Vista Vision
PREMIER FAMILY EYECARE

427 N. Loop 1604 W., Suite 203
San Antonio, TX 78232-1033
Office (210) 960-5494
Fax (210) 960-2261
www.vistavisionsa.com

Patient Name: _____ D.O.B. _____

Medical and Ocular History

Reason For Today's Visit *(including any eye concerns you have)*:

Please check all that apply:

Allergy Eyes ☐	Blurry Vision: Distance, Near, Intermediate ☐ ☐ ☐	Broken Glasses ☐	Cataract Check ☐
Contact Lenses ☐		Dry Eyes ☐	Glaucoma Check ☐
DMV Report ☐	Diabetic Eye Exam ☐	Floaters ☐	Itching Eyes ☐
Lost Glasses ☐	Flashes of Light ☐	Red/Painful Eye(s) ☐	Scratched Glasses ☐
Watery Eyes ☐	Macular Degeneration Check ☐		Other ☐
	Follow up Visit ☐		

Eye History

Please check if you have/had experience any of the following before.

Amblyopia ☐	Eye Infection ☐	Strabismus ☐
Blindness ☐	Eye Injury ☐	Surgery ☐
Cataracts ☐	Glaucoma ☐	Ulcer ☐
Color Vision Defect ☐	Macular Degeneration ☐	Other:
Diabetic Retinopathy ☐	Retinal Detachment ☐	
Dry Eyes ☐		

Please provide explanation for EACH condition *(how long, treatments received, drops using, etc):*

When was your last **Eye** Exam? _____

Who was your last eye doctor? _____

Are you using any eye drops? ☐ yes ☐ no
What kind?

***Medical History*:** (please check all that apply)

General:	**Psychological:**	**Gastrointestinal:**	**Skin/Integumentary**
Developmental Disabilities ☐	Depression ☐	Crohns ☐	Eczema ☐
Cancer ☐	ADD ☐	Colitis ☐	Rosacea ☐
Fatigue ☐	Bipolar ☐	Ulcer ☐	Psoriasis ☐
Other	Anxiety ☐	Celiac ☐	Herpes Simplex/Cold Sores ☐
	Other	Acid Reflux ☐	Herpes Zoster/Shingles ☐
		Other	Other
Ear, Nose & Throat:	**Cardiovascular:**	**Gyn/Urinary:**	**Endocrine:**
Hearing Loss ☐	Hypertension ☐	Kidney Disease ☐	Diabetes Type 1 Type 2 ☐
Sinusitis ☐	Heart Disease ☐	Prostate Disease ☐	Thyroid ☐
Dry Mouth ☐	Vasculitis ☐	Other	Hormonal Dysfunction ☐
Laryngitis ☐	Congestive Heart Failure ☐		Other
Other	Other	Nursing	
		Pregnant (trimester:)	**Hematology/Lymph:**
			Anemia ☐
			Large Volume Blood Loss ☐
			Ulcer ☐
			High Cholesterol ☐
Neurology:	**Respiratory:**	**Muscular/Skeletal:**	Other
Multiple Sclerosis ☐	Cigarette Smoker ☐	Arthritis/Osteoarthritis ☐	
Epilepsy ☐	Asthma ☐	Fibromyalgia ☐	**Allergy/Immunology:**
Cerebral Palsy ☐	Bronchitis ☐	Muscular Dystrophy ☐	Drug Allergies ☐
Tumors ☐	Emphysema ☐	Ankylosing Spondylitis ☐	Environmental Allergies ☐
Autism Spectrum Disorder ☐	COPD ☐	Gout ☐	Rheumatoid Arthritis ☐
Stroke/CVA ☐	Sleep Apnea ☐	Osteoporosis ☐	Lupus ☐
Migraines ☐	Other	Other	Sjogren's Syndrome ☐
Other			Other

Date of last physical/medical exam: _____

Name of Primary Care Doctor/Clinic: _____

Please Describe any Major Illnesses/Injuries/Surgeries/Procedures

_____

_____

Please List Your Current Medications and Vitamins: *(use additional paper if needed)*

Drug Name:	Dosage:	Taken How Often:	Reason for Taking:

Please List any Allergies to Medications:

_____

_____

Please List any Other Allergies (such as Latex, seasonal, etc.):

_____

_____

***Social History*:**

Do you drive? Yes ☐ No ☐

Alcohol Use: Yes ☐ No ☐ If yes, # _____ drinks per day/ week/ month ☐ ☐ ☐

Tobacco Use: Yes: Some days ☐ Everyday ☐ Never ☐

Former Smoker ☐ (For how long? _____ yrs/ mo) ☐ ☐

Type: cigarette/ cigar/ pipe/ smokeless/ vape Amount: _____ per day/ week

☐ ☐ ☐ ☐ ☐

Special Visual Needs for Work or Hobbies:

_____

_____

_____

Are you interested in LASIK or refractive surgery? Yes ☐ No ☐

***Family Medical History*:** *(check all that apply to blood relatives, parents, grandparents, siblings only)*

*Cancer	☐ Grandparents	☐ Father	☐ Mother	☐ Siblings
Hypertension	☐ Grandparents	☐ Father	☐ Mother	☐ Siblings
Hyperthyroid	☐ Grandparents	☐ Father	☐ Mother	☐ Siblings
Hypothyroid	☐ Grandparents	☐ Father	☐ Mother	☐ Siblings
Type 1 Diabetes	☐ Grandparents	☐ Father	☐ Mother	☐ Siblings
Type 2 Diabetes	☐ Grandparents	☐ Father	☐ Mother	☐ Siblings

*If checked yes, what type of cancer: _____

***Family Eye History**: (check all that apply to blood relatives, parents, grandparents, siblings only)*

Cataract	☐ Grandparents	☐ Father	☐ Mother	☐ Siblings
Macular Degeneration	☐ Grandparents	☐ Father	☐ Mother	☐ Siblings
Glaucoma	☐ Grandparents	☐ Father	☐ Mother	☐ Siblings
Blindness	☐ Grandparents	☐ Father	☐ Mother	☐ Siblings
Keratoconus	☐ Grandparents	☐ Father	☐ Mother	☐ Siblings
Other:	☐ Grandparents	☐ Father	☐ Mother	☐ Siblings

Contact Lens History:

Are you interested in Contact Lenses? Yes ☐ No ☐

What brand and type of lens are you currently wearing?

What is your current power? Right _____ Left _____

What is the lens base curve? Right _____ Left _____

What is your lens diameter ? Right _____ Left _____

How often do you change your lenses? _____

What solution do you use? _____

Do you sleep in your lenses? Yes ☐ No ☐

If so, how often do you take them out? _____ For how long? _____

How many years have you worn contacts? _____

Are you happy with your current lenses? Yes ☐ No ☐

Do you have dryness with your current contact lenses? Yes ☐ No ☐

If there was one thing you could change about your contact lenses, what would it be?

Vista Vision
PREMIER FAMILY EYECARE

427 N. Loop 1604 W., Suite 203
San Antonio, TX 78232-1033
Office (210) 960-5494
Fax (210) 960-2261

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY. Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice).

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health 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 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 or attorney). "Health care operations" mean those administrative and managerial functions that we must carry out in order to run our office. 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.

OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. 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;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures 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;
- disclosure 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;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures 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;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of 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;
- disclosures to "business associates" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for health care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION

The following are some specific uses and disclosures we may not make of your health information **without** your authorization:

Marketing activities. We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent to such payment.

Sale of health information. We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.

Psychotherapy notes. Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

- Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization.

- You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.

- We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.

- We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right:

- **To request restrictions on the health information we may use and disclose for treatment, payment and health care operations.** We are not required to agree to these requests. To request restrictions, please send a written request to us at the address below.

- **To receive confidential communications of health information about you in any manner other than described in our authorization request form**. You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.

- **To inspect or copy your health information.** You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.

- **To amend health information.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:

    - was not created by us, unless the person that created the information is no longer available to make the amendment,
    - is not part of the health information kept by or for us,
    - is not part of the information you would be permitted to inspect or copy, or
    - is accurate and complete.

- **To receive an accounting of disclosures of your health information.** You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).

- **To designate another party to receive your health information.** If your request for access of your health information directs us to transmit a copy of the health information directly to another person, the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

Contact Person:

Our contact person for all questions, requests or for further information related to the privacy of your health information is:
Toni Racoma, O.D.
Vista Vision Premier Family Eyecare
427 N. Loop 1604 W., Suite 203
San Antonio, TX 78232
eyes@vistavisionsa.com
Phone (210) 960-5494 Fax (210) 960-2261

Complaints:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown above. If you prefer, you can discuss your complaint in person or by phone.

Changes to This Notice:

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

Notice Revised and Effective: February 16, 2017

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Vista Vision Premier Family Eyecare, Notice of Privacy Practices.

Patient Name:_____

Date_____ Patient name_____

Parent name (if applicable) _____

Patient/Parent Signature _____

Vista Vision
PREMIER FAMILY EYECARE

427 N. Loop 1604 W., Suite 203
San Antonio, TX 78232-1033
Office (210) 960-5494
Fax (210) 960-2261

Financial Policy

The doctor and staff at Vista Vision Premier Family Eyecare are pleased that you have chosen us for your eyecare needs. Please review our financial policy and acknowledge it with your signature below.

1. Payment for professional services (eye examinations, specialty testing, medical visits) is due the day services are provided. Payment for eyeglasses and contact lenses is due in full the day materials are ordered. For your convenience, we accept cash, debit cards, Visa, Mastercard, Discover, and Care Credit.
2. Eyeglasses are customized products and all optical sales are final.
3. Payments for copays, deductibles, and items known not to be covered by your insurance is due at the time of your visit. You are ultimately responsible for all charges for which your insurance company denies payment when we receive your *Explanation of Benefits* statement from them. Payment is due within 30 days after having been notified by your insurance and/or providers.
4. In the event that we do not participate with your Vision Plan or Medical Insurance, payment is due in full when services are rendered. We will provide you with an itemized receipt so that you may file with your carrier for reimbursement.
5. Both established and new contact lens wearers are subject to a contact lens medical evaluation and fitting fee. This fee is due at the date of the initial evaluation.
6. For those with Flexible Spending Accounts, payment in full is due for services rendered and materials ordered. An itemized statement that can be submitted to your insurance company for reimbursement will be given to you at the time of your visit.
7. If payment from your insurance company has not been received in 60 days, you will be responsible for paying your account balance in full.
8. Finance charges at the rate of 1.5% month (18% APR) will accrue on all outstanding balances.
9. In some families, the question of who is responsible for a child's bill is uncertain. Since we are not party to any separation agreement or court order, this is strictly a matter between parents. We must insist, therefore, that the parent who requests evaluation and treatment for the child will be responsible for all fees incurred.
10. If our office pursues legal action to collect unpaid charges, you will be billed the cost of attorney fees, courts costs, and collection fees in addition to any unpaid balances.

I have read and understand the above information and agree to the terms set forth in this agreement. I understand that if I fail to make any payments my account may be turned over to a collection agency.

_____
Patient Name

_____ _____
Signature of Patient or Legal Guardian Date

Vista Vision
PREMIER FAMILY EYECARE

427 N. Loop 1604 W., Suite 203
San Antonio, TX 78232-1033
Office (210) 960-5494
Fax (210) 960-2261

Annual Contact Lens Agreement

At **Vista Vision Premier Family Eyecare** we carry the latest in contact lens technology and specialize in the 'difficult-to-fit' patients. This includes astigmatism-correcting lenses (toric), multifocal lenses, corneal diseases (like keratoconus), and post-surgical contact lens fits. We are dedicated to your eye health and to an enjoyable, comfortable contact lens experience!

Contact Lens Medical Evaluation and Fitting Fee:
Contact lenses are medical devices which require ongoing evaluation to ensure safe and comfortable wear. This service is in addition to your annual comprehensive examination and covers the initial evaluation and all contact lens related follow up visits for a period of two (2) months. The contact lens medical evaluation and fitting fee includes:

- Evaluation of current, or new lens, fit on the eye
- Evaluation of corneal, conjunctival, and eyelid health as related to contact lens wear
- Evaluation of visual acuity and comfort in current, or new lens
- Progress checks related to changes in contact lens prescription or material for a period of two (2) months following initial evaluation

The **Contact Lens Medical Evaluation and Fitting Fee** will range in price depending on the complexity of the lens worn:

- Soft Lenses $75
- Rigid Gas Permeable (RGP) $150
- Specialty Contact Lenses $250
    - Bifocal/Multifocal RGP
    - Scleral
    - Keratoconus
    - Post Corneal Surgery
    - Hybrid Gas Perm/Soft

In addition, all new contact lens wearers will undergo training for the insertion and removal of contact lenses and for the proper care of their contact lenses. This one-time fee of $50 covers as many training sessions as needed.

Please note:

Fitting fees cover up to two (2) months of follow-up care. If you elect to forego the follow-up care and return beyond the initial two-month period, you will be charged a fee of $50. You must have follow-up care in order to finalize contact lenses, unless otherwise authorized by the doctor.

Contact lenses must be paid in full when you order your supply. If within the two month follow-up period you feel contact lenses are not for you please note that the Contact Lens Medical Evaluation and Fitting Fee will NOT be refunded. _____ (*initial*)

Fairness to Contact Lens Consumers Act: This act went into effect February 4, 2004. As stated by this Act, you are entitled to a copy of your contact lens prescription once the prescription is finalized by the examining doctor. Receiving a diagnostic lens is NOT a finalized prescription. A finalized prescription is determined at the follow-up appointment after you have been wearing the diagnostic lenses. Contact lenses are valid for one year, per Texas state law.

I have read and understand the above information and agree to the terms set forth in this agreement. I also acknowledge that I have had all my questions answered.

_____
Patient Name

_____ _____
Signature of Patient or Legal Guardian Date