SHEINKOPF & TOMASIK
EYE CARE ASSOCIATES

Dr. Thomas D. Tomasik • Dr. Ashley Jadene Stevens
Optometrists
279 Station Ave • South Yarmouth, Ma 02664 • Phone: 508-398-6333 • Fax: 508-394-3468
www.eyedoctorcapecod.com • drsheintom@capecodeyecare.com

Welcome to our Office!

As a new patient to our practice, we would like to extend a warm welcome to you and thank you for choosing us to provide your eye health and vision care. In order for us to establish your medical record, and provide the most beneficial use of your time with us, the doctors have asked that you provide us with the following information:

Completed Patient Information Form: This background information includes personal and family eye and general health information needed to establish your medical record. Since many general health conditions can affect the health of the eye or your vision, the information that we ask for will allow us to care for you as a whole person rather than just a pair of eyes. This form includes current and past medical history, a list of prescription and non-prescription medications, as well as allergies to medications which may be brought in as a separate list if you prefer.

Insurance Cards: Please bring your cards that represent any vision and/or medical insurance you may be covered by. If your insurance is an HMO, your insurance company requires you to contact your Primary Care Physician's office to obtain a referral **PRIOR** to your appointment. Failure to do so could result in a denial of coverage for the exam and those charges will become your responsibility.

Eyeglasses and Contact Lenses: Please bring all pairs of eye glasses you currently use to the appointment. We have instruments that are used to compare the optical power of your old lenses with your new exam findings, thus enabling us to determine how your vision may have changed over time. We can also evaluate the condition and fit of your current eyewear.

It is best to wear your current contact lenses to your appointment if possible. Next best would bring them along in your case. It is very helpful for you to bring along your boxes that indicate the lens product name, parameters, power, or your most recent Contact Lens prescription.

It is the policy of Sheinkopf & Tomasik Eye Care Associates to require payment at the time of service.

Once again, thank you for choosing Sheinkopf & Tomasik Eye Care Associates. We look forward to seeing you on the date of your appointment. Please try to arrive 15 minutes prior to your appointment with the above mentioned materials and forms, so that we can complete your chart.

For more information about our office, please visit our website at www.eyedoctorcapecod.com or Like us on Facebook at @SheinkopfTomasikEyeCare

Dr. Thomas D. Tomasik & Dr. Ashley Jadene Stevens

Please complete the following confidential information. This information is extremely important for proper treatment. If you would like assistance in completing this form, our staff will be happy to assist you.

Legal Name _____Exam Date _____ OM# _____

Mailing Address _____Date of Birth _____

Home Phone _____ Day Phone _____ Ext. _____ Cell Phone_____

Gender: M / F Marital Status: M S W D Significant other _____ **Referred By** _____

Occupation/ Employer or School_____

Financially Responsible Party _____ If Child, Parent/ Guardian Name _____

Address (If Different) _____ E-mail _____

Primary Care Physician _____ Vision Insurance _____ Medical Insurance _____

Last Eye Exam _____ Last Physical Exam _____

Reason for Exam (Please circle) Routine - Cataract – Diabetes - Contact Lenses - Refractive Surgery

Are you having problems with: (Please check, if yes, please note which eye)

___ Blurred Vision	___ Eye Injury	___ Mucous Discharge	___ Itching	___ Burning
___ Changes in Vision	___ Flashes	___ Eye Pain	___ Tearing	___ Loss of Vision
___ Difficulty Driving	___ Floaters	___ Dryness	___ Glare	___ Loss of Side Vision
___ Difficulty Reading	___ Lid Swelling	___ Redness	___ Headaches	___ Fluctuating Vision
___ Double Vision	___ Halos	___ Soreness	___ Migraines	___ Other _____

Eye History: (Please check, if yes, please note which eye and how long or when)

___ Amblyopia / Lazy Eye R / L	___ Glaucoma R / L	**Eye Surgery: (Doctor and Approx. Date)**
___ Strabismus/ Eye Turn R / L	___ Macular Degeneration R / L	___ Cataracts R / L by Dr. _____
___ Blindness R / L	___ Retinal Problems R / L	___ Glaucoma R / L by Dr. _____
___ Color Blindness	___ Eye Injury R / L	___ Retinal Surgery R / L by Dr. _____
___ Cataracts R / L	___ Corneal Problem R / L	___ Laser Surgery R / L by Dr. _____

Social History:

___ Tobacco use Y / N ___ Alcohol use Y / N

Medical History:

___ Diabetes - Since _____	___ Respiratory	___ Neurological	___ Blood disorders
___ Hypertension - Since _____	___ Gastrointestinal	___ Endocrine	___ Skin/ breasts
___ Cardiovascular (heart, cholesterol)	___ Musculoskeletal	___ Psychiatric	___Constitutional
___ Ears, nose, throat	___ Genitourinary		

___ Allergies (Please list all, including specific medications)_____

_____

Please list all medications you are currently taking: _____

_____

Are you currently using any eye drops: Yes / No If so, please list them _____

Family Medical and Ocular History: (Please circle)

Diabetes	Heart Disease	Glaucoma	Color Blindness	Retinal Problems
Hypertension	Cancer	Cataract	Corneal Problems	Other _____

No changes in my ocular or medical history or medications since _____. Initial_____ Date _____

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EYE CARE ASSOCIATES

Dr. Thomas D. Tomasik Dr. Ashley Jadene Stevens
Optometrists

Demographic Addendum

As a part of a government initiative, our office is being asked to gather the following information. Please make your selections below. Thank you for your assistance.

Today's Date: _____

Preferred Language:

____ English
____ Spanish
____ Portuguese
____ French

Race:

____ White
____ American Indian and Alaskan Native
____ Native Hawaiian and other Pacific Islander
____ Black or African American
____ Asian
____ Hispanic

Ethnicity:

____ Native Hawaiian and other Pacific Islander
____ Hispanic or Latino
____ Not Hispanic or Latino

Communication Preference:

____ Postal
____ Telephone
____ E-Mail

279 Station Ave. South Yarmouth, Ma 02664
Phone 508-398-6333 * Fax 508-394-3468 * E-mail drsheintom@capecodeyecare.com

ASSIGNMENT OF INSURANCE BENEFITS AND NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

NAME OF PATIENT____

NAME OF SUBSCRIBER____

IF SIGNING AS A REPRESENTATIVE OF THE PATIENT, DESCRIBE THE RELATIONSHIP TO PATIENT AND THE SOURCE OF AUTHORITY TO SIGN THIS FORM:

RELATIONSHIP TO PATIENT_____________PRINT NAME____

SOURCE OF AUTHORITY____

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

I AUTHORIZE PAYMENT OF BENEFITS DIRECTLY TO DR. THOMAS TOMASIK OR DR. ASHLEY JADENE STEVENS FOR SERVICES RENDERED. I ALSO AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION THAT MAY BE REQUIRED IN DETERMINATION OF SUCH BENEFITS. ONCE A ONE-TIME AUTHORIZATION HAS BEEN OBTAINED, INSURANCE CLAIMS MAY BE SUBMITTED AT A LATER DATE ON EITHER AN ASSIGNED OR NON-ASSIGNED BASIS.

SIGNATURE____DATE________________________

I UNDERSTAND THAT SOME SERVICES MAY REQUIRE APPROVAL OF MY PRIMARY CARE PHYSICIAN FOR COVERAGE AND THAT, IF I DO NOT OBTAIN THAT APPROVAL, I AM FINANCIALLY LIABLE FOR THE SERVICES.

SIGNATURE____DATE________________________

I UNDERSTAND THAT MY INSURANCE CARRIER MAY NOT COVER SOME SERVICES AND PRODUCTS. BENEFIT AUTHORIZATION DOES NOT CONSTITUTE APPROVAL OF PAYMENT. SERVICE PROVIDED WITH AUTHORIZATION BUT NOT PAID BY YOUR INSURANCE CARRIER MAY BECOME YOUR RESPONSIBILITY. DEDUCTIBLES & FEES NOT PAID BY MY INSURANCE CARRIER WILL BE MY RESPONSIBILITY.

SIGNATURE____DATE_________________________

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IN THE COURSE OF PROVIDING SERVICES TO YOU, WE CREATE, RECEIVE AND STORE HEALTH INFORMATION THAT IDENTIFIES YOU. IT IS OFTEN NECESSARY TO USE AND DISCLOSE THIS HEALTH INFORMATION IN ORDER TO TREAT YOU, TO OBTAIN PAYMENT FOR OUR SERVICES, AND TO CONDUCT HEALTH CARE OPERATIONS INVOLVING OUR OFFICE. THE **NOTICE OF PRIVACY PRACTICES** POSTED IS AVAILABLE TO YOU AND DESCRIBES THESE USES AND DISCLOSURES IN DETAIL.

I ACKNOWLEDGE THAT I HAVE RECEIVED OR HAD ACCESS TO THE **NOTICE OF PRIVACY PRACTICES** FROM SHEINKOPF AND TOMASIK EYE CARE ASSOCIATES.

SIGNATURE____DATE________________________

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FOR POST CATARACT PATIENTS ONLY

HAVING BEEN INFORMED THAT AN EXTRA CHARGE IS BEING MADE BY THE DOCTOR FOR DELUXE FRAMES, THAT IS NOT COVERED BY MEDICARE, AND THAT A STANDARD FRAME IS AVAILABLE, I HAVE CHOSEN TO PURCHASE A DELUXE FRAME.

SIGNATURE____DATE_______________________

Notice of Privacy Practices

Effective date of notice: (9/23/13)
Sheinkopf & Tomasik Eye Care Associates
279 Station Ave, S. Yarmouth, MA 02664
Phone: 508-398-6333, Fax: 508-394-3468
email: drsheintom@capecodeyecare.com

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

General Rule

We respect our legal obligation to keep health information that identifies you private. "Protected health information" or "PHI" is health information, including individually identifiable information, related to your physical condition used in providing health care to you or for payment for health care services. The law obligates us to give you notice of our privacy practices.

Generally, we can only use your health information in our office or disclose it outside of our office, without your written permission, for purposes of treatment, payment or healthcare operations. In most other situations, we will not use or disclose your health information unless you sign a written authorization form. In some limited situations, the law allows or requires us to disclose your health information without written authorization.

Uses or Disclosures of Health Information

Examples of how we use information for **treatment** purposes:

- When we set up an appointment for you.
- When our technician or doctor tests your eyes.
- When the doctor prescribes glasses or contact lenses.
- When the doctor prescribes medication.
- When our staff helps you select and order glasses or contact lenses.
- When we show you low vision aids.

We may disclose your health information outside of our office for **treatment** purposes, for example:

- If we refer you to another doctor or clinic for eye care or low vision aids or services.
- If we send a prescription for glasses or contacts to another professional to be filled.
- When we provide a prescription for medication to a pharmacist.
- When we phone to let you know that your glasses or contact lenses are ready to be picked up.

Sometimes we may ask for copies of your health information from another professional that you may have seen before.

We may use your health information within our office or disclose your health information outside of our office for **payment** purposes. Some examples are:

- When our staff asks you about health or vision care plans that you may belong to, or about other sources of payment for our services.
- When we prepare bills to send to you or your health or vision care plan.
- When we process payment by credit card and when we try to collect unpaid amounts due.
- When bills or claims for payment are mailed, faxed, or sent by computer to you or your health or vision plan.
- When we occasionally have to ask a collection agency or attorney to help us with unpaid amounts due.

We use and disclose your health information for **health care operations** in a number of ways. Health care operations means those administrative and managerial functions that we have to do in order to run our office. We may use or disclose your health information, for example, for financial or billing audits, for internal quality assurance, for personnel decisions, to enable our doctors to participate in managed care plans, for the defense of legal matters, to develop business plans, and for outside storage of our records.

Appointment Reminders

We may call to remind you of scheduled appointments. We may leave a message on an answering machine or with an individual answering the phone if you are not available. We may send postcards to remind you of an upcoming appointment. We may also call to notify you of other treatments or services available at our office that might help you.

Uses & Disclosures without an Authorization

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never happen at our office at all. Such uses or disclosures are:

- A federal, state or local law that mandates certain health information be reported for a specific purpose.
- Public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the Food and Drug Administration regarding drugs or medical devices.
- Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence.

- Uses and disclosures for health oversight activities, such as for the licensing of doctors, audits by Medicare or Medicaid, or investigation of possible violations of healthcare laws.
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies.
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else.
- Disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations.
- Uses or disclosures for health related research.
- Uses and disclosures to prevent a serious threat to health or safety.
- Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service.
- Disclosures relating to workers' compensation programs.
- Disclosures to business associates who perform healthcare functions on our behalf or provide services if the PHI is necessary for those functions or services. All of our business associates are obligated, under contract with us, to protect the privacy of your PHI.
- Uses or disclosures to a member of your family, a relative, a close friend, or any other person you identify who is directly involved in your health care or payment related to your care.
- We may use PHI about you, such as name, address, telephone number, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information in an effort to raise money that will be used to expand and improve the services and programs we provide the community. You are free to opt out of each or all further fundraising solicitation by notifying us either in writing or by phone to the number listed above, and your decision will have no impact on your treatment or payment for services.

Other Disclosures

We will not make any other uses or disclosures of your health information such as diagnosis, nature of services or treatment unless you sign a written **authorization form**. You do not have to sign such a form. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it.

Your Rights Regarding Your Health Information

The law gives you many rights regarding your health information.

- We are required to notify you by first class mail of any breach of your Unsecured PHI as soon as possible, but no later than 60 days after we discover the breach. "Unsecured PHI" is PHI that has not been made unusable or unreadable. This notice will give you the following information:
  - A short description of what happened, the date of the breach and the date it was discovered.
  - The steps you should take to protect yourself from potential harm from the breach.
  - The steps we are taking to investigate the breach, mitigate losses, and protect again future breaches.
  - Contact information where you can ask questions and get additional information.
- You can ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or healthcare operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to **Dr. Thomas Tomasik** at the address, fax or e-mail shown at the beginning of this notice.
- You can ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using e-mail to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to **Dr. Thomas Tomasik** at the address, fax or e-mail shown at the beginning of this notice.
- You can ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. Primarily, however, you will be able to review or have a copy of your health information within 30 days of asking us. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally required. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we sent you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to **Dr. Thomas Tomasik** at the address, fax or e-mail shown at the beginning of this notice.
- You can ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to **Dr. Thomas Tomasik** at the address, fax or e-mail shown at the beginning of this notice.
- You can get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want), except disclosures for purposes of treatment, payment or health care operations, disclosures made in accordance with an authorization signed by you, and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your

request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to **Dr. Thomas Tomasik** at the address, fax or e-mail shown at the beginning of this notice.

Our Notice of Privacy Practices

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time in compliance with and as allowed by law. If we change this notice, the new privacy practices will apply to your health information that we already have, as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office and have copies available in our office.

Complaints

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to **Dr. Thomas Tomasik** at the address, fax or e-mail shown at the beginning of this notice. If you prefer, you can discuss your complaint in person or by phone.

For More Information

If you want more information about our privacy practices, call or visit **Dr. Thomas Tomasik** at the address or phone number shown at the beginning of this notice.