DR. KENNETH A. LEBOW, O.D. & GRIFFEY EYE CARE ("GRIFFEY EYE CARE")
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY:
Griffey Eye Care is required to comply with all applicable federal and state laws to maintain the privacy of your Protected Health Information ('PHI'). PHI is defined as "any individually identifiable health information that relates to any physical or mental health or that can otherwise be used to identify the individual".

Griffey Eye Care is also required to provide you with this notice about our privacy practices, our legal obligations, and your rights concerning your PHI. This notice is effective September 23, 2013 and is subject to any amendments enacted by the governing statutes. Periodic amendments may also be made in order to clarify certain language of the applicable laws and statutes. Due to the Health Information Technology for Economic and Clinical Health (HITECH) Act under the American Recovery and Reinvest Act (ARRA) of 2009, the HIPAA Privacy Rules have evolved and took final form with the release of the Omnibus Privacy Final Rules issued in January of 2013.

You may request a copy of this notice (or any subsequent revision of this notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information:
Griffey Eye Care may use and disclose your PHI to (1) facilitate your medical treatment, (2) obtain payment from your health insurance company for medical services, and (3) industry standard health care operations. Such use and disclosure of your PHI is considered under HIPAA as **"permissible use"**. Any and all "permissible use" of your PHI will be made within "**minimum necessary**" limitations, and only to facilitate specific activity directly relative to treatment, payment and / or operations.

Following are examples of permissible use of your PHI.

Treatment: Griffey Eye Care may use and disclose your PHI to provide, coordinate, or manage your health care and any related services as recommended by your medical provider. This includes the coordination or management of your health care with a third party or other physicians who may currently be involved with your medical care or whom it may be determined by your medical condition to be required with your medical care for the purposes of diagnosis and treatment (i.e. specialist, laboratory, hospital, or other facility).

Payment: Griffey Eye Care may use and disclose your PHI to obtain payment for your health care services. This may include providing copies of the pertinent medical record to your health insurance plan in order to determine eligibility and benefits, obtain pre-authorization on your behalf for recommended medical services, review of medical services provided to you to confirm medical necessity, and other health plan utilization review activities. For example, obtaining approval for a hospital admission may require that your relevant PHI be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: Griffey Eye Care may use and disclose your PHI in order to facilitate industry standard business and operational activities. These activities include, but are not limited to, daily clinic operations relative to scheduling, appointment reminders, assembly and maintenance of your medical record, and inter-departmental coordination of your medical care. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name, call you by name in the waiting room when your doctor is ready to see you, or contact you by telephone or mail to ensure necessary continuum of care or other related activities.

Griffey Eye Care may share your PHI with third party "**business associates**" that perform certain activities (i.e. billing, transcription services) for the company. Whenever an arrangement between our office and a business associates involves "permissible use" of your PHI, your PHI is protected by a **Business Associate Agreement** that contains terms that will protect your PHI.

Uses and Disclosures Based On Your Written Authorization: Any other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below.

You may give us written authorization to use your PHI or to disclose it to anyone for any purpose. Your written authorization may be revoked in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Without your written authorization, we will not disclose your health care information except as described in this notice.

Health information that has been properly de-identified is not protected by the HIPAA Privacy Rule and may be used for research and other statistical purposes.

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify as an emergency contact, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition, or death.

Patient Communication / Marketing: Patients in our practice may be contacted via SMS text messages for appointment reminders, appointment confirmations, to gather feedback regarding their experience or with promotional offerings. We may use your PHI to contact you with information about treatment alternatives that may be of benefit or interest to you via mail, email, or SMS text messaging. We may disclose your PHI to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

Uses and Disclosures Required by Law:

Research; Death; Organ Donation: Your (de-identified) PHI may be used or disclosed for research purposes in limited circumstances. Your PHI may be disclosed to a coroner, protected health examiner, funeral director, or organ procurement organization under specific circumstances.

Public Health and Safety: Your PHI may be disclosed to the extent necessary to avert a serious and imminent threat to your personal health or safety, or the public health or safety of others. Your PHI may be disclosed to a government health agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: Your PHI may be disclosed to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: Your PHI may be disclosed to a public health authority that is authorized by law to receive reports of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: Your PHI may be disclosed to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable state and federal laws, your PHI may be disclosed, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: Your PHI may be disclosed when we are required to do so by law. For example, we must disclose your PHI to the U.S Department of Health and Human Services upon request for purposes of determining whether we are in compliance with privacy laws. We may disclose your PHI when authorized by Workers' Compensation or other similar laws.

Process and Proceedings: Your PHI may be disclosed to legally authorized law enforcement officials in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Griffey Eye Care may disclose PHI of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose PHI where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or who has escaped from lawful custody.

Access: You have the right to review or obtain copies of your PHI, with limited exceptions. You must make a request in writing to the primary practice location where you have most recently received medical services. You may also request access by sending us a letter to the address at the end of this notice. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you.

Accounting for Disclosures: You have the right to receive a list of instances in which we or our business associates used or disclosed your PHI for purposes other than treatment, payment, health care operations and certain other activities after April 14, 2003. After April 14, 2003, the accounting will be provided for the past six (6) years. We will provide you with the date on which we made the disclosure, the name of the person or entity to which we disclosed your PHI, a description of the PHI we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction Requests: You have the right to request that we place additional restrictions on the use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency or as required by law). Any agreement we may make on such a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your PHI by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it (1) is reasonable, (2) specifies the alternative means or locations, and (3) continues to permit Griffey Eye Care to bill and collect payment for medical services rendered to you in good faith.

Amendment: You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. If we comply with your request, we will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of the information.

Electronic Notice: If you receive this notice on our website or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain the notice in written form.

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.

Breaches: You will be notified immediately if we receive information that there has been a breach involving your PHI.

Website Privacy: Any personal information you provide us with via our website, including your e-mail address, will never be sold or shared with any third party without your express permission. If you provide us with any personal contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason. While we may track the volume of visitors on specific pages of our website and download information from specific pages, these numbers are used in aggregate and without any personal information. This demographic information may be shared with our partners, but it is not linked to any personal information that can identify you or any visitor to our site.

Our site may contain links to other websites. We cannot take responsibility for the policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim, or damages caused in whole or part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. **Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use it.**

Questions and Complaints:

If you want more information about our privacy practices or if you have questions or concerns, please contact Griffey Eye Care's HIPAA Privacy Officer indicated below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI or in response to a request you made, please submit your concerns in writing to the Griffey Eye Care HIPAA Privacy Officer indicated below. You also may submit your concerns to the U.S Department of Health and Human Services upon request.

We support your right to protect the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S Department of Health and Human Services.

HIPAA Privacy Officer:

Telephone: (757) 410-9500
Office: 560 Kempsville Road, Suite 100, Chesapeake, VA 23320

GRIFFEY EYE CARE & LASER CENTER

Kenneth A. Lebow, O.D., F.A.A.O. & Associates

DR. KENNETH A. LEBOW, O.D. & GRIFFEY EYE CARE (GEC)
PATIENT ACKNOWLEDGEMENT AND AUTHORIZATION

Patient Name: _____ Patient Medical Record #: _____

Consent to Use and Disclose PHI & Acknowledgement of Receipt of Notice of Privacy Practices:
General consent to use and disclose personal health information to carry out treatment, payment for treatment and health care operations.

With my signature below, I give GEC permission to disclose my personal health information as necessary to carry out treatment, obtain payment for treatment provided to me and to carry out its health care operations. I understand that I may be contacted via SMS text messages for appointment reminders, appointment confirmations, to gather feedback regarding my experience or with promotional offerings.

A complete description of how GEC will use and disclose my personal health care information can be found in its Notice of Privacy Practices which has been made available to me.

I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that the Notice of Privacy Practices may be revised at any time by GEC and that I may view changes to the Notice of Privacy Practices at their website at www.drlebow.com or by requesting a printed copy of revision from the Compliance department in writing. I hereby acknowledge that I have received, and have had the opportunity to ask questions regarding, a copy of the GEC Notice of Privacy Practices.

I have the right to request restrictions regarding how my personal health information is used or disclosed in the course of carrying out treatment, obtaining payment for treatment provided to me and carrying out health care operations. I may request restrictions by filling out the appropriate form which will be provided to me upon request. GEC is under no obligation to implement any of the restrictions that I may request but will be bound by any restrictions that it agrees to implement.

I understand that I may revoke this consent at any time notifying GEC in writing, except to the extent that action has been take in reliance on it.

Patient's / Patient's Legal Representative Signature: _____ **Date:** _____

If signed by Representative, state relationship to patient: _____

Authorization to Release Protected Health Information (PHI):

I hereby authorize GEC to release my PHI to the following person(s) and understand that I may revoke this authorization in writing at any time. I understand that such disclosures may include, but not be limited to, discussing my medical condition(s) and treatment(s) with individuals that accompany me to my appointments and / or are responsible for my care-giving, leaving voice mail messages regarding appointments and / or balances due on my account, and any emergency situation which may arise in the course of my care.

Name of Authorized Person	Relationship	Daytime Phone Number

Patient's / Patient's Legal Representative Signature: _____ **Date:** _____

If signed by Representative, state relationship to patient: _____

Documentation of Good Faith Efforts (To be completed if patient unable or unwilling to sign above):

On this day, patient presented for treatment and was provided a copy of the GEC's Notice of Privacy Practices. Although a good faith attempt was made to obtain a written Acknowledgement of Receipt and Authorization to Release, signatures were not obtained because:

_____ Patient / Legal Representative refused
_____ Patient / Legal Representative unable due to medical disability
_____ Emergency medical condition required immediate attention (signature to be obtained at next appointment)

Printed Name of GEC Employee: _____

Signature of GEC Employee: _____ **Date:** _____

Internal Use Only

GRIFFEY EYE CARE
& LASER CENTER

Kenneth A. Lebow,
O.D., F.A.A.O.
& Associates

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

Dr. Kenneth A. Lebow, O.D. and Griffey Eye Care (GEC) are privately-owned medical facilities that provide medical services on a fee-for-service basis. GEC relies solely on insurance reimbursement and patient payment(s) for services rendered in good faith. GEC receives no federal, state or other third-party funding; as such, GEC does not have provision for providing on-going indigent care. The following Financial Agreement is developed in accordance with Office of Inspector General (OIG) guidelines as well as all applicable State and Federal reimbursement guidelines.

For the convenience of our patients, GEC participates with most medical insurance companies and vision plans. GEC will submit claims for all medically necessary services to your insurance company. Please note that payment is ultimately due from you if your insurance company denies payment for any service(s); i.e. termination of coverage, coordination of benefits, non-payment of premium, non-participating status, etc. If we do not participate with your medical or vision insurance(s), we will provide you with an itemized receipt so that you may file with your insurance company for any out-of-network benefits to which you may be entitled.

Deductibles, coinsurances, and any non-covered services are the responsibility of the patient. To the extent possible and feasible, all patient financial responsibilities are payable at the time of service and / or prior to surgical procedures. Not all health insurance companies publish their (allowable) fee schedule; therefore, coinsurance percentages cannot always be accurately calculated for pre-payment. A GEC statement will be sent to you after your health insurance has processed your claim(s); the balance due will compare to the Explanation of Benefits you will receive from your health insurance company. Should you dispute any amount on your Explanation of Benefits / statement, please contact your health insurance company member services for clarification of your benefits.

Please note that GEC medical providers are ethically obligated to assign diagnosis code(s) as indicated by the provider's diagnostic findings and in accordance with prudent medical standards. It is therefore inappropriate to request that a diagnosis be changed in the event your health insurance plan denies coverage at their discretion. Any such request will be denied; to comply would constitute insurance fraud and misrepresentation of the medical documentation relative to your care.

Copayment(s), as stipulated by your health insurance company, are due on the date of service.

Please note that OIG guidelines (FR Vol. 65, No. 194, Oct.5, 2000) relative to anti-kickback statutes, as well as contractual obligations to the health insurance companies from whom GEC will seek reimbursement for medical services, prohibit the routine discounting of published fees, "insurance-only billing" or waiver of any insurance-assigned charges otherwise due from the patient.

Self-Pay: In the event that (1) you are uninsured, (2) GEC and / or its affiliated facilities does not have a participating relationship with your health insurance plan(s), or (3) you elect to have non-covered medical services (i.e., cosmetic or other services determined by your health insurance plan to be "not medically necessary", etc.), GEC accepts self-pay patients with this signed agreement that payment is due on the day services are rendered or in the case of surgical procedures, payment is due prior to the surgical procedure(s).

GEC does not accept litigated cases and services are not provided on a contingency basis under any circumstances.

GEC is not a banking institution and does not assess finance charges to cover the operational cost of managing payments by installment; therefore, no internal financing options (i.e. budget or other installment plans) can be extended.

For your convenience, GEC accepts cash, check, money order and credit cards. In addition, GEC offers financing options through third party vendors.

I understand all the terms defined above; I consent to receiving treatment under the stated terms and I agree to honor all my financial obligations to GEC. I hereby authorize the provider and its employees, agents, and assignees, to contact me via e-mail, text message and to my cellular device.

I hereby assign all medical / surgical benefits to GEC, for services rendered to me by the medical providers contracted under GEC and request that payment of authorized benefits be made to assignee on my behalf. I authorize release of any medical information as may be required by Medicare and / or my other health insurance company to determine my benefits and issue payment to assignee for related medical claims.

My signature below constitutes my Financial Agreement, Assignment of Benefits, and Lifetime Signature Authorization.

Patient Name Printed	Patient / POA Signature	Date

Failure to honor your financial obligations to GEC in accordance with this signed Agreement will result in your account being referred to Collections and termination of the treatment relationship in accordance with the regulations that govern ethical medical care.

Griffey Eye Care & Laser Center

Kenneth A. Lebow, O.D., F.A.A.O. & Associates

EXPLANATION OF COVERAGE

Section 1: Coding & Billing for Your Comprehensive Eye Exam:

At Dr. Kenneth A. Lebow, O.D. & Griffey Eye Care (GEC), we ask that patients take some time to fully understand the coverage and benefits of their medical and vision insurance(s). Routine and medical benefits are very different in terms of the services they cover. Vision plan coverage is designed for routine eye exams which may include an annual eye exam to evaluate the health of the eyes, determine of the need for glasses / contact lenses and certain benefits to help pay for glasses or contact lenses.

It is the responsibility of the patient to notify GEC prior to their exam if they have routine coverage or a separate vision plan. **If a medical diagnosis is identified (or suspected) during a routine eye exam and additional testing and treatment is medically indicated, the provider reserves the right to evaluate and treat such medical issues.** GEC is required by our medical insurance and vision plan contractual relationships to submit the claim(s) to the appropriate carrier. To minimize out-of-pocket expense to our patients, we will submit the routine exam to your vision plan (which typically imposes a lesser copayment). However, any medical evaluation, diagnostic testing and treatment will be billed to your medical insurance, and you will be financially responsible for any applicable deductibles, co-insurances, and non-covered services in accordance with the benefits of your medical insurance.

The chart shown below helps illustrate the coding process for comprehensive eye exams.

Comprehensive Eye Exam includes:

- A health, medication and vision history
- A refraction (best visual acuity test) – See the Refraction Service & Fee section below.
- An examination of the front of the eye which includes the sclera, cornea, pupil iris, eyelid and conjunctiva
- A dilated examination and / or diagnostic image of the back of the eye which allows the Physician to observe your retina and optic nerve

Based on the results of the exam, the Physician determines if the visual changes you are experiencing are due to refractive error or are disease-related changes. The Physician may order additional testing, refer you to another specialist or advise other treatments as needed.

Routine Coding:

If you have vision changes of normal refractive error, including nearsightedness, farsightedness or astigmatism your exam will be coded as routine.

Medical Coding:

If the Physician diagnoses a medical condition such as high blood pressure, diabetes, or an eye disease such as, cataracts, glaucoma, infections, dry eyes, allergy, etc. your exam will be coded as a medical comprehensive eye exam.

Comprehensive exams that are billed **medically** are not covered under your routine or vision plan coverage and will be submitted to your medical insurance company. Please note that even if your exam is billed to your medical insurance, any glasses / contact lens benefits that you may have would still be available to you. In the event you want a routine exam for a glasses or contact lens prescription only, it is your responsibility to immediately inform the Physician and understand that any medical complaints or findings will be addressed at a separate visit.

Section 2: Refraction Service & Fee:

A refraction is a vision test that is routinely performed during an eye exam and is vital to determine your best potential vision. A refraction evaluates the function of your eyes and provides essential information to determine if you would benefit from a prescription for glasses and / or contact lenses. This important part of your eye exam helps the Physician to better

understand the full potential of your visual system, identify any medical concerns that may be impacting your vision and determine your correct prescription.

The refraction is **not** a covered service by Medicare and many other medical insurance plans. **The fee for the refraction is $45** and unless your plan covers the refraction fee, it is collected at the time of service in addition to any copayment your plan may require. Separate vision plans will cover a refraction fee. Should your plan pay for the refraction, we will reimburse you accordingly.

Section 3: Contact Lens Management & Fee:

If you are having an eye examination and currently do not wear contact lenses, your Physician may provide contact lenses as an option to, or in addition to, wearing glasses. In addition to the comprehensive eye exam and the cost of the contact lens, a professional management fee is charged. Management fees vary and are determined by the complexity of your medical diagnosis and required prescription and include 60 days of follow-up care related to your new contact lenses.

If you are having an eye examination and wear contact lenses, our professional staff will be evaluating your current contact lenses to determine the present appropriateness of your lenses. **Contact lens prescriptions generally are valid for one to two years**. An evaluation is performed every year in order to manage your prescription. *Additional fees will apply regardless of changes to your contact lens prescription.*

Contact lens management fees are collected at the time of service in addition to any copayment your plan may require. Some vision plans provide limited coverage for contact lens fitting. Should your plan pay for the management fee, we will reimburse you accordingly.

Section 1: Coding & Billing for Your Comprehensive Eye Exam:

I understand that I am here today for a comprehensive eye exam, and I have checked with my insurance to understand my medical and/or routine benefits. I understand that the exam will be coded as routine or medical based on the results, diagnosis and suggested treatment of the comprehensive eye exam performed by my doctor.

Initials: _____

Section 2: Refraction Service & Fee:

I understand the refraction is an important and necessary part of a comprehensive eye exam and that some insurance plans, including Medicare, do not cover this cost. I understand the cost is $45 and is due at the time of service.

Initials: _____

Section 3: Contact Lens Management & Fee:

I understand that contact lens fitting is an additional service to a comprehensive eye exam and is not covered by most insurances. The cost of the contact lens fitting is dependent on the type of contact lenses I am being fit for and the time, measurement and trials that go into that particular lens fitting. I understand I will be made aware of the cost of the fitting by my doctor and this cost will be due upon checkout after my comprehensive eye exam.

Initials: _____

I have read and understand the above information. I authorize Dr. Kenneth A. Lebow & Griffey Eye Care to file claim(s) with my appropriate insurance(s). I accept full financial responsibility for the cost of a refraction and / or contact lens management, if provided, and understand payment is due at time of service. I understand that any copayment, coinsurance or deductible I may have are separate from and not included in either the refraction fee or contact lens management fee. My signature below constitutes my understanding of this explanation of coverage and Lifetime Signature Authorization.

_____	_____	_____
Patient Name Printed	**Patient / POA Signature**	**Date**

Griffey Eye Care & Laser Center

Kenneth A. Lebow, O.D., F.A.A.O. & Associates

PATIENT REGISTRATION FORM

Today's Date: _____

Patient Name: Mr. Mrs. Ms. Dr. _____

Date of Birth: _____ **SSN:** _____ ☐ Male ☐ Female

Address: _____

Home Number: _____ **Cell Phone:** _____

Email Address: _____ **Marital Status:** _____

Race: ☐ White ☐ American Indian/Eskimo/Aleut ☐ Asian ☐ Black or African American

☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Decline to Specify

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify

Language: ☐ English ☐ Haitian Creole ☐ Russian ☐ Spanish ☐ Other: _____

VA Resident: ☐ Full Time ☐ Part Time If Part Time, please complete information below.

From: _____ To: _____ Secondary Home Phone: _____

Secondary Address: _____

Other Eye Care Physician: _____ Phone: _____ Fax: _____

Responsible Party Information (If different from above):

Name: _____ Date of Birth: _____

Primary Insurance: _____ **Policy #:** _____

Secondary Insurance: _____ **Policy #:** _____

Are you or your spouse employed full time or part time? ☐ Yes ☐ No

If so, do you have health insurance through your employer? ☐ Yes ☐ No

Are you enrolled in an HMO? ☐ Yes ☐ No

Do you need authorization from your Primary Physician to see a specialist? ☐ Yes ☐ No

Have you been in a skilled nursing a facility and/or hospice care in the past 6 months? ☐ Yes ☐ No

If yes, what is the name of the Facility? _____

How did you hear about Dr. Lebow / Griffey Eye Care? ☐ Billboard/Building Signage ☐ Doctor ☐ Event

☐ Family/Friend ☐ Google/Online Search ☐ Other: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Primary Care Physician: _____ Phone: _____

Address: _____ Fax: _____

Primary Eye Physician: _____ Phone: _____

Address: _____ Fax: _____

Height: _____ **Weight:** _____

Ocular History:

☐ Yes	☐ No	Cataracts	☐ Yes	☐ No	LASIK / Epi-LASEK
☐ Yes	☐ No	Cornea Transplant	☐ Yes	☐ No	Macular Degeneration
☐ Yes	☐ No	Diabetic Retinopathy	☐ Yes	☐ No	Punctal Plugs
☐ Yes	☐ No	Dry Eye Syndrome	☐ Yes	☐ No	Retinal Detachment
☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	YAG Laser

☐ Other: _____

What is the reason for your visit today?

☐ Blurred Vision	RT	LT	☐ Dry Eyes	RT	LT	☐ Itching	RT	LT
☐ Decreased Vision	RT	LT	☐ Flashes	RT	LT	☐ Pain	RT	LT
☐ Discharge	RT	LT	☐ Floaters	RT	LT	☐ Red Eye	RT	LT
☐ Double Vision	RT	LT	☐ Headache	RT	LT	☐ Tearing	RT	LT

☐ Other: _____

Immunization / Vaccination:

☐ Yes ☐ No Influenza Date/s: _____

☐ Yes ☐ No Pneumococcal Date: _____

Surgical History:

☐ Yes	☐ No	Appendectomy	☐ Yes	☐ No	Hemorrhoidectomy
☐ Yes	☐ No	Carotid Endarterectomy	☐ Yes	☐ No	Hysterectomy
☐ Yes	☐ No	Gallbladder	☐ Yes	☐ No	Mastectomy
☐ Yes	☐ No	Heart Bypass	☐ Yes	☐ No	Prostate
☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Skin Cancer Removal

☐ Other: _____

Allergies:

☐ Yes ☐ No Latex Please describe: _____

☐ Yes ☐ No Anesthesia Please describe: _____

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Family History:

☐ Yes	☐ No	Cataracts	☐ Mother	☐ Father	☐ Other: _____
☐ Yes	☐ No	Diabetes	☐ Mother	☐ Father	☐ Other: _____
☐ Yes	☐ No	Glaucoma	☐ Mother	☐ Father	☐ Other: _____
☐ Yes	☐ No	Macular Degeneration	☐ Mother	☐ Father	☐ Other: _____
☐ Yes	☐ No	Retinal Detachment	☐ Mother	☐ Father	☐ Other: _____
☐ Other: _____			☐ Mother	☐ Father	☐ Other: _____

Social History:

Occupation: _____ ☐ Retired ☐ Disabled ☐ Not Working

Living Conditions: ☐ Alone ☐ Family ☐ Skilled Nursing ☐ Assisted Living

Hobbies: ☐ Computer ☐ Golf ☐ Reading ☐ Tennis ☐ Walking ☐ Other: _____

Driving: ☐ Yes ☐ No

Alcohol: ☐ Never ☐ Occasional / Social ☐ 1-2 Drinks / Day ☐ 3-4 Drinks / Day

Smoking / Tobacco: ☐ Never ☐ Former ☐ Light Smoker ☐ Heavy Smoker

Past / Present Medical History:

☐ Yes	☐ No	Abdominal Pain	☐ Yes	☐ No	Hearing Loss
☐ Yes	☐ No	Alzheimer's	☐ Yes	☐ No	Heart Attack: Year _____
☐ Yes	☐ No	Anxiety	☐ Yes	☐ No	High Blood Pressure/Hypertension
☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Irregular Heartbeat
☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Kidney Disease
☐ Yes	☐ No	Autoimmune Disease	☐ Yes	☐ No	Kidney Failure
☐ Yes	☐ No	Bleeding	☐ Yes	☐ No	Kidney Stones
☐ Yes	☐ No	Bruises	☐ Yes	☐ No	Migraine
☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Nausea
☐ Yes	☐ No	Cardiovascular Disease	☐ Yes	☐ No	Parkinson
☐ Yes	☐ No	Cholesterol	☐ Yes	☐ No	Psoriasis
☐ Yes	☐ No	COPD	☐ Yes	☐ No	Seasonal Allergies
☐ Yes	☐ No	Dementia	☐ Yes	☐ No	Sinus Problems
☐ Yes	☐ No	Depression	☐ Yes	☐ No	Skin Rashes
☐ Yes	☐ No	Diabetes: Type 1 or Type 2	☐ Yes	☐ No	Stroke: Year _____
☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Stomach Ulcers
☐ Yes	☐ No	Hearing Aides	☐ Yes	☐ No	Thyroid Disease

☐ Other: _____

GRIFFEY EYE CARE
& LASER CENTER

Kenneth A. Lebow,
O.D., F.A.A.O.
& Associates

MY LIST OF MEDICATIONS & DRUG ALLERGIES

Patient Name: _____ **Date:** _____

Preferred Pharmacy: _____

Pharmacy Address or Crossroads: _____

Current Medications: This list includes all prescribed medications, over-the-counter medications, vitamins and other supplements (herbal or non-traditional).

Medication Name	Dose (i.e. 100 mg)	Times / Day	Date Updated	Medication is Taken (oral, injections, topical, etc.)

Drug Allergies: This list includes all known drug allergies and type of reaction.

☐ No known drug allergies.

Medication Name	Type of Reaction

Medication Name	Type of Reaction