Massachusetts Eye Associates
Notice of Privacy Practices

I understand that the doctors and staff at Massachusetts Eye Associates are called "providers" and that if I want to receive care, I need to give them permission to share information about my health among themselves and with other individuals for evaluation, treatment, and continuity of my health care.

I understand that **Massachusetts Eye Associates has a Notice of Privacy Practices that describes in detail how my health care information is used and shared with others.** This notice explains when I need to give further approval for providers to use my health information or share it outside of the Practice, and when my permission is not needed for the providers to use it or share it outside of the Practice. I understand that I have a right to request a copy of the Notice and I have the right to read the Notice of Privacy Practices before signing this consent.

By signing below, I acknowledge that I have read and understood the Notice of Privacy Practices Policy for Massachusetts Eye Associates and consent to the uses and disclosures therein.

_____
Patient Name (please print)

_____
Patient/Guardian Signature

Patient Financial Agreement

The following information outlines your financial responsibility related to payment for professional services.

We participate in most major health plans. We have contracts with many HMO's, PPO's, insurance companies, vision plans and government agencies including Medicare and Medicaid. Our business office will submit claims for any services provided to a patient who is a member of one of these plans and will assist you in any reasonable way we can to help get your claim paid; however, this is not a guarantee of payment.

You are responsible for any charges not paid by your insurance. It is your responsibility to provide all necessary information before leaving the office. If you have a secondary insurance, we will automatically file a claim with them as soon as your primary insurance has paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

By obtaining medical services provided by Massachusetts Eye Associates, I authorize my insurance carrier to make payments directly to Massachusetts Eye Care, P.C. for medical, diagnostic, or surgical services rendered.

_____
Patient/Guardian Signature

Health History

Name:_____ **Date:**_____

Ocular History	YES	NO	Description
Cataracts	_____	_____	_____
Glaucoma	_____	_____	_____
Retinal Disease	_____	_____	_____
Macular Degeneration	_____	_____	_____
Diabetic Retinopathy	_____	_____	_____
Eye Injury	_____	_____	_____
Strabismus (e.g. Crossed Eyes)	_____	_____	_____
Amblyopia (e.g. Lazy Eye)	_____	_____	_____
Dry Eyes	_____	_____	_____
Glasses	_____	_____	_____
Contact Lenses	_____	_____	_____
Other	_____	_____	_____

Family History	YES	NO	Relation
Cataracts	_____	_____	_____
Glaucoma	_____	_____	_____
Retinal Disease	_____	_____	_____
Macular Degeneration	_____	_____	_____
Strabismus (e.g. Crossed Eyes)	_____	_____	_____
Amblyopia (e.g. Lazy Eye)	_____	_____	_____
Blindness	_____	_____	_____
Cancer	_____	_____	_____
Heart Disease	_____	_____	_____
Diabetes	_____	_____	_____
Other	_____	_____	_____

Please list all medical conditions:

_____
_____
_____
_____
_____

Please list all medications you are now taking, including over the counter drugs and supplements. Please list dosage if possible:

_____
_____
_____
_____
_____

Please list all medications you are allergic to: _____

Please list all surgeries you have had, including date of surgery and doctor who performed the surgery if possible:

_____
_____
_____
_____
_____

Social History	**Yes**	**No**	**If so, how much**	**Former Smoker**
Smoking	_____	_____	_____	_____
Alcohol	_____	_____	_____	
Recreational Drugs	_____	_____	_____	
Occupation	_____			
Hobbies	_____			

Please turn the page to complete the other side ➔

Name: _____ **Date:** _____

Review of Systems Check here if all normal _____

Constitutional	YES	NO
Fever	____	____
Chills	____	____
Night Sweats	____	____
Fatigue	____	____
Weight Change	____	____
Cardiovascular		
Chest Pain	____	____
Irregular heart rhythm	____	____
Irregular heart rate	____	____
Leg Swelling	____	____
Syncope (Fainting)	____	____
Ear, Nose & Throat (ENT)		
Ear Pain	____	____
Hearing Loss	____	____
Sinus Pain	____	____
Sore Throat	____	____
Tinnitus (ringing in ears)	____	____
Vertigo	____	____
Respiratory		
Cough	____	____
Wheezing	____	____
Shortness of Breath	____	____
Sleep Apnea	____	____
Gastrointestinal		
Abdominal Pain	____	____
Change in Appetite	____	____
Constipation	____	____
Diarrhea	____	____
Nausea	____	____
Vomiting	____	____
Genitourinary		
Dysuria (painful urination)	____	____
Hematuria (blood in urine)	____	____
Change in urine stream	____	____
Urethral discharge	____	____
Lesion	____	____

Musculoskeletal	YES	NO
Back Pain	____	____
Neck Pain	____	____
Joint Pain	____	____
Muscle Pain	____	____
Integumentary		
Bruising	____	____
Skin Rash	____	____
Skin Lesion	____	____
Neurological		
Abnormal Balance	____	____
Confusion	____	____
Numbness	____	____
Weakness	____	____
Difficulty with Speech	____	____
Headache	____	____
Psychiatric		
Anxiety	____	____
Depression	____	____
Mania	____	____
Suicidal Thoughts	____	____
Delusional	____	____
Hallucinations	____	____
Endocrine		
Excessive Thirst	____	____
Polyuria (excessive urination)	____	____
Cold Intolerance	____	____
Heat Intolerance	____	____
Excessive Hunger	____	____
Hemato/Lymphatic		
Excessive Bleeding	____	____
Excessive Bruising	____	____
Allergy		
Immunocompromised	____	____
Recurrent Fevers	____	____
Recurrent Infections	____	____
Malaise	____	____

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION WITH DESIGNATED PARTIES

Patient Name: _____ Date of Birth: _____

I authorize the doctors and staff of Massachusetts Eye Associates to discuss the medical care of the patient named above with the people listed below.

PLEASE DESIGNATE FAMILY MEMBERS AND/OR INDIVIDUALS WITH WHOM WE CAN SHARE YOUR MEDICAL INFORMATION:

	Name	Phone Number	Relationship
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

I understand that I can revoke this authorization at any time and that my treatment is not contingent on my signing this authorization.

Patient: _____
(print name)

Patient representative: _____
(print name)

Signature of patient or patient's representative: _____

Date: _____

Please bring your signed forms and completed health care questionnaire with you to your appointment.