



personalized eye care and eyewear boutique

702-459-3937

Welcome to our Office

Patient Information

Today's Date _____

Last _____

First _____ MI _____

Street _____

City _____ State _____

Zip Code _____

Home Phone _____

Work Phone _____

Patient's SSN _____

Date of Birth _____ Age _____

Employer (or School) _____

Occupation (or Grade) _____

Spouse (or Parent's) Name _____

Spouse (or Parent's) Work _____

Sex M F

Email Address _____

What is the major purpose of this visit? _____

Are you having any problems with your current contact lenses or glasses? _____

If this is your first visit here, who may we thank for referring you to our office? _____

If not referred, how did you choose our office?

- checkbox Another Dr.
checkbox Insurance List
checkbox Saw Sign/Building
checkbox Yellow Pages: Which directory?
checkbox Web Page: Which Web Site?
checkbox Other

Would you like more information on retinal photography, a painless, optional procedure which can help diagnose eye diseases and non-eye diseases at earlier stages? Yes No

At eye studio, our mission is to maximize your quality of life by providing state-of-the-art eye health and vision care as well as the finest eyewear products available in a comfortable and convenient setting.

Insurance Information

Primary Medical Insurance ID #

Subscriber Name

Subscriber SSN

Subscriber Birth Date

Secondary Medical Insurance ID#

Subscriber Name

Subscriber SSN

Subscriber Birth Date

Vision Insurance ID#

Subscriber Name

Subscriber SSN

Subscriber Birth Date

Lifestyle Questions

- Do you.....(check box if your answer is yes)
checkbox ..work at a computer?
checkbox ..think you might benefit from thinner, lighter lenses?
checkbox ..have interest in a "test drive" of the latest contact lens designs?
checkbox ..spend time outdoors?
checkbox ..have difficulty seeing the road or other vehicles?
checkbox ..have prescription sunwear?
checkbox ..prefer not to wear your glasses at times?
checkbox ..want information on Laser Vision Correction surgery?
checkbox ..have more than one pair of current Rx eyewear?
checkbox ..have children?
checkbox ..have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

- checkbox Blurry Vision
checkbox Burning
checkbox Cataracts
checkbox Corneal Abrasions
checkbox Crossed eye / Eye turn
checkbox Double Vision
checkbox Eye Infections
checkbox Eye Injury
checkbox Flash of light
checkbox Floaters/Spots
checkbox Glaucoma
checkbox Grittiness
checkbox Headaches
checkbox Iritis / Uveitis
checkbox Itchiness
checkbox Lazy Eye
checkbox Macular Degeneration
checkbox Dryness
checkbox Retinal Detachment
checkbox Sunlight Sensitivity
checkbox Tearing
checkbox Trouble seeing at night
checkbox Uncomfortable glasses
checkbox Other eye concerns

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History		
Name of Family Physician _____		
Address _____		
Phone # _____		
Date of Last Physical Check-up _____		
CURRENT MEDICATIONS (Rx or Over the Counter)		
(List name of medications including eye drops, vitamins, and birth control pills) _____		

Allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If so, what medications? _____		

Have you had any surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If so, please list _____		
Do you use cigarettes/tobacco, alcohol, or other substances? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever been diagnosed or treated for the following health problems?		
	Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood / Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears / Nose / Throat	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Muscle / Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>

Patient Eye History	
Date of Last Eye Exam _____	
By Whom? _____	
Have you ever tried contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What kind? _____	
Solutions used _____	
Are you satisfied with the vision and comfort of your contact lenses?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Would you prefer clear contact lenses or colored contact lenses?	
<input type="checkbox"/> Clear <input type="checkbox"/> Colored	
If you wear bifocals, do the lines or head tilting bother you?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Family Medical/Eye History (Check all that apply)	
Is there a family medical history of any of the following:	
<input type="checkbox"/> No <input type="checkbox"/> Yes (Please check boxes)	
	Relationship (Mother's or Father's side)
Blindness	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____
Assignment and release:	
I certify that I and/or my dependent(s) have insurance as listed on front page and assign directly to Korman Optometry Ltd. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Korman Optometry Ltd. may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.	
X _____	X _____
Signature of patient, or guardian Date	



Computer User Questionnaire

Many people experience a variety of symptoms after working at their computer for some period of time. Surprisingly, many don't relate those symptoms directly to using the computer. Instead, they mistakenly attribute headaches and tired eyes to overall stress at work, rather than to visual fatigue that can be alleviated simply with the proper eyewear prescription.

If you experience any of these symptoms, please indicate the level of discomfort below:

<i>Symptom</i>	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>
Headaches during or after working at the computer	_____	_____	_____
Overall bodily fatigue or tiredness	_____	_____	_____
Burning eyes	_____	_____	_____
Distance vision is blurry when looking up from the computer	_____	_____	_____
Dry, tired or sore eyes	_____	_____	_____
Squinting helps when looking at the computer	_____	_____	_____
Neck, shoulders, or back pain	_____	_____	_____
Double vision	_____	_____	_____
Letters on the screen run together	_____	_____	_____
Driving/night vision is worse after computer use	_____	_____	_____
"Halos" appear around objects on the screen	_____	_____	_____
Need to interrupt work frequently to rest eyes	_____	_____	_____

If you experience any of these symptoms, we offer a new type of eyewear lens that can eliminate the symptoms and dramatically improve your comfort level when working on a computer. These eyewear lenses result from new technology developed specifically for computer users. Our office has been trained and certified to pass this exciting technology on to you.

Please give this questionnaire to the Doctor for an explanation of how these eyewear lenses can help you.

Patient name: _____ Date: _____

FOR CONTACT LENS WEARERS:



We will take care of you when you get contact lenses from our office.

When you get fit with contact lenses at our office, all of your follow up visits for 3 months are included.

With a full year's supply of lenses, you'll get...

- ✓ The convenience of always having fresh contact lenses on hand so that your eyes remain healthy
- ✓ To exchange unopened boxes of lenses if your prescription changes during the year
- ✓ To use your insurance benefits
- ✓ Rebate offers (for most lenses), which we have already filled out for you
- ✓ To exchange opened boxes of lenses which you feel may be defective
- ✓ Complimentary shipping to your home if you choose
- ✓ **Complimentary** polarized sunglasses (non-prescription) or \$50 toward any sunglasses you desire



We all know how bright it gets here...

All of our sunglasses will protect your eyes and surrounding skin from ultraviolet radiation (UV) which can cause cataracts, macular degeneration, and cancer.

Quality polarized sunglasses will also help prevent wrinkles by minimizing squinting.

Polarized lenses eliminate blinding glare (as from your windshield) increasing your comfort, depth perception, contrast vision, color vision, and central vision (ability to see shapes and details clearly).

We feel so strongly about being your partner in eye health that we will **GIVE YOU** a pair of polarized sunglasses (safety driving lenses) to wear over your contact lenses when you get your year's supply of contacts from our office.

Acknowledgment of Receipt

Federal law requires that we seek your acknowledgment of receipt of this Notice of Privacy Practices. Please sign below.

I acknowledge that I have received this Notice of Privacy Practices with an effective date of January 28, 2008, and that I understand that if I have any questions regarding this Notice, I may contact the Privacy Officer.

Signature: _____ Date: _____

Printed Name: _____

Signature of Parent/Guardian (specify which):

_____ Date: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY KORMAN OPTOMETRY LTD. AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

effective date: January 28, 2008

UNDERSTANDING YOUR PATIENT HEALTH INFORMATION (PHI):

Understanding what is in your health record and how your health information is used will help you to ensure its accuracy, allow you to better understand who, what, when, where and why others may access your health information, and assist you in making more informed decisions when authorizing disclosure to others. When you visit us, we keep a record of your symptoms, examination, test results, diagnoses, treatment plan, and other medical information. We also may obtain health records from other providers. In using and disclosing this protected health information (PHI) we will follow the Privacy Standards of the Federal Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Part 464. The law allows us to use and disclose PHI without your specific authorization for treatment, payment, operations and other specific purposes explained on the next page. This includes contacting you for appointment reminders and follow-up care. All other uses and disclosures require your specific authorization.

YOUR HEALTH INFORMATION RIGHTS: You have the right to:

- Request a restriction on the uses and disclosures of PHI as described in this notice, although we are not required to agree to the restriction you request. You should address your request in writing to the Privacy Officer. We will notify you within 30 days if we cannot agree to the restriction.
- Obtain a paper copy of this Notice and upon written request, inspect and obtain a copy of your health record for a fee of \$.20 per page and the actual cost of postage per **NRS 629.061**, except that you are not entitled to access to, or to obtain a copy of, psychotherapy notes and information compiled for legal proceedings.
- Amend your health record by submitting a written request with the reasons supporting the request to the Privacy Officer. In most cases, we will respond within 30 days. We are not required to agree to the requested amendment.
- Obtain an accounting of disclosures of your health information, except that we are not required to account for disclosures for treatment, payment, operations, or pursuant to authorization, among other exceptions.
- Request in writing to the Privacy Officer that we communicate with you by a specific method and at a specific location. We will typically communicate with you in person; or by letter, e-mail, fax, and/or telephone.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

OUR RESPONSIBILITIES: The law requires us to:

- Maintain the privacy of PHI and provide you with notice of our legal duties and privacy practices with respect to PHI.
- Abide by the terms of the notice currently in effect. We have the right to change our notice of privacy practices and we will apply the change to all of your protected health information, including information obtained prior to the change.
- Post notice of any changes in our privacy policy in the lobby and make a copy available to you upon request.
- Use or disclose your health information only with your authorization except as described in this notice.
- Follow the more stringent law in any circumstance where other state or federal law may further restrict the disclosure of your health information.

FOR MORE INFORMATION OR TO REPORT A PROBLEM, you may contact the designated Privacy Officer, Dr. Shana Korman, in writing at 2870 Bicentennial Parkway, Suite 130, Henderson, NV 89044 or by calling 702-459-3937. If you feel your rights have been violated, you may file a complaint in writing with the Privacy Officer. If you are not satisfied with the resolution of the complaint, you may also file a complaint with the Secretary of Health and Human Services. Filing a complaint will not result in retaliation.

We may use or disclose your protected health information for treatment, payment and operations, and for purposes described below:

Treatment: We will use and exchange information obtained by a physician, nurse practitioner, nurse or other medical professionals, staff, trainees and volunteers in our office to determine your best course of treatment. The information obtained from you or from other providers will become part of your medical records. We may also disclose your health care information to other outside treating medical professionals and staff as deemed necessary for your care. For example, we may disclose your health information to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment.

Payment: We may send a bill to you or to your insurance carrier. The information on or accompanying the bill may include information that identifies you, as well as that portion of your PHI necessary to obtain payment.

Health Care Operations: Members of the medical staff, trainees, medical students, a Risk or Quality Improvement team, or similar internal personnel may use your information to assess the care and outcomes of your care in an effort to improve the quality of the healthcare and service we provide or for educational purposes. For example, an internal review team may review your medical records to determine the appropriateness of care. There may also be times in which our accountants, auditors or attorneys may be required to review your health information to meet their responsibilities.

Other uses and disclosures not requiring authorization

- Business Associates: There are some services provided to our organization through contracts with business associates, such as laboratory and radiology services. We may disclose your health information to our business associates so that they can perform these services. We require the business associates to safeguard your information to our standards.
- Notification: We may disclose limited health information to friends or family members identified by you as being involved in your care or assisting you in payment. We may also notify a family member, or another person responsible for your care, about your location and general condition.
- Legally Required Disclosures, Public Health & Law Enforcement: We may disclose PHI as required by law, or in a variety of circumstances authorized by federal or state law. For example, we may disclose PHI to government officials to avert a serious threat to health or safety or for public health purposes, such as to prevent or control communicable disease (which may include notifying individuals that may have been exposed to the disease, though in such circumstance you will not be personally identified), to an employer to evaluate whether an employee has a work related injury, and to public officials to report births and deaths.
- We may disclose PHI to law enforcement such as limited information for identification and location purposes, or information regarding suspected victims of crime, including crimes committed on our premises. We may also disclose PHI to others as required by court or administrative order, or in response to a valid summons or subpoena.
- Information Regarding Decedents: We may disclose health information regarding a deceased person to: 1) coroners and medical examiners to identify cause of death or other duties, 2) funeral directors for their required duties and 3) to procurement organizations for purposes of organ and tissue donation.
- Research: We may also disclose PHI where the disclosure is solely for the purpose of designing a study, or where the disclosure concerns decedents, or an institutional review board or privacy board has determined that obtaining authorization is not feasible and protocols are in place to ensure the privacy of your health information. In all other situations, we may only disclose PHI for research purposes with your authorization.
- Marketing: We may contact you with information about treatment alternatives or other health related benefits and services that may be of interest to you.
- Fund raising: We may contact you as part of a fund raising effort.
- Directory information: We may disclose limited information regarding your name and location for directory purposes to those persons who ask for you by name or to members of the clergy. You may request that we not include your name in the directory.

Disclosures requiring authorization

All other disclosures of protected health information will only be made pursuant to your written authorization, which you have the right to revoke at any time, except to the extent we have already relied upon the authorization.