Dr. James P. Powers
Board Certified Ophthalmologist, Vitreoretinal Surgeon

Healthy Vision
INSTITUTE

A Complete Diabetic & Senior Care Center

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, is kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provided penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service.

An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of July 25, 2012 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violation of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information: For more information about HIPAA or to file a complaint:

The US Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue SW
Washington, DC 20201
(202) 619-0257 (Toll Free 1-877-696-6775)

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. **I understand that "protected health information" is information about me, including demographic information, that may identify me and that relates to my past, present or future physical or mental health or condition and related health care services.**

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____Date: ____ / ____ / _____

Please list the names of persons who we may share your Personal Health Information with (e.g. diagnosis, treatment, labs etc.) We must have your signed permission to give your Personal Health Information to family members or close friends.

_____	_____	_____
Name	Relationship	Phone #
_____	_____	_____
Name	Relationship	Phone #

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Patient Name: _____ **DOB:** _____ **Today's Date:** _____

Eye Medical History: Please place a checkmark and approximate date under each eye that applies to you.

Eye Diagnosis:	**Right Eye/Date:**	**Left Eye/Date:**
Macular Degeneration		
Diabetic Retinopathy		
Cataracts		
Dry Eye Disease		
Choroidal Nevus/Freckle		
Macular Pucker		
Scar Tissue		
Retinal Detachment		
Retinal Tear		
Bleeding in Eye		
Glaucoma		
PVD/Floaters		
Retinal Vascular Occlusion		
Retinal Artery Occlusion		

Do You Wear OTC Readers? If so, what strength +1.50 +2.00 +2.50 +3.00 +3.50. How Long? _____
How Old Are your Current Spectacles ? _____

Please List All Medicine Allergies: _____
Have You ever had an Allergic Reaction to Anesthsia? YES NO Drug:_____

Have you ever had any major surgery? If so, please list: _____

Eye Surgical History: Please place a checkmark and approximate date under each eye that applies to you.

Surgery Type:	**Right Eye/Date:**	**Left Eye/Date:**
Cataract Surgery:		
Diabetic Laser:		
YAG Capsulotomy:		
PI Laser/Narrow Angle Glaucoma:		
Glaucoma Laser:		
Retinal Surgery:		
Brow/Eyelid Lift:		
Retinal Laser:		
Eye Injections:		

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Patient Name: **DOB:** **Today's Date:**

Eye Drop Medications?

Drop Name:	**Right Eye:**	**Left Eye:**	**How Many Times a Day:**	**Start Date:**
Artificial Tears/Gel				

Family Eye Medical History: Please place a check mark where appropriate.

Family Medical History	**Yes**	**No**	**Mother**	**Father**	**Sister**	**Brother**	**GrandParent**
Blindness							
Macular Degeneration							
Glaucoma							
Retinal Detachment							
Cancer							
Diabetes							
High Blood Pressure							

Are You Being Treated For Any Medical Conditions? Please check YES or NO.

Diagnosis :	**YES**	**NO**
HTN		
HEART DZ		
TYPE 1 DIABETES	**A1C:**	
TYPE 2 DIABETES	**A1C:**	
HCHO		
CANCER	**What Type?** **Chemo?** **Radiation?**	
ARTHRITIS	**Have you ever taken Plaquenil?**	
OTHER:		
OTHER:		

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Patient Name: _____ **DOB:** _____ **Today's Date:** _____

Social History	**Yes/No**	**How Much?**	**# Day**	**# Week**	**Occasional**	**Former**
Do you drink alcohol ?						
Do your smoke?						

Please Circle "YES" or "NO" for each of the following questions:

Have you ever had TB? YES NO
Have you lived with anyone in the past year who has had TB? YES NO
Do you experience severe coughing or coughing up blood? YES NO
Have you had your COVID Vaccine? YES NO Date: _____
Have you ever had a blood transfusion? YES. NO

Review of Symptoms	**Yes**	**No**
CardioVascular: chest pain, irregular heartbeat, shortness of breath		
Ear/Nose/Throat: dizziness, hearing loss, sore throat		
Musculoskeletal: back pain, joint pain, muscle aches, stiffness, swelling		
Respiratory: cough, trouble breathing, wheezing		
Constitutional: fatigue, fever, night sweats, weakness, weight loss		
Hematologic: bleeding, bruising, tender nodes		
Neurological: balance problems, headache, numbness, tingling		
Skin: hair loss, rash, skin lesions		
Genitourinary: genital discharge, painful ruination, blood in urine		
Metabolic: excess hunger, excess thirst , frequent urination		
Psychiatric: anxiety, depression, insomnia		
Allergy: itching, hives, runny nose, seasonal allergies		

Patient Signature: _____ **Date:** _____

Dr. James Powers has reviewed this Medical/Surgical/ROS History..

Dr. James Powers: _____ **Date:** _____

Healthy Vision Medication Log

Key Below

By Mouth	PO	OD	Discontin	D/C
Subcutaneous (Inj.)	SQ	OS	Reviewed	√
Sublingual	SL	OU	New	N

Patient Name:

Medication	Dosage	FREQ.	Route	Diagnosis	Date	Date	Date	Date	Date	Date	Date	Date	Date
Technician Updated Initials													

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Patient Name:

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