



- Patient's Information -
(Please Print)

Last Name _____ First Name _____ Middle Initial _____
Address _____ Home Phone# _____ Work # _____
City _____ State _____ Zip _____
Date of Birth: _____ Male /Female Social Security# _____
Primary Care Physician: _____
Emergency Contact _____ Phone # _____
Referred by Whom _____
Parent or Guardian (if Minor) _____
I authorize release and /or discussion of information with: _____
I have the right to rescind the designation at any time but realize it must be done in writing.

-Parent / Guardian's Information -

Guardian's Name: _____
Address (if different than above) _____
Date of Birth: _____ Social Security # _____

- Insurance Information -

Medicaid # _____ Medicare# _____
Insurance Co _____ Member # _____
Group # _____

*** AUTHORIZATION AND ASSIGNMENT***

I have reviewed the Pediatric EyeCare of Western Colorado, PC "Notice of Privacy Practices" and understand my rights as they pertain to protected health information (PHI). I authorize Pediatric EyeCare of Western Colorado, PC to release all information necessary to insurance carriers related to claims filed by the practice, on my behalf or on behalf of my dependents. I understand that I may be financially responsible for all or a portion of services provided for me and/or the above named patient whether or not covered by insurance. I also understand that I will be responsible for fees incurred for a collection agency and reasonable attorney fees, should I fail to pay for the services rendered. I hereby assign all insurance payments related to claims filed by the practice, on my behalf or on behalf of my dependents, to Pediatric EyeCare of Western Colorado, PC.

Date _____ Signed _____

Name: _____
 Date: _____

PERSONAL HISTORY

Do you have allergies to medications? YES NO
 If YES, please list: _____
 Please list any surgical procedures and dates: _____

 Please list all major medical illness: _____

 Allergies: _____
 Current Medications: _____
 Glasses: YES NO First pair at What Age? _____

SOCIAL HISTORY

Does vision limit any activities of daily living? YES NO
 Does the patient drink alcohol? YES NO If YES, how much? _____
 Does the patient use tobacco? YES NO If YES, quantity/length? _____
 Hobbies: _____ Occupation: _____

FAMILY HISTORY

Please circle any of the following conditions related to Mother, Father, Grandparents, Siblings ONLY

Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis, Other Heritable Disease
 Strabismus (eye misalignment), Amblyopia (lazy eye), Blindness, Glaucoma, Cataracts, Retinal Disease/Detachment

REVIEW OF SYSTEMS

Does the patient have any problems in the following areas? If YES, please provide details.

	YES	NO	Details
Eyes (poor vision, pain, redness, swelling, tearing, discharge, lesions, abrasions)			
General/Constitutional (fever, rash, heat stroke, weight loss, weight gain, unusual tiredness, etc.)			
Ears/Nose/Throat (hard of hearing, stuffy nose, earache, cough, dry mouth, ringing in ears, dizziness, etc.)			
Cardiovascular (high blood pressure, fast heart rate, irregular beat, etc)			
Respiratory (congestion, wheezing, short of breath, etc)			
Gastrointestinal (stomach upset, pain, burning, diarrhea, constipation, ulcers, etc)			
Genitourinary (herpes, pregnancy, painful urination, blood in urine, urgency, frequency, etc)			
Musculoskeletal (swelling, cramps, arthritis, joint pain, stiffness,)			
Neurologic (numbness, headaches, seizures, paralysis)			
Hematologic (anemic, iron deficient, bleeding, bruising)			
Endocrine (diabetes, hypothyroid, etc)			
Psychiatric (anxiety, depression, insomnia,)			
Skin (pimples, warts, rash, growth, etc)			
Immunologic/Allergic (sneezing, swelling, redness, hives, lupus, etc)			

ADULT

 Deborah S. Lenahan, M.D.



Pediatric Eyecare
of Western Colorado, P.C.

Deborah S. Lenahan, M.D.

PROVIDER NOTICE OF PRIVACY PRACTICES

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.

USES AND DISCLOSURES: We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Information may be shared with other providers by paper mail, electronic mail, fax or other methods. We may use or disclose identifiable health information about you without your authorization in several situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you.

YOUR RIGHTS: In most cases, you have the right to look at or get a copy of health information about you. If you request copies, we will charge you only normal photocopy fees. You also have the right to receive a list of certain types of disclosures of your information that we make. If you believe that information in your records is incorrect, you have the right to request that we correct the existing information.

COMPLAINTS: If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

OUR LEGAL DUTY: We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below. If you have any questions or complaints, please contact:

Office Manager: Mitzi Gurule
3150 N. 12th Street
P.O. Box 10700
Grand Junction, CO 81502
Phone: (970) 254-4600

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:
Please sign and print your name and the date on this acknowledgement form. Return the signed acknowledgement to the receptionist or the address above

Signature: _____ Date: _____
(Patient/Guardian)

Printed Name: _____



Pediatric Eyecare of Western Colorado, P.C.

Deborah S. Lenahan, M.D.

Advanced Beneficiary Notification

A refraction (regardless of patient's age) is performed as part of a complete eye examination. This part of the examination is important when making medical decisions regarding the health and/or treatment of the patient's visual needs.

All children have a refractive error, and it is important to determine if this refractive error is normal and the same in both eyes. Glasses may/may not be prescribed based on the outcome of this examination.

Some insurance companies do not pay for a refraction, even though it is part of a comprehensive evaluation. Therefore, we collect this minimal charge in advance. If you are charged for a refraction and it is found to be a covered benefit by your insurance company, you will be issued a full refund.

I, _____, agree to make payment for the refraction charge of \$40.00 to Pediatric EyeCare of Western Colorado, P.C. at the time of service.

I, _____, decline having a refraction performed at this time.

Date _____