Colin V. Connors, O.D.
Richard M. Jun, O.D.
Aja L. Kimrey, O.D.
Callie Maursetter, O.D.
Timothy N. Wilson, O.D.

Welcome to Isthmus Eye Care, S.C.!

Date: __________ / __________ / __________

Patient's Name: ______________________________________

Address: ______________________________________

____

____

Home: (_______) __________-______________

Work: (_______) __________-______________

Cell: (_______) __________-______________

Text Message Reminders: ☐ Yes ☐ No

Social Security #: __________-_______-_________

Date of Birth: __________/_______ /__________

E-mail Address:

____

For **ADULT** Patients:

Employer: ______________________________________

Occupation: ______________________________________

Spouse's/Partner's Name: ______________________________

Spouse's/Partner's Occupation: __________________________

Names/Ages of Children at Home:

____

For **SCHOOL-AGED** Patients:

School Name: ______________________________________

Grade: ______________________________________

Parent/Guardian Name(s): ______________________________

____

Referred by: ☐ Person: ________________________ ☐ Insurance ☐ Internet/Website ☐ Other: ________________________

I understand the above information is necessary to provide me with ocular and vision care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. With my approval, I authorize the doctor to perform diagnostic procedures and treatments as may be necessary for proper ocular and vision care.*

*Consent in place until revoked from patient

Signature of Patient/Parent/Guardian: ________________________________Date:______/______/______

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received the chance to review a copy of the Isthmus Eye Care, S.C. Notice of Privacy Practices.

Patient Name____

Signature _________________________________Date_____________

I give consent to the release of any or all of my Isthmus Eye Care records to the following persons listed below that may need access to them.*

*Consent in place until revoked from patient

Name_____________________________Relation to patient_____________ Date__________

Name_____________________________Relation to patient_____________ Date__________

Name_____________________________Relation to patient_____________ Date__________

~ ~

I give consent to the release of any or all of my Isthmus Eye Care records through the online "Personal Health Records" portal to the following persons listed below that may need access to them and are current patients at Isthmus Eye Care.*

*Consent in place until revoked from patient

□ All family members that are patients at Isthmus Eye Care

□ Name: ____ Date__________

□ Name: ____ Date__________

□ Name: ____ Date__________

□ Do not link my Personal Health Records/Withdrawal Consent

Colin V. Connors, O.D.
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Timothy N. Wilson, O.D.

To Whom It May Concern,

The patient below is in office for an appointment. Please fax an updated medication list as soon as possible. Our fax number is **(608) 831-8470**.

If you have any further questions, please call our office at (608) 831-3366.

Thank you,
Isthmus Eye Care

Patient Name:____

DOB:____

Clinic Location:____

Clinic Fax Number:____

Primary Care Physician:____

Patient/Parent/Guardian Signature:_______________________________Date:________________

7601 University Avenue
Middleton, WI 53562

P: (608) 831-3366
F: (608) 831-8470

Review of Systems (Medical History): Please check if current or past medical conditions apply

Patient's History:

Are you currently pregnant and/or nursing: □ No □ Yes

Constitutional □ Negative
□ Developmental Disabilities
□ Cancer
□ Fatigue Syndrome
□ Other _________________________
Medications:

Eyes □ Negative
□ Glaucoma
□ Cataract
□ Age-related Macular Degeneration
□ Surgery
□ Patching Therapy
□ Inflammatory Disorders
□ Other _________________________
Medications:

Cardiovascular □ Negative
□ High Blood Pressure
□ Heart Disease
□ Vascular Disease
□ Congestive Heart Failure
□ Other _________________________
Medications:

Endocrinology □ Negative
□ Diabetes Type 1 (Insulin Dependant)
□ Diabetes Type 2 (Non-Ins Dependant)
□ Thyroid Dysfunction
□ Hormonal Dysfunction
□ Other _________________________
Medications:

Neurological □ Negative
□ Multiple Sclerosis
□ Epilepsy
□ Cerebral Palsy
□ Tumor
□ Stroke / CVA
□ Migraines
□ Other _________________________
Medications:

Integumentary (Skin) □ Negative
□ Eczema
□ Rosacea
□ Psoriasis
□ Cold Sores (h. simplex)
□ Shingles (h. zoster)
□ Other _________________________
Medications:

Ears/Nose/Throat □ Negative
□ Hearing Loss
□ Sinusitis
□ Dry Mouth
□ Laryngitis
□ Other _________________________
Medications:

Respiratory □ Negative
□ Cigarette Smoker
□ Asthma
□ Bronchitis
□ Emphysema
□ Chronic Obstructive Pulmonary Disease
□ Sleep Apnea
□ Other _________________________
Medications:

Musculoskeletal □ Negative
□ Osteoarthritis
□ Osteoporosis
□ Fibromyalgia
□ Muscular Dystrophy
□ Ankylosing Spondylitis
□ Gout
□ Other _________________________
Medications:

Gastrointestinal □ Negative
□ Crohn's Disease
□ Colitis
□ Ulcers
□ Acid Refux
□ Celiac Disease
□ Other _________________________
Medications:

Genitourinary □ Negative
□ Pregnant / Nursing
□ Kidney Disease
□ Prostate Disease / Cancer
□ Herpetic / Chlamydia
□ Other _________________________
Medications:

Hematology / Lymphatic □ Negative
□ Anemia
□ High Volume Blood Loss
□ High Cholesterol
□ Ulcers
□ Other _________________________
Medications:

Psychiatric □ Negative
□ Depression
□ ADHD
□ Anxiety
□ Bipolar Disorder
□ Other _________________________
Medications:

Allergy / Immunology □ Negative
□ Drug Allergies
____
□ Environmental Allergies
____
□ Lupus
□ Rheumatoid Arthritis
□ Sjogren's Syndrome
□ Other _________________________
Medications:

Family History: Please indicate family relation: Mother = M, Father = F, Brother = B, Sister = S, Other = O

Ocular: □ Glaucoma___ □ Age-related Macular Degeneration___ □ Cataract___ □ Other ________________

Medical: □ High Blood Pressure___ □ Diabetes (Type 1/Type 2)___ □ Cancer___ □ Thyroid Conditions (Hyper/Hypo) ___
□ Other ____________________

Current Medications: List all medications including dosage (include oral contraceptives, aspirin, over the counter medications and home remedies)

□ See attached medication list

Isthmus Eye Care Financial Policy

Payment Terms: Thank you for choosing Isthmus Eye Care for your eye care needs. We will require payment at the time of your office visit. This may include amounts for co-pays, services, orders of glasses and/or contact lenses, and past-due balances.

Billing Information: Please provide your complete and accurate information (address, phone number, insurance), and notify us of changes to any of your information. We will use reasonable efforts to submit claims to your payer and provide you with statements. Charges that are not covered by insurance, including deductibles, will remain your responsibility. If for any reason amounts that you owe are not paid promptly, including statements returned as undeliverable, your account may be subject to additional finance charge fees.

Finance Charge Fees: For any past due amounts over 30 days Isthmus Eye Care shall be entitled to payment from you with interest at a rate of 1.5% per month (18% per annual). Delinquent accounts will be turned over to an outside collection agency if unpaid after 90 days without further notice. You are responsible for all associated court fees and a one time $30 collection agency fee.

I have thoroughly read and agree to this Financial Policy. I also hereby authorize the release of pertinent medical information to the insurance carrier(s). This consent is in place until revoked in writing.

Patient Name: ____

Signature of Patient/Parent/Guardian: ______________________________ Date____/____/____

Effective Date of Notice: January 31, 2017

NOTICE OF PRIVACY PRACTICES

Isthmus Eye Care S.C.
www.isthmuseye.com
7601 University Ave. Ste. 102
Middleton, WI 53562
608-831-3366

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations.

- Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us.
- Examples of how we use or disclose your health information for payment purposes are: asking 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 or attorney).
- Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records."Health care operations" mean those administrative and managerial functions that we have to do in order to run our office.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- To governmental authorities about victims of suspected abuse, neglect or domestic violence;
- Health oversight activities, such as for the licensing of doctors; for audits by Medicare and Medicaid; or for investigation of possible violations of health care laws;
- For judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- For law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- To a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- For health related research;
- To prevent a serious threat to health or safety;
- For specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- De-identified information;
- Relating to worker's compensation programs;
- A "limited data set" for research, public health, or health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- To "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

APPOINTMENT REMINDERS

We may call, email, text or mail you to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we may leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form". The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can ask us:

- To restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations.
  - We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office.
- To communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using email to your personal email address.
  - We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office.
- To see or to get photocopies of health information.
  - By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off–site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of time to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office.
- To amend your health information if you think that it is incorrect or incomplete.
  - If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to the person who we know got the wrong information, and any others that you specify.
  - If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office.
- To get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want).
  - By law, the list will not include: disclosures for purpose of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other

limited disclosures.
  - You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notices in our office, have copies available in our office, and post it on our website.

COMPLAINTS

- You can complain if you feel we have violated your rights by contacting us using the information on the top of page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W. Washington, D.C., 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

FOR MORE INFORMATION

If you want more information about our privacy practices, call the office.