CHRISS & ASSOCIATES, M.D., P.A.

LISA W. CHRISS, M.D., F.A.C.S.

OPHTHALMOLOGY
DISEASES AND SURGERY OF THE EYE

your eye mds®

1925 MIZELL AVENUE, SUITE 302
WINTER PARK, fl 32792
407.629.6646
407.740.5089 (Fax)

Dear New Patient:

Thank you for choosing us as your ophthalmologists. We look forward to seeing you in our office on

_____ at _____.

When you come for your examination, please bring the following with you:

1. Prescription eyeglasses.
2. All eye drops you are currently using.
3. All oral medicines you take.
4. Your contact lens bottles or prescriptions available.
5. All of your contact lens solutions.
6. Insurance cards and Identification card.
7. Sunglasses.

If you are scheduled for a complete exam, your pupils will be dilated. This will cause some blurring of your vision for a limited time, usually no more than 4 to 5 hours. Occasionally the blurring may last 12 to 24 hours. You may want to have a driver with you to drive you home from your visit.

Our policy is that all visits are paid at the time of service. Medicare patients are financially responsible for yearly deductibles and the 20% that Medicare does not pay. We accept cash, check, American Express, MasterCard, Visa, and Discover, for your convenience.

Again, we thank you for allowing us to provide your eye health care and look forward to getting to know you.

Sincerely,

The Office of Chriss & Associates, M.D., P.A.

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Information and Consent for Refractions
(Exam for glasses)

Refraction is the process of determining your need for corrective eyeglasses or contact lenses. Unless you have a vision care option on your insurance policy, refraction is **NOT** a covered service by Medicare or most insurance plans. Major medical insurance companies do not pay for a non-covered service. Insurance companies consider the provision of a written prescription for glasses a separate and distinct service. Our office attempts to screen your vision prior to the refraction to determine if you would benefit by having one. If it is determined that your vision could improve refraction will be recommended.

The fee for refraction must be collected from the patient, in addition to any co-payment or deductible amounts your plan requires, at the time of service. Our current charge for refraction is $40.00.

Feel free to contact your insurance carrier after your appointment to see if this is a covered service under your plan. If so, you will be able to send your receipt to them for reimbursement.

Patient Consent:

I have read the above and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand that payment of $40.00 is due at the time refraction is performed. I understand that any co-payment or deductible amounts I may have are separate from the refraction fee.

_____ _____

Patient Name Date

_____ _____

Patient Signature Date

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PATIENT INFORMATION SHEET

Last Name:_____ First Name:_____ Init: _____Preferred Name:_____

Age: _____ Gender: _____Marital Status:_____ Spouse or Guardian:_____

Street: _____ City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Email:_____ SSN:_____ DL #:_____DOB:_____

RACE: 1.) Black / African American 2.) American Indian / Alaskan Native 3.) Native Hawaiian / Pacific Islander

4.) Asian 5.) White

ETHNICITY (country of heritage): 1.) Non-Hispanic or Non-Latino 2.) Hispanic or Latino

EMPLOYER INFORMATION

Patient's Employer:_____ Occupation:_____

Employer Address:_____

EMERGENCY CONTACT

Name: _____Phone: _____

PHARMACY INFORMATION

***I give permission for my doctor and her office staff to communicate with my pharmacy to facilitate my care._____ (Init.)**

Pharmacy or Mail Order Pharmacy_____ Phone Number: _____

Pharmacy Address: _____ Fax Number: _____

PHYSICIAN INFO

Primary Care Physician: _____Phone:_____Fax:_____

Address: _____

Please list any other doctors that you would like our office to correspond with regarding your care.

Name:	Type:	Phone:	Fax:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

INSURANCE INFORMATION

Are you over 65, employed and covered by your employer's group health? Yes / No

Are you over 65, retired and covered by Medicare & a supplemental plan? Yes / No

Primary Insurance:

Insurance company:_____ Policy #:_____ Group #: _____

Address: _____Phone Number: _____

Policy Holder Name:_____Date of Birth:_____

SSN:_____Relationship to Patient: _____

Secondary Insurance:

Insurance company:_____ Policy #:_____ Group #: _____

Address: _____Phone Number: _____

Policy Holder Name:_____Date of Birth:_____

SSN:_____Relationship to Patient: _____

Release of Information ***(HIPAA Release Form):***

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Spouse: _____

Child(ren): _____

Other: _____

☐ Information is **NOT** to be released to anyone.

Messages:

Please call the number(s) below to remind of my appointments:

☐ My Home ☐ My Cell ☐ My Work

If unable to reach me:

☐ You may leave a detailed message ☐ Please leave a message asking me to return you call ☐ Do NOT leave me a message

****** This Release of Information will remain in effect until terminated by me in writing. ******

Lifetime Signature Authorization

I hereby authorize said assignee to release all information necessary to secure payments for medical services rendered to myself or dependents. I authorize the name insurance carriers to pay directly the doctors named. I am aware that Medicare may deem some services as not medically necessary or are non-covered services based on the Medicare B guidelines. I acknowledge and accept liability for payment of these services.

Patient Signature:_____**Date:**_____

This form will assist your physician in your care. Please read and fill out carefully.

Patient Name: _____ Referring Doctor _____

Have you ever been treated/ informed you have any of the following? Please circle and provide the date.

	Yes/No	When?		Yes/No	When?
Eye injury	Y N	_____	Glaucoma	Y N	_____
Cataract	Y N	_____	Retinal Detachment	Y N	_____
Amblyopia	Y N	_____	Lazy/cross eye	Y N	_____
Glasses	Y N	_____	Dry Eyes	Y N	_____
Corneal Disease	Y N	_____	Uveitis	Y N	_____
Inflammation of the eye	Y N	_____	Shingles on your face	Y N	_____
Brain Tumor	Y N	_____	Autoimmune Disease (Lupus, Sjogrens, Rheumatoid)	Y N	_____

Please circle all that apply:

Difficulty Sleeping	Sense of Smell	Ulcers	Decreased ROM
Drowsiness	Allergies	Cramps	Arthritis
Fatigue	Sinusitis	Difficulty Swallowing	Blood Disorder
Malaise	Non-Insulin Diabetes	Depression	Bleeding Disorder
Poor Appetite	Insulin Dependent	Manic-Depression	Bruise Easily
Weight Loss	Diabetes	Panic Attacks	Anemia
Weight Gain	Borderline Diabetic	Anxiety	Leukemia
Stroke	Hypoglycemic	Suicide Attempts	Hepatitis
TIA (Stroke)	Thyroid Problems	Mood Swings	HIV
Seizures	Goiter	Bi-Polar	Rashes
Headaches	Nervousness	Difficulty Urinating	Itching
Migraine Headache	High Cholesterol	Frequent Urination	Psoriasis
Paralysis	Heart Attack	Incontinence	Color Change
Tremor	Angina	Blood in Urine	Masses/Lesions
Alzheimer's	High Blood Pressure	Frequent Bladder	Tags
Asthma	Varicose Veins	Infections	Acne
COPD	Blood Clots in Legs	Kidney Stones	Rosacea
Emphysema	Murmur	Prostate Cancer	Melanoma
Shortness of Breath	Irregular Heart Beat	STD	
Wheezing	Heart Problems	Yeast Infection	Other:
TB	Hypertension	Joint Pain	_____
Bronchitis	Heart Disease	Muscle Aches	_____
Hearing Problems	Constipation	Muscle Weakness	_____
Tinnitus	Diarrhea	Back Pain	_____
Vertigo	Bowel Habits Change	Neck Pain	_____
Ear Infections	Acid Reflux	Leg Cramps	

Besides yourself, has anyone in your immediate family ever been treated/informed they had any of the following?

	Family Member		Family Member
Glaucoma	_____	Amblyopia	_____
Cataract	_____	Lazy eye/cross eye	_____
Retinal Detachment	_____	Migraine headache	_____
Macular Degeneration	_____	Other eye problems	_____

SEE BACK →

List names and allergic reactions to medications _____

_____

List any previous surgeries_____

_____

Approximate date of last eye exam _____ How old are your glasses? _____

Have you ever worn contact lenses? _____ Type _____

Do you use tobacco? ____ How many packs a day? _____ Do you drink alcohol? ____ How often? _____

Please list ALL of your medications, vitamins, and supplements that you are CURRENTLY taking and return this form to our office at your next appointment or before your surgery.

MEDICATION	DOSAGE	DIRECTIONS

Patient Signature _____ Date _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME _____

ADDRESS_____

TELEPHONE_____ EMAIL_____

SOCIAL SECURITY #_____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practice: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our Privacy Practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time, by contacting:

Contact: CHRISS & ASSOCIATES, M.D., P.A.
Telephone: 407-629-6646
Address: 1925 Mizell Ave Ste. 302
Winter Park, FL 32792

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to one of the locations listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your

revocation, and that we may decline to treat you or to continue treating you if your revoke this Consent.

SIGNATURE

I _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature _____ Date _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative' Name: _____
Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed consent in patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my consent.

Signature _____ Date _____

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NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

Date: _____

I acknowledge that I was provided with a copy of the Chriss & Associates, M.D., P.A., Notice of Privacy Practices.

_____ _____

Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below.

_____ _____

Personal Representative (Print) Personal Representative's Signature

_____

Relationship

****

For Chriss & Associates, M.D., P.A. use only

Complete this section if this form is not signed and dated by the patient or patient's personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of the C & A privacy practices but was unable to for the following reason:

____ Patient Refused to Sign
____ Patient Unable to Sign
____ Other

_____

Employee Name Date

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YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director

- Address workers' compensation, law enforcement, and other government requests.
- Respond to lawsuits and legal actions.

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical records

- You can ask to see or get an electronic or paper copy your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hippa/complaints/.**
- We will not retaliate against you for filling a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your case.
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hippa/understanding/consumers/index.html.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy laws.

Respond to organs and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hippa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Notice must also include:

Effective Date of this Notice: 4.30.15