eye Surgery	Y	N	Y	N	_____
Glaucoma	Y	N	Y	N	_____
Headaches	Y	N	Y	N	_____
Lazy Eye	Y	N	Y	N	_____
Retinal Issues	Y	N	Y	N	_____
Eye Injury	Y	N	Y	N	_____

Are you interested in LASIK? ☐Yes ☐No

MEDICAL HISTORY

Are you taking medications? ☐Yes ☐No
If YES, what? _____
_____

Are you allergic to any medications? ☐Yes ☐No
If YES, what? _____
_____

Primary Care Physician: _____
Address: _____
Phone: _____
Date of last exam: _____

Have you had any of the following:			Self or Relative?
Arthritis	Y	N	_____
Asthma	Y	N	_____
Blood Issues	Y	N	_____
Cancer	Y	N	_____
Depression/Anxiety/Psychiatric	Y	N	_____
Diabetes	Y	N	_____
Ear/Nose/Throat	Y	N	_____
Fever/Fatigue	Y	N	_____
Heart Problems	Y	N	_____
High Blood Pressure	Y	N	_____
Immune Problems	Y	N	_____
Lung Problems	Y	N	_____
Stomach/Digestion Issues	Y	N	_____
Thyroid	Y	N	_____
Urinary/Kidney	Y	N	_____
Weight Loss/Gain	Y	N	_____
Other: _____	Y	N	_____

Do you smoke? ☐Yes ☐No

Do you drink alcoholic beverages? ☐Yes ☐No

Females: Are you currently pregnant? ☐Yes ☐No

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Detect eye diseases early with OCT Imaging

Epstein Eye Associates has always stayed up-to-date on the latest technologies to provide patients with the best possible vision care. We are, therefore, proud to announce that we have invested in a highly sophisticated digital diagnostic device—the Cirrus HD-OCT. If you have been diagnosed with macular degeneration, glaucoma or diabetes, you are most likely familiar with OCT. We are pleased to be able to provide this testing here in our office now!

Optical Coherence Tomography (OCT) is a relatively new imaging technique that can be used to detect or even prevent certain eye diseases. OCT machines work similar to an ultrasound but use infra-red light waves, enabling the doctor to discern healthy tissue from diseased tissue with unsurpassed depth and clarity. OCT generates images of the retina at high resolution, allowing your eye care provider to see the layers and details of the retina.

The 3-D images which are created by OCT reveal a huge amount of information about vision and play a big part in preventing blindness. No symptoms are apparent with certain eye diseases, which is why **early detection is so important**. At Epstein Eye, we can now see the tiniest details inside the eye, and detect and treat potentially blinding eye diseases BEFORE damage is done.

Dr. Epstein, Dr. Kim, and Dr. Pok strongly recommend this test, since it provides a more thorough medical analysis of your eyes than standard dilated eye examinations alone. At this time, medical insurances only covers this testing if disease is detected or highly suspected; otherwise, it is not covered by insurance or vision benefits. We are offering this optional testing at a nominal fee of $40. While the doctors would prefer to have *all* patients receive a baseline analysis, it is ***strongly recommended*** if you answer YES to ***any*** of the following questions:

INCREASED RISK FACTORS	YES	NO
Are you over the age of 50?	☐	☐
Is there a family history of macular degeneration?	☐	☐
Is there a family history of glaucoma?	☐	☐
Are you diabetic or diagnosed as pre-diabetic?	☐	☐
Do you have a strong eyeglass prescription?	☐	☐
Do you see spots or flashes of light?	☐	☐

Please check the appropriate line below and initial at the bottom:

_____ I WOULD like the OCT imaging and analysis in addition to my annual eye exam.

_____ I WOULD NOT like the OCT imaging and analysis in addition to my annual eye exam.

Initials: _____

EPSTEIN EYE ASSOCIATES, P.A.
169 CHRISTIANA ROAD
NEW CASTLE, DE 19720

PUBLIC INFORMATION OFFICER:
RACHEL WENDE, OFFICE MANAGER
PHONE: 302.322.4444 (EXT. 19)
FAX: 302.322.0875

NOTICE OF PRIVACY PRACTICES

REVISED: AUGUST 15, 2013

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you our Notice of Privacy Practices. This Notice describes how we use and protect your **personal health information (PHI)** and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

Under the Health Insurance Portability and Accessibility Act (HIPAA), we may use or disclose your PHI for treatment, payment and health care operations without any special permission:

a) Treatment: for example, we may use or disclose your PHI when setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; referring you to another doctor for eye care services; or getting copies of your health information from another professional that you may have seen before us.

b) Payment: For example, we may use or disclose your PHI when asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency).

c) Health care operations: For example, we may use or disclose your PHI for financial or billing audits; participation in managed care plans; defense of legal matters.

Most uses and disclosures that do not fall under treatment, payment, or health care operations will require your written authorization. We will not use your PHI for marketing or fundraising purposes without your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time. We will not sell your PHI.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

Emergency Situations-in the event of your incapacity or an emergency situation, we will disclose PHI to a family member, or another person responsible for your care, using our professional judgment. We will only disclose PHI that is directly relevant to the person's involvement in your healthcare.

Required by Law-We may also use or disclose your PHI when we are required to do so by law.

Abuse or Neglect-We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your PHI to the extent necessary to avert a serious threat to you or other people's health or safety.

National Security-We may disclose the PHI of Armed Forces personnel to military authorities under certain circumstances. We may disclose PHI to authorized federal officials required for lawful intelligence, counter intelligence and other national security activities. We may disclose PHI of inmates or patients to the appropriate authorities under certain circumstances.

Business Associates-We may use or disclose your PHI to 'business associates' who perform health care or billing operations for us and who commit to respect the privacy of your health information.

Other-Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care. We may also access your PHI in order to inform you about alternate services or products that might benefit you.

APPOINTMENT REMINDERS

We may use or disclose your PHI to provide you with appointment reminders via phone, e-mail, postcard, or letter. This may involve leaving a message on e-mail, an answering machine or by postcard which could be received or intercepted by others.

YOUR RIGHTS AS A PATIENT

-You have the right to restrict the disclosure of your PHI; however, such request may be denied if the information is required for treatment, payment or health care operations as outlined above.

-You have the right to restrict disclosure of your PHI to your healthcare plan if you pay fully out of pocket in full for a healthcare item or service.

-You have the right to ask us to communicate with you in a confidential way.

-You have the right to inspect and request a copy of your PHI. Because we maintain Electronic Health Records, you have a right to obtain your PHI in an electronic format.

-You have the right to amend your PHI if you think that it is incorrect or incomplete. Your record will either be amended or a statement of your position included in your record.

-You have the right to receive an account of disclosures of your PHI and to be notified following a breach of unsecured PHI if you are affected.

-You have the right to a paper copy of this Notice of Privacy Practices.

You may send a letter to the Public Information Officer at the address or fax number listed at the top of this Notice for any of the above requests, along with verification of identity (i.e., copy of driver's license). We will respond to your request within 30 days of receipt.

LEGAL REQUIREMENTS

Epstein Eye Associates, P.A. is required by law to maintain the privacy of your PHI. We are required to abide by the terms of this Notice as it is currently stated, and reserve the right to change this Notice. If we change our Notice of Privacy Practices, we will post the new Notice in our office, have copies available, and post it on our website. If a risk assessment demonstrates that a breach has occurred compromising your PHI, we are required to notify the affected individual(s) and the U.S. Department of Health and Human Services (HHS) Secretary not later than 60 days after the end of the calendar year in which the breach was discovered.

COMPLAINTS and/or REQUESTS FOR ADDITIONAL INFORMATION

If you think we have not properly respected the privacy of your PHI, you may submit a complaint in writing to our Public Relations Officer at the address or fax number listed at the top of this Notice, or to the U.S. Department of Health and Human Services, Office for Civil Rights. You will not be retaliated against in any manner for a complaint. If you need more information about our privacy practices, contact the Public information Officer at the address, phone or fax number listed at the top of this Notice.

CHRISTIANA OFFICE PAVILION – 169 CHRISTIANA ROAD
NEW CASTLE, DE 19720

ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES (NPP)

I acknowledge that I received a Notice of Privacy Practices (NPP) from Epstein Eye Associates:

Patient Name (please print): _____

Patient (or Guardian) Signature: _____

Date: _____