PLAZA VISION CENTER
ADVANCED EYE CARE SPECIALISTS

New Patient Packet

Please take a moment to read over this information. Our goal is to offer you the most effective and comprehensive care possible. To help us help you, please fill out the following forms. We will hold any information that you provide us in the strictest confidence.

BEFORE YOU COME TO SEE US

- Please make a note of each and every medication, both prescription and "over the counter," that you take, and the dosages of each medication.
- Please check with your human resource personnel at your company to see if you have any vision plans that we do not know about.
- Please make a note of each contact lens storage solution that you use.
- Please fill out each of the forms that we have provided you and return them to us by e-mail of facsimile. If return these forms to use prior to your visit, then we can prepare your patient record in advance, thus, shortening your visit.

WHEN YOU COME TO SEE US

- Please bring your medical insurance and your vision insurance cards with you to your examination.
- If you wear contact lenses, please wear your lenses in for your visit.
- Please bring any copies of any written contact lens or glasses prescriptions that you may have with you to your examination.
- Please bring the boxes or lens packs from your current contact lenses with you to your examination.
- Please bring all of your glasses with you to the examination.

HOW TO FIND US

You can find us on the web at: www.drnewman.com

Our physical address is:

Clarke D. Newman, OD, PC
Plaza Vision Center
Plaza of the Americas
600 North Pearl Street, Suite G-204
Dallas, TX 75201-7492
214-969-0467 (Telephone)
214-969-0468 (Facsimile)

FREE PARKING AND ARRIVAL AT PLAZA VISION CENTER

When you reach Plaza of the Americas, you can park in the Plaza of the Americas Garage. We offer three-hours of free parking. You do not need to bring your parking ticket with you. We can provide a validation ticket to you when you arrive. However, please make sure to secure your parking ticket in a safe place. Lost tickets cannot be validated, and it costs more than $10.00 to exit the garage if you lose your ticket!

You enter the Plaza Garage off of San Jacinto Street. It is the first parking entrance on your right-hand side after you cross Pearl Street. It is a tight spiral upward. Park and then come down one of the four glass elevators to the "L" Level. Turn to your right after you exit the elevators. We are about 100 feet down on your left.

PLAZA VISION CENTER
ADVANCED EYE CARE SPECIALISTS

Tell Us About You!

Please take a few moments to fill out the following information. Just type in the information in the grey boxes. To advance to the next box, hit the "Tab" key. If you e-mail it to Plaza Vision Center in advance, then we can prepare your patient record ahead of time. We value your time, and we want to make your examination as efficient as possible. Thank You!

Please Fill in this Information About the Patient to Be Seen											
First Name											
Middle Name											
Last Name											
Name Preference (Nick Name)											
Salutation	■ Mr. ☐ Ms. ☐ Mrs. ☐ Miss ☐ Dr. ☐ Father ☐ Reverend										
Sex	■ Male ☐ Female										
Date of Birth	Month		Day		Year		Age				
Social Security Number											
Driver's License Number	State				Number						
Address ■Home ☐Work						Apt. #					
City											
State											
Zip											
Home Telephone	Area Code		Number								
Work Telephone	Area Code		Number			Extension					
Cellular Telephone	Area Code		Number			Extension					
E-Mail Address	@										
Occupation											
Employer											
How Did You Find Us?	☐ Location ☐ Vision Plan ☐ Web Site ☐ Yellow Pages ☐ Mailings ☐ Referral										
Who Referred You?											
Previous Eye Doctor											
Current Physician											
Marital Status	■ Single ☐ Married ☐ Divorced ☐ Widowed										
Spouse / Partner Name											
Children' Name			Age				Age				
			Age				Age				
Hobbies											

Plaza Vision Center • 600 North Pearl Street, Suite G-204 • Dallas, Texas 75201-7492
Voice: 214.214.969.0467 • Facsimile: 214.969.0468 • E-Mail: www.drnewman.com

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Insurance Verification Form

To insure that we know about all of your insurance, please take a moment to complete the following information. We need to verify all of your insurance information prior to your visit. The requested information on this form can be found on the front and the back of your insurance card. To complete this form, press the "Tab" key to move to the next field.

YOUR MEDICAL HEALTH INSURANCE INFORMATION

PRIMARY MEDICAL INSURANCE	
Name of Patient	
Name of Insured	
Relation to Patient	☐ Self ☐ Spouse ☐ Partner ☐ Other:
Insurance Company	☐ BC/BS PPO ☐ United HealthCare ☐ CIGNA HMO ☐ Humana ☐ PHCS ☐ Aetna ☐ True-Choice ☐ Medicare ☐ Medicaid
Plan Group Number	
Member Identification Number	
Verification Telephone Number	
SECONDARY MEDICAL INSURNACE	
Name of Patient	
Name of Insured	
Relation to Patient	☐ Self ☐ Spouse ☐ Partner ☐ Other:
Insurance Company	☐ BC/BS PPO ☐ United HealthCare ☐ CIGNA HMO ☐ Humana ☐ PHCS ☐ Aetna ☐ True-Choice ☐ Medicare ☐ Medicaid
Plan Group Number	
Member Identification Number	
Verification Telephone Number	

YOUR VISION INSURANCE INFORMATION

Name of Patient							
Name of Insured							
Relation to Patient	☐ Self ☐ Spouse ☐ Partner ☐ Other:						
Insurance Company	☐ Vision Service Plan ☐ Eye-Med ☐ Vision Benefits of America ☐ Vision Care Plan of America						
Plan Group Number							
Insured's Social Security Number							
Insured's Date of Birth	Month		Day		Year		

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NEW PATIENT MEDICAL HISTORY AND REVIEW OF SYSTEMS FORM

PATIENT NAME:	AGE:	TODAY'S DATE: MM	DD	201

WHEN WAS YOUR LAST EYE EXAMINATION? ☐FIRST EXAM

WHEN WAS YOUR LAST MEDICAL EXAMINATION?

DO YOU WEAR GLASSES? ☐YES ☐NO ☐I USED TO WEAR GLASSES ☐BROKEN ☐LOST

DO YOU WEAR CONTACT LENSES? ☐NO ☐SOFT LENSES ☐RIGID GAS PERMEABLE LENSES ☐I USED TO WEAR LENSES

PLEASE LIST THE NAMES AND RESPECTIVE DOSAGES OF ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING, INCLUDING BIRTH CONTROL PILLS, HERBAL REMEDIES, AND NON-PRESCRIPTION MEDICATIONS

LIST ANY KNOWN DRUG ALLERGIES: ☐NONE

PLEASE CHECK ANY CONDITIONS THAT APPLY TO YOU OR YOUR BLOOD RELATIVES

CONDITION	PATIENT HISTORY	FAMILY HISTORY	RELATIONSHIP TO PATIENT / NOTES
BLURRY VISION	☐YES ☐NO ☐???		
EYE PAIN	☐YES ☐NO ☐???		
CATARACT	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
GLAUCOMA	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
RETINAL PROBLEMS	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
MACULAR DEGENERATION	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
STRABISMUS (EYE TURN)	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
AMBLYOPIA (LAZY EYE)	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
EYE INJURY	☐YES ☐NO ☐???		
EYE SURGERY	☐YES ☐NO ☐???		
DRY EYES	☐YES ☐NO ☐???		
ITCHY EYES	☐YES ☐NO ☐???		
LIGHT FLASHES	☐YES ☐NO ☐???		
FLOATERS	☐YES ☐NO ☐???		
RED EYES	☐YES ☐NO ☐???		
HIGH BLOOD PRESSURE	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
CARDIOVASCULAR DISEASE	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
DIABETES	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
THYROID DISEASE	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
KIDNEY DISEASE	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
ARTHRITIS / JOINT PAIN	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
LUPUS	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
STROKE	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
CANCER	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
HEARING DISORDER	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
HIV / AIDS	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
HEPATITIS	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
TUBERCULOSIS	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
DRY SKIN / DRY MOUTH	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
WEIGHT LOSS / GAIN	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
SHORTNESS OF BREATH	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
ULCER	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
DIGESTIVE PROBLEMS	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
DIZZINESS	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
HEADACHES	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
MIGRAINE HEADACHES	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
SINUS PROBLEMS	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
ALLERGIES	☐YES ☐NO ☐???	☐YES ☐NO ☐???	

IF YOU ANSWERED "YES," PLEASE LIST YOUR ALLERGIES:

SEIZURE DISORDER	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
DEPRESSION	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
NUMBNESS	☐YES ☐NO ☐???	☐YES ☐NO ☐???	
SLEEP PROBLEMS	☐YES ☐NO ☐???	☐YES ☐NO ☐???	

DO YOU USE TOBACCO PRODUCTS?

☐NO ☐YES, FOR YEARS ☐I QUIT_____YEARS AGO
☐CIGARETTES, _____PACKS PER DAY ☐OTHER

DO YOU USE A COMPUTER?

☐NO ☐YES, FOR_____HOURS PER DAY

ARE YOU INTERESTED IN WEARING CONTACT LENSES?

☐YES ☐MAYBE ☐NO ☐I'D LIKE TO KNOW MORE

ARE YOU INTERESTED IN REFRACTIVE SURGERY?

☐YES ☐MAYBE ☐NO ☐I'D LIKE TO KNOW MORE

Plaza Vision Center Notice of Privacy Practices

Clarke D. Newman, OD, PC
d/b/a Plaza Vision Center
600 North Pearl Street, Suite G-204, Dallas, TX 75201
214-969-0467 ***www.drnewman.com***
Clarke D. Newman, OD, FAAO, Privacy Officer

IN COMPLIANCE WITH THE STATE AND FEDERAL PRIVACY RULES, THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO IT. PLEASE REVIEW IT CAREFULLY

We respect our legal obligation to keep private any health information that might identify you. We are obligated by law to provide you with 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 reasons we would use or disclose your health information is for treatment, payment, or business operations. We routinely use and disclose medical information among the office staff. We do not need specific permission to use or disclose your medical information in the following matters, although you have the right to request that we do not.

Examples of how we might use or disclose health information for treatment purposes might include:

Making or changing appointments, including leaving messages with those at your home or office who may answer the phone, or leaving messages on answering machines, voice mails or e-mails; prescribing glasses, contact lenses, or medications, as well as relaying this information to suppliers by phone, fax or other electronic means including initial prescriptions and requests from suppliers for refills; notifying you that your ophthalmic goods are ready, including leaving messages at your home or office with whomever may answer the telephone, or leaving messages on answering machines, voice mails or e-mails; referring you to another doctor for care not provided by this office; obtaining copies of health information from doctors you have seen before us; discussing your care with you directly or with family or friends you have inferred or agreed may listen to information about your health; sending you postcards or letters or leaving messages with those at your home who may answer the phone or on answering machines, voice mails or e-mails reminding you it is time for continued care.

Examples of how we might use or disclose health information for payment purposes might include:

Asking you about your vision or medical insurance plans or other sources of payment; preparing and sending bills to your insurance provider or to you; providing any information required by third party payers to insure payment for services rendered to you; collecting unpaid balances either ourselves or through a collection agency, attorney, or district attorney's office.

Examples of how we might use or disclose health information for health care operations might include:

Financial or billing audits; internal quality assurance programs; participation in managed care plans; defense of legal matters; business planning; certain research functions; informing you of products or services offered by our office; compliance with local, state, or federal government agencies request for information; oversight activities such as licensing of our doctors; Medicare or Medicaid audits.

USES AND DISCLOSURES FOR OTHER REASONS NOT NEEDING PERMISSION

In some other limited situations, the law allows us to use or disclose your medical information without your specific permission. Most of these situations will never apply to you, but they could.

- **When a state or federal law mandates that certain health information be reported for a specific purpose**
- **For public health reasons, such as the reporting of a contagious disease, investigations or surveillance, and notices to and from the Federal Food and Drug Administration regarding drugs or medical devices**
- **Disclosures to government or law enforcement agencies about victims of suspected abuse, neglect, domestic violence, or when someone is, or suspected to have been, a victim of a crime**
- **Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative hearings**
- **Disclosures to a medical examiner to identify a deceased person or determine cause of death or to funeral directors to aid in burial**
- **Disclosures to organizations that handle organ or tissue donations**
- **Uses or disclosures for health related research**
- **Uses or disclosures to prevent a serious threat to the health or safety of an individual or individuals**
- **Uses or disclosures to aid military purposes or lawful national intelligence activities**
- **Disclosures of de-identified information**
- **Disclosures related to a workman's compensation claim**
- **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 and disclosures**
- **Disclosures to business associates who perform health care operations for Clarke D. Newman, OD, PC d/b/a Plaza Vision Center, and who commit to respect the privacy of your information**
- **Unless you object, disclosure of relevant health information to family members or friends who are helping you with your care, who through their presence, implies that we may do so**

USES OR DISCLOSURES TO PATIENT REPRESENTATIVES (DESIGNATED AGENT)

It is the policy of Plaza Vision Center for the staff to take phone calls from individuals, acting as your designated agent, requesting information about making or changing an appointment; the status of eyeglasses, contact lenses, or other optical goods ordered by or for you. The staff will make every effort to insure that the individual is in fact your designated agent. The Plaza Vision Center staff will also assist individuals on your behalf in the delivery of eyeglasses, contact lenses, or other optical goods. During a telephone or an in-person contact, every effort will be made to limit the encounter to only the specifics needed to complete the transaction required. No information about your vision or health status shall be disclosed without proper patient consent. The Plaza Vision Center staff and doctors will also infer that if you allow another person in an examination or treatment room with you while testing is performed or discussions held about your vision or health care that you consent to the presence of that individual.

OTHER USES AND DISCLOSURES

We will not make any other use or disclosure of your health information unless you sign a written *Authorization for Release of Identifying Health Information*. Federal law determines the content of this authorization. The request for signing an authorization may be initiated by Clarke D. Newman, OD, PC, or by you as the patient. We will comply with your request if it is applicable to the State or the Federal policies regarding authorizations. If we ask you to sign an authorization, you may decline to do so. If you do not sign the authorization, we may not use or disclose the information we intended to use. If you do elect to sign the authorization, you may revoke it at any time. Revocation requests must be made in writing to the Privacy Officer named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your personal health information.

You may ask us to restrict our uses and disclosures for purposes of treatment (except in emergency care), payment, or business operations. This request must be made in writing to the Privacy Officer named at the beginning of this Notice. We do not have to agree to your request, but if we agree, we must abide by the restrictions you ask for.

You may ask us to communicate with you in a confidential manner. Examples might be only contacting you by telephone at your home or using some special e-mail address. We will accommodate these requests if they are reasonable and if you agree to pay any additional cost, if any, incurred in accommodating your request. Requests for special communication requests must be made to the Privacy Officer named at the beginning of this Notice.

You may ask to review or get copies of your health information. There are a very few limited situations in which we may refuse your access to your health information. For the most part, we are happy to provide you with the opportunity to either review or obtain a copy of your medical information. All requests for review or copy of medical information must be made in writing to the Privacy Officer named at the beginning of this Notice. While we usually respond to these requests in just a day or so, by law we have fifteen (15) days to respond to your request. We may request an additional thirty (30) day extension in certain situations.

You may ask us to amend or change your health care information if you think it is incorrect or incomplete. If we agree, we will make the amendment to your medical record within thirty (30) days of your written request for change sent to the Privacy Officer named at the beginning of this Notice. We will then send the corrected information to you or any other individual you feel needs a copy of the corrected information. If we do not agree, you will be notified in writing of our decision. You may then write a statement of your position and we will include it in your medical record along with any rebuttal statement we may wish to include.

You may request a list of any non-routine disclosures of your health information that we might have made within any six (6) year, or shorter, period beginning from April 15, 2003. Routine disclosures would include those used your treatment, payment, and business operations of Clarke D. Newman, OD, PC d/b/a Plaza Vision Center. The routine disclosures listed above will not be included in your list of disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you must pay for them in advance at a fee of $75.00 per list. We will usually respond to your written request (made to the Privacy Officer named at the beginning of this Notice) within thirty (30) days but we are allowed one thirty (30) day extension if we need the time to complete your request.

You may obtain additional copies of this Notice of Privacy Practices from our business office or online at our website address shown at the beginning of this Notice.

CHANGING OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change the Notice. We reserve the right to change this Notice at any time. If we change this Notice, the new privacy practices will apply to your existing health information as well as any additional information generated in the future. If we change this Notice, we will post a new Notice in our office and on our website.

COMPLAINTS

If you think that anyone at Plaza Vision Center has not respected the privacy of your health information, you are free to complain to the Privacy Officer named at the beginning of this Notice. We are more than happy to try to resolve any concern you may have in writing or by phone. You may also file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you if you make such a complaint.

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

State and Federal laws require that Clarke D. Newman, OD, PC d/b/a Plaza Vision Center make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

(Please choose from the following, and check only one box.)

☐ I have read, or have had explained to me, Plaza Vision Center's Notice of Privacy Practice, and I agree to continue my care with Plaza Vision Center under the terms of that Notice.

☐ I was given the opportunity to read Plaza Vision Center's Notice of Privacy Practice and declined, but I wish to continue my care with Plaza Vision Center under the terms of that Notice.

☐ I have read, or have had explained to me, Plaza Vision Center's Notice of Privacy Practice, and I do not wish to continue my care with Plaza Vision Center under the terms of that Notice.

☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care, or due to some other reason described below:

_____

_____

REQUEST FOR INFORMED CONSENT FOR PUPILLARY DILATION AND OTHER TESTS

Pupillary Dilation is the use of medicine eye drops that act, temporarily, to increase the size of the light opening, or pupil, of the eye. **Dilation is a necessary part of a complete eye examination. Without a dilated eye examination, certain eye diseases and abnormalities can go undetected. Dr. Newman strongly recommends pupillary dilation each time you have a routine eye examination.** These drops sting slightly upon installation, but this effect lasts only a few seconds. They also temporarily decrease your ability to change focus. This effect can blur your near vision, and, if you are far-sighted, can blur your distance vision as well. Following dilation, you will be light sensitive, and your vision may be blurry. **Great caution is advised after leaving our office—especially when driving or going up or down stairs!**

In some patients, pupillary dilation can cause a rare condition called, "Acute Narrow Angle Glaucoma." If you are at risk for this condition, Dr. Newman will discuss it thoroughly with you before he dilates your eyes. If Dr. Newman determines that your eyes do not need to be dilated today, he will tell why it is not necessary.

Based on the results of your examination, additional tests may be medically necessary. Dr. Newman will thoroughly discuss those tests with you should the need arise. There may be additional charges for these tests, and they may or may not be covered under your general health insurance. If these tests are covered by your health insurance, then you may be responsible for unmet deductibles and co-payments.

☐ I consent to pupillary dilation ☐ I consent to additional testing

☐ I do not consent to pupillary dilation ☐ I do not consent to additional testing

_____ / /201

PATIENT SIGNATURE **TODAY'S DATE**

_____ _____

PATIENT REPRESENTATIVE **RELATIONSHIP TO PATIENT**