PATIENT INSTRUCTION FORM

Vision Quest Medical Center strives to provide quality care to our patients.
We appreciate your attention to the following information.

It is **your responsibility** to know and understand your insurance coverage. Please contact your insurance carrier before your appointment to verify eligibility and benefits.

As a courtesy we will bill your insurance for you. If for any reason your claim is denied, you will be responsible for payment of the charges.

Deductibles, copays and non-covered charges are to be paid **in full** at the time of service.

If you are more than 15 minutes late, we will reschedule your appointment.

PLEASE BRING THE FOLLOWING WITH YOU TO YOUR APPOINTMENT

_____ PHOTO ID (drivers license/State ID card/military ID/passport)

_____ HEALTH INSURANCE CARD

_____ VISION INSURANCE CARD IF ONE IS ISSUED

_____ THIS FORM AND YOUR COMPLETED PAPERWORK SIGNED AND DATED

______________________________ ______________________

Signature Date

VISION QUEST MEDICAL CENTER

5680 GAGE STREET, BOISE, ID 83706

3025 W. CHERRY LN., SUITE 207, MERIDIAN, ID 83642

(208) 377-3937

PATIENT INFORMATION

PATIENT'S FULL NAME:______________________________ DATE OF BIRTH:__________

FIRST MIDDLE LAST MM/DD/YY

WHAT DO YOU LIKE TO BE CALLED? (NICKNAME):______________________

NAME OF SPOUSE (PARENT IF MINOR):______________________________

ADDRESS: ______________________ CITY:____________ ST:____ ZIP:________

HOME PHONE:______________________ MARITAL STATUS: M / S / D / W SEX: M / F

SOCIAL SECURITY # :______________________

PATIENT'S EMPLOYER:______________________________ PHONE:____________

ADDRESS:______________________________ POSITION:____________

EMPLOYER OF SPOUSE OR PARENT:______________________ PHONE:____________

ADDRESS:______________________________ POSITION:____________

PERSON TO CONTACT IN CASE OF EMERGENCY:______________________ PHONE:__________

ADDRESS: ______________________ CITY:____________ ST:____ ZIP:________

REFERRED BY:____

INSURANCE

ALL CHARGES ARE THE PATIENT'S RESPONSIBILITY, HOWEVER, AS A COURTESY, WE WILL BILL YOUR INSURANCE CO

UNPAID PATIENT DUE ITEMS OVER 60 DAYS WILL BE CHARGED 18% INTEREST PER YEAR

PLEASE PRESENT YOUR INSURANCE CARDS SO WE MAY MAKE A PHOTOCOPY

IS ANY PART OF YOUR EYE EXAMINATION COVERED BY INSURANCE? (PLEASE CIRCLE ONE) YES NO

PRIMARY CARRIER:__________________________ ID NUMBER:______________

INSURED'S NAME: __________________ INSURED'S DATE OF BIRTH REQUIRED:__________

SECONDARY CARRIER:__________________________ ID NUMBER:______________

INSURED'S NAME: __________________ INSURED'S DATE OF BIRTH REQUIRED:__________

FAMILY MEDICAL DOCTOR:______________________ PHONE:________________

INDUSTRIAL ACCIDENT

EMPLOYER AT TIME OF INJURY:______________________________________

ADDRESS:____

DATE OF INJURY:__________ DATE INJURY REPORTED:__________ CLAIM # :________________

STATE WHERE INJURY OCCURRED:__________________ COUNTY WHERE INJURY OCCURRED:__________

INDUSTRIAL INSURANCE CARRIER:______________________________________

ADDRESS:____

BRIEF DESCRIPTION OF ACCIDENT:______________________________________

____

____

LIFETIME INSURANCE AUTHORIZATION

I AUTHORIZE THE RELEASE OF ANY INFORMATION NEEDED FOR PAYMENT OF CLAIMS. THIS AUTHORIZATION ALSO PERMITS THE RELEASE OF INFORMATION BY HEALTH CARE FINANCE ADMINSTRATION (HCFA), ITS INTERMEDIARIES OR CARRIERS, ON ANY UNASSIGNED MEDICARE CLAIMS FOR SERVICES RENDERED FOR THIS PROVIDER. I ALSO AUTHORIZE PAYMENTS UNDER MY INSURANCE POLICY(IES) TO BE MADE DIRECTLY TO THE PROVIDERS, JOHN R. SONNTAG, M.D., THOMAS R. HAMMOND, O.D. AND GARY R. PABALIS, O.D., (DBA VISION QUEST MEDICAL) FOR ANY SERVICES RENDERED TO ME. I FURTHER PERMIT COPIES OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

______________________________________ ____________________

SIGNATURE OF PATIENT (OR RESPONSIBLE PARTY) DATE

FOR OFFICE USE ONLY

Name: ______________________ DOB: ____/____/____

Referring Dr: ______________________ Date: ____/____/____

EYE PROBLEM LIST

DATE

DATE	

MEDICAL

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

MEDICATIONS

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
11.
12.
13.
14.
15.

ALLERGIES

1.
2.
3.
4.
5.
6.

FAMILY HISTORY

- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Diabetes
- ☐ Hypertension
- ☐ Other ______________________

Updated H&P (MO/YR) **Primary MD:**

NAME: ______________________ DATE: ____/____/____

DO YOU HAVE? / HAVE YOU HAD?

(CHECK ALL THAT APPLY)

____ decreased far vision
____ decreased near vision
____ decreased side vision
____ decreased color vision
____ poor driving vision (day)
____ poor driving vision (night)
____ floaters
____ flashing lights
____ redness of eyes
____ itching of eyes
____ mattering of eyes
____ sensitivity to light
____ halos around lights
____ glare
____ poor depth perception
____ double vision
____ previous eye surgery
____ previous eye injury
____ "crossed" eyes
____ out-turning eyes
____ lazy eye
____ eyes which bulge
____ retinal disease
____ macular degeneration
____ glaucoma
____ heart disease
____ blood disease (ie. Hepatitis, anemia)
____ reproductive system problem
____ neurologic disease
____ skin problems
____ diabetes
____ high blood pressure
____ shortness of breath lying flat
____ chest pains
____ rheumatic fever
____ a cold in the past 2 weeks
____ unexplained weight loss
____ rectal exam within the last year
____ mammogram within the last year (female)
____ pelvic exam within the lat year (female)
____ asthma
____ excessive dryness of mouth
____ slow pulse rate
____ persistent cough
____ ulcer (gastrointestinal)
____ persistent fever
____ difficulty urinating
____ bleeding problems
____ cancer
____ immunosuppression
____ abnormal anesthesia reaction
____ blood thinner or aspiring in last month
____ environmental allergies
____ immunizations NOT up-to-date
____ lung problems (ie. Emphysema, TB)
____ kidney / bladder disease
____ GI problems (ie. stomach, bowels, etc.)
____ extremity problems
____ endocrine gland disease
____ head, neck or throat problems
____ psychiatric problems

DESCRIBE CHECKED ITEMS

____
____
____
____
____
____

NAME:____

DATE_____________ WEIGHT____________ HEIGHT__________

MEDICATION LIST

MEDICATION NAME	DOSAGE mg, meq, ml , ect.	ROUTE	FREQUENCY	REASON FOR USE

RX THIS ADMISSION

ALLERGIES

____

____

____

____

VISION QUEST MEDICAL CENTER

Consent to treat minor

Patient: ______________________________ Date: ______________

I, ______________________________, give Vision Quest Medical Center physicians and staff authorization to treat my child who is under the age of 18. I do hereby consent to clinic care, including diagnostic procedures and medical treatment deemed appropriate by the Vision Quest Medical Center staff.

Authorization is in effect for one year.

____
(Signature of Parent or Legal Guardian)

____
(Please print name)

VISION QUEST MEDICAL CENTER, PA

Effective Date: 10/15/02

NOTICE OF PRIVACY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ IT CAREFULLY.

Please contact Vision Quest Medical Center, PA if you have any questions regarding this Notice.

A. Who will follow this Notice?

This Notice describes our information privacy practices and that of:

1. Any health care professional authorized to enter information into your medical record created and/or maintained at our center;
2. All employees, students, residents and other personnel who have access to your health information at the center;
3. Any member of a volunteer group which we allow to help you while receiving services at our center; and
4. Other entities and/or individuals including authorized regulatory or standard surveyors.

B. Our Philosophy Regarding Health Information

We understand that the health information created and/or maintained by us regarding your health is personal. We are committed to protecting your health information. We create a record of care and services which you receive from our health care professionals. We need this record to provide you with appropriate and consistent quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care created and/or maintained by our health care providers. Other health care providers or facilities, such as hospitals, may have different policies or notices regarding their use and disclosure of your health information created and/or maintained at their offices or facilities.

This Notice tells you about the ways in which we may use and disclose your health information. We also describe your rights and certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

1. protect the privacy and confidentiality of your health information;
2. give you notice of our legal duties and privacy information practices with respect to your health information; and
3. follow the terms of the Notice that is currently in effect.

C. How We May Use and Disclose Your Health Information

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures, we will provide you with an explanation and some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose health information will fall within one of the categories.

1. Treatment. We may use your health information to provide you with health care treatment and services. We may disclose your health information to

doctors, nurses, technicians, medical and nursing students, or other personnel who are involved in your health care. For example, a physician treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. The physician may need to talk with a dietician so that appropriate dietary modifications can be made to facilitate your healing process. We also may disclose your health information to people outside of our center who may be involved in your health care, such as family members, social services, or home health agencies.

2. Payment. We may use and disclose your health information so that the treatment services you receive at our center may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give information to your health plan regarding the services you received from our health care providers so that your health plan will pay us or reimburse you for the services. We also may tell your health plan about a treatment you are going to receive in order to obtain prior approval for the services or to determine whether your health plan will cover the treatment.

3. Health Care Operations. We may use and disclose your health information to perform certain center operations. These uses and disclosures are necessary to operate our center and to make sure that our patients receive quality care. For example, we may use your health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We also may combine health information about many of our patients to decide what additional services we should provide, what services are not needed, and whether certain new treatments are effective. We also may disclose your health information to physicians, nurses, technicians, medical and nursing students, and other clinic personnel for review and learning purposes. We also may combine health information with information from other health care providers and/or facilities to compare how we are doing and see where we can make improvements in the care and services offered to our patients. We may remove information that identifies you from this set of health information so that others may use the information to study health care and health care delivery without learning the specific identities of our patients.

4. Appointment Reminders. We may use and disclose your health information to contact you as a reminder that you have an appointment for treatment or health care at our center.

5. Treatment Alternatives. We may use and disclose health information to tell you about or to recommend possible treatment options or alternatives that may be of interest to you.

6. Health-Related Benefits and Services. We may use and disclose health information to tell you about health-related benefits or services that may be of interest to you.

7. Fundraising Activities. We may use your health information to contact you in an effort to raise money for our center and it operations. We may disclose health information to a foundation related to our center so that the foundation may contact you regarding our fundraising activities. We only would release contact information, such as your name, address and telephone number. If you do not want us to contact you for fundraising efforts, you must notify Vision Quest Medical Center, PA in writing.

8. Individuals Involved in Your Care or Payment for Your Care. We may release health information to a friend of family member who is involved in your care. We also may give information to someone who helps pay for your care.

9. Research. Under certain circumstances, we may use and disclose health information for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received a different medication for the same condition. All research subjects are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with patients' needs for privacy of their health information. Before we use or disclose health information for research purposes, the project will have been approved through this research approval process. We may, however, disclose health information to people preparing to conduct a research project in order to assist them in identifying patients with specific health care needs. Information reviewed for these purposes will not leave the center site. We will almost always ask for your specific permission if the researcher requests access to your name, address, or other information that reveals who you are, or will be involved in your care.

10. As Required By Law. We will disclose health information when required to do so by federal, state, or local law.

11. To Avert a Serious Threat to Health and Safety. We may use and disclose health information when necessary to prevent a serious threat to your health and safety or to the health and safety of the public or another person. Any disclosure, however, would be made only to an individual or entity who is able to help prevent and/or minimize the threat.

D. Special Situations

1. Organ and Tissue Donation. If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye, or tissue transplantation, or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

2. Military and Veterans. If you are a member of the armed forces, we may release health information about you as required by military command authorities. We also may release health information about foreign military personnel to the appropriate foreign military authority.

3. Workers' Compensation. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

4. Public Health Risks. We may disclose health information about you for public health activities. These activities generally include the following:

   a. to prevent or control disease, injury or disability

   b. to report births and deaths

   c. to report child abuse and neglect

   d. to report reactions to medications or problems with products

   e. to notify people of recalls of products they may be using

   f. to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition

   g. to notify the appropriate government authority if we believe a patient has been a victim of abuse, neglect, or domestic violence. We will make this disclosure only if you agree or when required or authorized by law.

5. Health Oversight Activities. We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and licensure. These activities

are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

6. Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We also may disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

7. Law Enforcement. We may release health information if asked to do so by a law enforcement official:

   a. In response to a court order, subpoena, warrant, summons or similar process

   b. To identify or locate a suspect, fugitive, material witness, or missing person

   c. About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement

   d. About a death we believe may be the result of criminal conduct

   e. About criminal conduct at our offices

   f. In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime

8. Coroners, Medical Examiners, and Funeral Directors. We may release health information to a coroner or medical examiner. This may be necessary to identify a deceased person or to determine the cause of death. We also may release health information about patients to funeral directors as necessary to carry out their duties.

9. National Security and Intelligence Activities. We may release health information to authorized federal officials for intelligence, counterintelligence, and other national security activities as authorized by law.

10. Protective Services for the President and Others. We may disclose health information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

11. Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information to the correctional institution or law enforcement official. This release would be necessary (a) for the institution to provide you with health care; (b) to protect your health and safety or the health and safety of others; or (c) for the safety and security of the correctional institution and/or its personnel.

E. Your Rights Regarding Your Health Information

You have the following rights regarding your health information which we create and/or maintain about you:

1. Right to Inspect and Copy. You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

   To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to Vision Quest Medical Center, PA. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with you request.

We may deny your request to inspect and copy your health information in certain limited circumstances. If you are denied access to your health information, you may request that the denial be reviewed. Another licensed health care professional selected by the clinic will review your request and the denial. The person conducting the review will not be the person who initially denied your request. We will comply with the outcome of this review.

2. Right to Amend. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our clinic.

   To request an amendment, your request must be made in writing and submitted to Vision Quest Medical Center, PA. In addition, you must provide a reason that supports your request.

   We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

   a. Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
   b. Is not part of the health information kept by or for our clinic;
   c. Is not part of the information which you would be permitted to inspect and copy; or
   d. Is accurate and complete.

3. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of your health information. This accounting will not include disclosures of health information which we made for purposes of treatment, payment or health care operations.

   To request this list or accounting of disclosures, you must submit your request in writing to Vision Quest Medical Center, PA. Your request must state a time period which may not be longer that six (6) years and may not include dates before April 16, 2003. Your request should indicate in what form you want the list (for example, on paper or via electronic means). The first list you request within a twelve (12) month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved, and ;you may choose to withdraw or modify your request at that time before any costs are incurred.

4. Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information regarding a particular treatment that you received.

   We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment to you.

   To request restrictions, you must make your request in writing to Vision Quest Medical Center, PA. In your request, you must tell us (a) what information you want to limit; (b) whether you want to limit our use, disclosure or both; and (c) to whom you want the limits to apply (for example, disclosures to a family member).

5. <u>Right to Request Confidential Communications</u>. You have the right to request that we communicate with you about health care matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

   To request confidential communications, you must make your request in writing to Vision Quest Medical Center, PA. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

6. <u>Right to a Paper Copy of this Notice</u>. You have the right to a paper copy of this notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

F. Changes to this Notice.

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in our clinic offices. The first page of the Notice will contain the effective date and any dates of revision.

G. Complaints

If you believe your privacy rights have been violated, you may file a complaint with our clinic or with the Secretary of the Department of Health and Human Services (“DHHS”). To file a complaint with our clinic, contact the practice administrator at Vison Quest Medical Center, PA. All complaints must be submitted in writing.

You will NOT be penalized for filing a complaint.

H. Other Uses of Medical Information

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us with permission to use or disclose your health information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we already made with your permission, and that we are required to retain our records of the care that we provided to you.