PERSONAL INFORMATION

NAME (LAST) (FIRST) (MIDDLE)		NICKNAME	DATE OF BIRTH
SOCIAL SECURITY	HOME ADDRESS CITY, STATE, ZIP		HOME PHONE #
AGE / GENDER	EMPLOYER NAME		WORK #
MARITAL STATUS	EMPLOYER ADDRESS CITY, STATE, ZIP		CELL PHONE # ☐ OK TO TEXT
DATE OF LAST EYE EXAM	PREVIOUS EYE DOCTOR		
DATE OF LAST MEDICAL EXAM	PRIMARY CARE PHYSICIAN		
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE			
EMERGENCY CONTACT		RELATIONSHIP	CONTACT #

SPOUSE/PARENT/GUARDIAN INFORMATION

SPOUSE/PARENT/GUARDIAN	ADDRESS (IF DIFFERENT)	CELL PHONE #	DATE OF BIRTH
EMPLOYER	EMPLOYER ADDRESS	WORK PHONE #	SOCIAL SECURITY

INSURANCE INFORMATION

MEDICAL INSURANCE		ID#	
POLICYHOLDER'S NAME	DATE OF BIRTH	SOCIAL SECURITY #	REALTIONSHIOP TO PATIENT
POLICYHOLDER'S EMPLOYER & ADDRESS			POLICYHOLDER'S WORK#
VISION INSURNACE		ID#	
POLICYHOLDER'S NAME	DATE OF BIRTH	SOCIAL SECURITY #	RELATIONSHIPO TO PATIENT
WORKER'S COMP CLAIM?	EMPLOYER ADRESS	CONTACT PERSON	PHONE #

SPECIAL PERMISSIONS

Please initial and date ALL statements below	INITIAL	DATE
I give Crystal Vision permission to leave voicemail/answering machine message at my home, cell, or email	__________	__________
I give Crystal Vision permission to discuss my medical care/billing with:		
Name: ________________________ Relationship: ________________________	__________	__________
Name: ________________________ Relationship: ________________________	__________	__________
Notice of privacy practice has been made available..	__________	__________

CORRESPONDANCE

Please enter your current email address below. This will give you access to the online eye exam portal.

☐☐

NOTE: all patient information is kept strictly confidential. Your address is NEVER shared.

Communication preference (please circle one): Phone Text Message Email

NON-COVERED SERVICES

There is an additional charge for the contact lens part of our exam. Most insurance companies do not cover contact lens-related office visits, so I understand the additional charge will be my responsibility. If you are a new contact lens wearer or are fit in a different type of contact lens, there will be an additional fee. I also understand that digital retinal screening is not covered by insurance companies and if I choose to have that procedure, I am responsible for the additional fee.

Signature: ____ Date: ____________________

Signature: ____ Date: ____________________

INSURANCE SIGNATURE ON FILE

MEDICARE

I request that payment of authorized Medicare benefits be made on my behalf to Crystal Vision for services furnished to me by Crystal Vision. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Crystal Vision accepts the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination by the Medicare carrier.

Signature: ____ Date: ____________________

Patient, Parent or Legal Guardian

MEDIGAP

If a Medigap policy or other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made either to me or on my behalf to Crystal Vision.

Signature: ____ Date: ____________________

Patient, Parent or Legal Guardian

OTHER INSURANCE

I authorize payment of insurance benefits be made to the office of Crystal Vision for any services or materials furnished. I authorize this office and the insurance company to release pertinent information so the benefits payable may be determined for the services and/or materials provided. In the event my deductible has not been met, or my insurance company does not pay in full or denies payment, I understand that I or the person responsible for the account will be required to pay the balance.

Signature: ____ Date: ____________________

Patient, Parent or Legal Guardian

TREATMENT AUTHORIZATION

AUTHORIZATION TO TREAT

I authorize Crystal Vision to provide treatment and, when appropriate, to share my protected health information with other healthcare providers—such as specialists—in order to coordinate my care. The *Notice of Privacy Practices* provided by Crystal Vision outlines in detail how my health information may be used and disclosed.

Signature: ____ Date: ____________________

Patient, Parent or Legal Guardian

AUTHORIZATION TO TREAT A MINOR

I authorize Crystal Vision to provide medical treatment to the minor child in my care. I affirm that I have the legal authority to consent to treatment on behalf of this minor and authorize the staff of Crystal Vision to administer care as deemed necessary.

Signature: ____ Date: ____________________

Patient, Parent or Legal Guardian

NOTICE OF PRIVACY PRACTICE

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY.

Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice).

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we must carry out in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHROIZATION OR CONSENT

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

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal 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; for audits by Medicare or Medicaid; or for investigation of possible violations of health care 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 of de-identified information;
- Disclosures relating to worker's compensation programs;
- Disclosures of a "limited data set" for research, public health, or health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to "business associates" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA.

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for heath care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION

The following are some specific uses and disclosures we may not make of your health information without your authorization:

Marketing activities. We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent to such payment.

Sale of health information. We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

- Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization.
- You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.
- We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.
- We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. We may be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right:

- To request restrictions on the health information we may use and disclose for treatment, payment and health care operations. To request restrictions, please send a written request to us at the address below.
- To receive confidential communications of health information about you in any manner other than described in our authorization request form. We reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.
- To inspect or copy your health information. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.
- To amend health information. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. We may deny your request if the health information: (1) if it is not in writing or does not provide a reason to support your request, (2) was not created by us, unless the person that created the information is no longer available to make the amendment, (3) is not part of the health information kept by or for us, (4) is not part of the information you would be permitted to inspect or copy, or (5) is accurate and complete.
- To receive an accounting of disclosures of your health information. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request. Your request must state how you would like to receive the report (paper, electronically).
- To designate another party to receive your health information. If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

CONTACT PERSON

Our contact person for all questions, requests or for further information related to the privacy of your health information is:

Dr. Heather Triggs, OD | 2945 SW Wanamaker Drive, Suite 100, Topeka, KS66614 | heather.triggs@crystalvisionks.com | 785.480.2064

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 the office contact person at the address, fax or email addresses shown above. If you prefer, you can discuss your complaint in person or by phone.

CHANGES TO THIS NOTICE

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

Notice Revised and Effective: 08/01/2025