Welcome to the office of
Dr. Daniel R. Obermark
Dr. Cassidy D. Obermark

Thank you for choosing our practice for your eye care needs.
Please help us help you by completing this form.
If you have any questions, concerns, or don't understand an entry, please ask. We are happy to help.

Demographics—Patient Information

Today's Date _____ **Please present your insurance cards to the receptionist**

Patient: _____

Address _____

City _____ State _____ Zip _____

e-mail _____

Home Phone _____ Cell Phone _____ Work Phone _____

Patient's Date of Birth _____ Patient's Social Security # _____

Occupation _____ If student, current grade _____

Employer _____ School or University _____

Emergency Contact Name _____ Phone _____

Other family members.
If they have been a patient of ours, please put a check in the box by their name.

Spouse's Name

_____ ❑

Children's Names	Ages	
_____	____	❑
_____	____	❑
_____	____	❑
_____	____	❑
_____	____	❑

Guarantor—Person Responsible for Bill

Person responsible for bill ❑ Self ❑ Spouse ❑ Parent ❑ Workers Compensation ❑ Other _____

Guarantor's Name _____

Address _____

City _____ State _____ Zip _____

Guarantor's Phone _____ Guarantor's Social Security # _____

Referral Information

Whom may we thank for telling you about our practice? ❑ Yellow Page ad ❑ Newspaper ad ❑ Sign ❑ Radio ad ❑ TV ad

Person's Name _____ Doctor's or Optician's Name _____ Other _____

Insurance / HIPAA Authorization

Agreement of Responsibility

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductibles and co-insurance may be collected at the time of service. I understand that I am financially responsible for charges not covered by my insurance company.

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her medical judgment.

Release of Information/Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me.

Medicare Authorization

I request payment of authorized Medicare benefits be made on my behalf to Dr Obermark, Optometry, PC for any services furnished me by that physician. I authorize the holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests that payment be made and authorizes 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 or electronically submitted claims, my signature authorizes the release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Medigap Authorization

A Medigap or Medicare Supplemental policy is a health insurance policy or other health benefit plan, offered by a private company, to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered by an employer to employees or former employees, as well as a policy or plan offered by a labor organization to members or former members. This Agreement is in effect until revoked in writing by the patient.

I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable.
I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
I further authorize and request that insurance payments be made directly to Dr. Daniel R. Obermark, Optometry, PC.
I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.
I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

Date: _____ Signature: _____

FEES DUE UPON SERVICES RENDERED. Please check your preferred method of payment: ❑ Cash ❑ Check ❑ Credit Card

Please continue medical history on back

Over Please

Medical History:

Please name your medical doctor: _____

Please ☑ check each box that describes a condition you have ever had or have been diagnosed and list the medication, treatment, or surgery taken for the condition.

Eyes
- ❑ No Eye Problems

- ❑ cataracts
- ❑ corneal disease
- ❑ glaucoma
- ❑ iritis
- ❑ macular degeneration
- ❑ retinal disease
- ❑ dry eye
- ❑ lazy eye
- ❑ crossed eye
- ❑ eye surgery

List current eye medications / Vitamins

_____

_____

_____

_____

Neurological
- ❑ No Neurological Problems

- ❑ epilepsy
- ❑ head ache
- ❑ multiple sclerosis
- ❑ seizures

Ears, Nose, & Throat
- ❑ No Ear Nose & Throat Problems

- ❑ mouth or throat cancer
- ❑ respiratory tract infection

Respiratory
- ❑ No Respiratory Problems

- ❑ asthma
- ❑ bronchitis
- ❑ emphysema
- ❑ cigarette smoker, packs per day _____ since age _____
- ❑ lung cancer

List current medications next to the condition for which you take them

_____

_____

_____

Cardiovascular
- ❑ No Cardiovascular Problems

- ❑ angina/chest pain
- ❑ heart disease
- ❑ high cholesterol
- ❑ hypertension
- ❑ stroke
- ❑ vascular disease

_____

_____

_____

Hematologic/Lymphatic
- ❑ No Hematologic/ Lymphatic Problems

- ❑ anemia
- ❑ blood clots
- ❑ large volume blood loss
- ❑ leukemia

_____

Endocrine
- ❑ No Endocrine Problems

- ❑ insulin dependent diabetes
- ❑ non-insulin diabetes
- ❑ hepatitis
- ❑ hormonal dysfunction
- ❑ thyroid dysfunction

_____

_____

_____

Gastrointestinal
- ❑ No Gastrointestinal Problems

- ❑ colitis
- ❑ Crohn's
- ❑ digestive
- ❑ ulcer

_____

_____

_____

Constitutional
- ❑ No Constitutional Problems

- ❑ developmental disability
- ❑ fatigue
- ❑ fever
- ❑ trauma
- ❑ weight loss

_____

_____

_____

Musculoskeletal
- ❑ No Musculoskeletal Problems

- ❑ ankylosing spondylitis
- ❑ arthritis
- ❑ fibromyalgia
- ❑ muscular dystrophy

_____

_____

Integumentary
- ❑ No Integumintary Problems

- ❑ eczema
- ❑ psoriasis
- ❑ rosacea
- ❑ skin cancer

_____

_____

_____

Genitourinary
- ❑ No Genitourinary Problems

- ❑ herpes
- ❑ chlamydia
- ❑ cervical cancer
- ❑ prostate cancer

_____

_____

_____

Psychiatric
- ❑ No Psychiatric Problems

- ❑ bipolar
- ❑ depression
- ❑ panic disorder
- ❑ schizophrenia

_____

_____

_____

Immunologic
- ❑ No Immunologic Problems

- ❑ HIV
- ❑ lupus
- ❑ rheumatoid arthritis

_____

Allergic
- ❑ No Allergies

environmental allergy
- ❑ hay fever
- ❑ other:

drug allergy
- ❑ penicillin
- ❑ sulfa
- ❑ codeine
- ❑ aspirin
- ❑ other:

Social Medications

Do you drink alcohol ❑ Yes ❑ No

List illegal drugs used:

List prior eye surgeries

Date	Diagnosis/Condition	Doctor

Check if you know of a relative with — **describe relationship**
- ❑ cataracts
- ❑ corneal disease
- ❑ glaucoma
- ❑ macular degeneration
- ❑ retinal disease
- ❑ lazy eye
- ❑ crossed eye
- ❑ blindness

List prior surgeries

Date	Diagnosis/Condition	Doctor

Women

Are you pregnant ❑ Yes ❑ No

Are you nursing ❑ Yes ❑ No

List any birth control / hormones

_____

_____

Vision History:

Have you ever worn glasses? ❑ Yes ❑ No

If so, are they bothersome to you? ❑ Yes ❑ No

Have you ever worn contact lenses? ❑ Yes ❑ No

If so, what type of lenses? _____

Who prescribed them? _____

Are you interested in new contacts? ❑ Yes ❑ No

Have you considered Laser Vision Correction? ❑ Yes ❑ No

Do you ever have problems with glare? ❑ Yes ❑ No

Do you ever have problems when driving at night? ❑ Yes ❑ No

How many hours per day do you spend on the computer? _____

Do your eyes ever feel strained while working on the computer? ❑ Yes ❑ No

Please list your hobbies or leisure activity.
- ❑ auto repair
- ❑ carpentry/woodworking
- ❑ computer
- ❑ crafts/sewing
- ❑ driving/biking
- ❑ golf
- ❑ hiking/nature watching
- ❑ hunting/fishing
- ❑ internet
- ❑ movies
- ❑ sports
- ❑ TV
- ❑ Other:

Warranty

Your frame is warranted for one year against manufacturer's defects, with the exception of our basic frames. The warranty year is from the original purchase date. Abuse or obvious neglect is not covered. Frame and lenses must be presented for warranty. Your lenses are warranted for one year against scratches, with the purchase of scratch protection. This is not "scratch-proofing". Glass lenses do not carry warranty. Warranty entitles you to one free replacement of scratched lenses within one year of purchase date. Progressive lenses carry a satisfaction guarantee. If, within 30 days of dispensing, you are not satisfied with their performance, we will remake your prescription in the lens style of your choice of equal or lesser value, at no additional charge.

Prescription Eyewear Refund Policy

Went want you to be completely satisfied with your new eyewear. If for any reason you do not love your new glasses or prescription sunglasses, you can exchange them within 30 days of dispensing. As your prescription is a custom product incurring cost of manufacturing, requests for refunds within 30 days will be half the purchase price.

Contact Lens Refund Policy

Since there are many variables in prescribing contact lenses, there is no guarantee that you will become a successful contact lens wearer. If at any time during the 30 days after dispensing, you decide or Dr. Obermark recommends that contact lens wear be discontinued, we will refund the cost of contact lenses returned in original unblemished, unexpired packages. The fee for the eye health examination and contact lens prescription fitting fee are non-refundable. There will be no cash refunds, credits issued or exchanges made 30 days after the dispensing date.

Patient's Own Frame Notice

If you decide to use your own frame, we are happy to make new prescription lenses for your the frame if it's in good condition and fits your face properly. If we accept your frame for re-use, we pledge to use the utmost care in handling it, but in a small percentage of cases, the frame material may be worn or brittle to the point it will not support a new pair of lenses.

Please be aware that older frame styles are often discontinued by the manufacturer and replacement parts are usually not available. This presents a problem if the frame breaks and can't be repaired.

If your frame breaks during our lens insertion process, the lenses initially made for that frame cannot be re-used for a different frame style. We will make new lenses at no additional charge for any new frame you choose, but the cost of the replacement frame will be at your expense.

Re-using your frame requires a manufacture of a pattern to edge your new prescription in the frame. The fee for this is $20.00.

I have read and understand all policies listed above.

Patient's Signature _____ Date _____

NOTICE OF PROTECTED HEALTH INFORMATION PRACTICES

This notice describes how information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. We will ask that you sign a form acknowledging that you have received information about Protected Health Information Practices. This signed document will be kept in your medical record.

UNDERSTANDING YOUR HEALTH RECORD AND INFORMATION

Each time you visit Dr. Obermark Optometry PC; a record of your visit is made. This record contains your symptoms, examination and findings; diagnosis, treatments and a plan for your future care and treatment. This information, often referred as your medical record serves as a basis for:

- Planning your care and treatment
- Providing a means of communication among health professionals who contribute to your care
- The legal document describing the care that you received
- Providing a means for you or a third party payer to verify the services billed were actually provided
- Providing a source of data for medical research
- Providing a source for facilities planning and marketing. A tool with which we can assess and continually work to improve the care we rendered and the outcomes we achieve

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information
- Obtain a paper copy of the notice of information practices upon request
- Inspect and obtain a copy of your health record
- Request to amend your health record
- Obtain an accounting of disclosures of your health information
- Request communications of your health information to alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information you may contact our Privacy Officer at (573) 471-1080.

If you believe that your privacy rights have been violated, you can file a complaint with our Privacy Officer or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT ON HEALTH OPERATIONS

We will use your health information for treatment

Information obtained by our health care team will be recorded and used to determine the course of treatment that should work best for you. The health care team will record the actions they took and their observation. That way, the doctor will know how you are responding to treatment.

We will use your health information for payment

A bill may be sent to you or your insurance company. The information accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations

Members of the health care team may use the information in your medical record to assess the care and outcomes in your case. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide at Dr. Obermark Optometry PC.

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Business Associates
There are some services provided at Dr. Obermark Optometry PC through contact with business associates. Examples include physician services, hospital departments, material laboratories, other medical professionals such as school nurse, and public health officials. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do. To protect your health information, however, we require the business associates to appropriately safeguard your information.

Notification
We may use or disclose information for the purpose of notifying a family member, personal representative, or another person responsible for your care, your location and/or general condition.

Communication with family
Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research
We may disclose information to researchers when an institutional review board has reviewed the research proposal and establishes protocols to ensure the privacy of your health information.

Clinical follow-up
We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Food and Drug Administration (FDA)
We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product or product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Worker's Compensation
We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to Workers Compensation and other similar programs estimated by law.

Public Health
As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement
We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Employee/Employer Health Requests
We may disclose your health information to your employer for the purpose of the provision of safety eyewear through that respective employer.

OUR RESPONSIBILITIES
Dr. Obermark Optometry PC is required to

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by this notice and notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means and alternative locations

We reserve the right to change and to make provisions affective for all protected health information we maintain. We will not use or disclose your health information without your authorization.

ACKNOWLEDGEMENT OF RECEIPT
I acknowledge that I received a copy of Dr. Obermark – Eye Health Care Notice of Privacy Practices.

Signature _____ Date _____

Patient's Printed Name _____