PeposeVision
INSTITUTE

Dear Patient,

Thank you so much for selecting Pepose Vision Institute for your eye care. Our entire staff would like to welcome you to our office.

To make your visit to our office more expedient, we are enclosing a Patient Registration Form and a Medical History Questionnaire. Please complete these forms prior to your visit and bring them with you on your appointment day. Bring any medications and eye drops you are currently using, along with your eyeglasses and/or contact lenses.

First visits can take up to two hours. You should expect that your eyes will be dilated.

Also, have all of your insurance cards and a current credit card with you. If you have insurance coverage that requires pre-authorization or a referral form, please obtain this prior to your visit to the office and bring it with you. Applicable co-payments and deductibles must be collected at the time of your visit. Payment for any services that are not covered by your insurance must also be paid at that time. Payment may be made in cash or by check (under $200) or credit card. (Visa, MasterCard, and Discover).

We appreciate the trust you have placed in Pepose Vision Institute to care for your vision; your eye sight is a precious gift that deserves the highest quality of care.

If you have any questions, please call: 636-728-0111 or toll free: 877-862-2020.

Sincerely,

Jay S. Pepose, M.D., Ph.D. Mujtaba A. Qazi, M.D. Nancy M. Holekamp, M.D.

Enclosures:
Directions
Medical History Questionnaire
Patient Registration Form

NOTICE OF PRIVACY PRACTICES

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

PeposeVision INSTITUTE

This Notice is intended to inform you about our practices related to your medical records. It will explain how Pepose Vision Institute may use and disclose your medical information, our obligations related to the use and disclosure of your medical information, and your rights related to any medical information that we have about you.

We have listed some of the reasons why we might use or disclose your medical information with some examples. Not every potential use or disclosure is discussed, but all of the ways that we are allowed to use and disclose information falls into one of the categories below.

Use and Disclosure of Medical Information:

For Treatment: To provide you with medical treatment or services, we may need to use or disclose information about you to personnel involved in your treatment. For example, a physician may need to consult with another provider regarding your condition while providing care.

For Payment: We may use and disclose your medical information to bill and receive payment for the treatment that you received. For example, we may use or disclose your medical information to your insurance company about a service you received from Pepose Vision Institute so that your insurance company can pay us or reimburse you for the service.

For Health Care Operations: We can use and disclose medical information about you for our operations. For example, we may use or disclose medical information about you to evaluate our staff's performance in caring for you.

Uses and Disclosure of Medical Information that Do Not Require Your Authorization:

We can use or disclose health information about you without your authorization when there is an emergency, when we are required by law to treat you, or when we are required by law to use or disclose certain information. We may use or disclose your health information without your authorization in any of the following circumstances:

- When it is required by federal, state or other law;
- When it is needed for public health activities;
- When reporting information about victims of abuse, neglect or domestic violence;
- When disclosing information for the purpose of health oversight activities;
- When disclosing information for judicial and administrative proceedings;
- When disclosing information for law enforcement purposes;
- When disclosing information about deceased persons to medical examiners, coroners and funeral directors
- When disclosing or using information for organ and tissue donation purposes;
- When disclosing information for research purposes;
- When we believe in good faith that the disclosure is necessary to avert a serious health or safety threat;
- When disclosure is necessary for specialized government functions;
- When disclosure is necessary to comply with worker's compensation laws or purposes.

Planned Uses or Disclosures

We may use or disclose your health information for any of the purposes described in this section unless you affirmatively object to or otherwise restrict a particular release. You may direct your objections or restrictions in writing to the office where you received this Notice.

- We may use or disclose your health information to contact you and remind you about an appointment for treatment or medical care.
- We may use or disclose your health information to provide you with information about or recommendations of possible treatment options or alternatives that may interest you.

Planned Uses or Disclosures (continued)

- We may release health information about you to a friend and/or family member who is involved in your care. We can tell your family and/or friends of your condition and that you are using Pepose Vision Institute for treatment or services. We can also give this information to someone who will help or is helping to pay for your care.
- We can disclose health information about you to a public or private entity that is authorized by law or its charter to assist in disaster relief efforts (e.g., the American Red Cross).

Other Uses or Disclosures

If you provide us written authorization to use or disclose your health information, you can change your mind and revoke your authorization at any time, as long as you revoke your authorization in writing. If you revoke your authorization, we will no longer use or disclose the information, but we will not be able to take back any disclosures that we have already made.

Your Rights with Respect to Health Information

- **Right to Inspect and Copy Your Health Information:** You have the right to inspect and copy your health information, with certain exceptions. If you request copies of information, we may charge a fee for costs associated with your request, including the cost of copies, mailing or other supplies.
- **Right to Request Information in Certain Form and Location:** You have the right to request health information in a certain form or at a specific location. For instance, you can request that we not contact you at work. The request must tell us how and/or where you want to receive information. We will accommodate reasonable requests.
- **Right to Request Amendment to Your Health Information:** You have a right to request that your health information be amended if you believe that it is incorrect or incomplete. You must provide the reason that you want the amendment added to your health information. Your request must be in writing.
- **Right to an Accounting of Disclosures:** You have the right to receive an accounting of disclosures of medical information that we have made with some exceptions. You have the right to receive one (1) free accounting every twelve (12) months. If you request more than one (1) accounting in any twelve (12) month period, we may charge you a reasonable fee for the costs of providing that list.
- **Right to Request Restrictions:** You have the right to request that we restrict any use or disclosure of your health information. If we agree to your restriction, we will comply with your request. For example, a patient who does not want his or her physician to share health information with other physicians involved in his or her care may request to restrict such disclosure. We are not required to accept any restriction that you request.

Federal law gives all patients a right to a paper copy of this Notice. If you have agreed to receive this Notice in another form, you can still request a paper copy of this Notice. To obtain a paper copy of the Notice or to submit a written request related to "Your Rights" contact the office where you received this Notice.

Privacy Complaints

If you have any questions about the content of this Notice, of if you need to contact someone regarding the privacy of your health information, please contact:

Privacy Officer
Pepose Vision Institute
1815 Clarkson Road
Chesterfield, MO 63017

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint with either Pepose Vision Institute or the U.S. Department of Health and Human Services.

Changes to This Notice

We reserve the right to change or modify the information contained in this Notice. Any changes that we make will comply with appropriate federal, state or other laws. Pepose Vision Institute will provide its patients with the most recent copy of this Notice and post this version at our facilities. You can also call or write the Privacy Officer to obtain the most recent version of this Notice.

PeposeVision INSTITUTE

PATIENT INFORMATION FORM

MidAmerica SURGERY CENTER

Whom may we thank for referring you? ☐Family/Friend ☐ Doctor: _____ ☐ TV/Print

LAST NAME*: _____ **FIRST NAME*:** _____ **MI*:** _____
DATE OF BIRTH*: _____ **AGE**: ____ **SEX***: ☐ Male ☐ Female **SOCIAL SECURITY #**: _____
ADDRESS: _____ **HOME PHONE #:** _____
_____ **CELLPHONE #:** _____
_____ **EMAIL**: _____

RACE*: ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ African American
☐ Asian ☐ American Indian ☐ Other: _____

ETHNICITY*: ☐ Hispanic/Latino ☐ Other **PREFERRED LANGUAGE***: ☐ English ☐ Spanish ☐ French
☐ Other: _____

MARITAL STATUS: ☐ Married ☐ Divorced ☐ Widowed ☐ Single

PATIENT EMPLOYER: _____ **OCCUPATION**: _____
ADDRESS: _____ **PHONE #:** _____
_____ **SECONDARY #:** _____
_____

EMERGENCY CONTACT: _____ **RELATIONSHIP**: _____
PHONE #: _____

*****Please fill out the insurance information below **ONLY** if you are **NOT** the primary card holder*****

PRIMARY INSURANCE: _____
SECONDARY INSURANCE: _____

POLICY HOLDER'S INFORMATION
LAST NAME*: _____ **FIRST NAME*:** _____ **MI*:** _____
DATE OF BIRTH*: _____ **AGE**: ____ **SEX***: ☐ Male ☐ Female **SOCIAL SECURITY#**: _____
ADDRESS: _____ **PHONE #:** _____
_____ **SECONDARY #:** _____
_____ **EMAIL**: _____
EMPLOYER: _____ **OCCUPATION**: _____

Authorization to Release Medical Information:

I hereby authorize the physician, PVI and/or MidAmerica Surgery Center to release any information from Patient Medical Records required in the course of my examination and treatment to any insurance company against which claims are filed for me or my dependents.

I am aware of my rights to privacy of personal health information under the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Occasionally you may be contacted by our affiliated nonprofit Foundation (Lifelong Vision Foundation) to inform you of (i) new clinical studies that may be appropriate for your specific vision condition; or (ii) new community-based outreach programs that you may wish to support as a volunteer or donor. Should you wish to opt out of these communications please initial here. _____

I understand payment for all office services is expected at the time of my visit, unless other arrangements have been made prior to my visit. I hereby authorize payments to be made directly to PVI and MidAmerica Surgery Center for all sums due for services rendered. Any past due balance sent to an attorney or collection agency is the responsibility of the guarantor and he/she agrees to pay ALL collection fees and court costs.

_____ _____ _____
Patient or Guardian Signature Relationship Date

PATIENT QUESTIONNAIRE

LAST NAME*: _____ **FIRST NAME*:** _____ **MI*:** _____

PRIMARY CARE DOCTOR: _____

ADDRESS: _____ **PHONE #:** _____

_____ **SECONDARY #:** _____

_____ **EMAIL**: _____

PHARMACY NAME*: _____ **PHARMACY #:** _____

1. **Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, arthritis, etc)?**
   ☐**Yes** ☐**No** If yes, please explain: _____
2. **Have you ever been diagnosed with any eye disease (glaucoma, cataract, "lazy" eye, retinal detachment)?**
   ☐**Yes** ☐**No** If yes, please explain: _____
3. **Have you ever had surgery?**
   ☐**Yes** ☐**No** If yes, please explain: _____
4. **Do you take any medications?**
   ☐**Yes** ☐**No** If yes, please list: _____
5. **Are you allergic to any of the following drugs (check the box for all that apply)?**
   ☐**Sulfa** ☐**Cipro** ☐**Levequinn** ☐ **Aspirin**
   ☐**Other:** _____
6. **Do you currently have any of the following problems?** ☐ **Yes** ☐**No**
   A.) Chronic Fever, unexpected weight loss/gain, fatigue, If yes, explain: _____
   Ear/nose/throat (e.g. hearing loss, sinus problems, sore throat)

   B.) Heart Problems (e.g. chest pain, irregular heart beat)? ☐ **Yes** ☐**No**
   If yes, explain: _____

   C.) Respiratory Problems (e.g. shortness of breath, wheezing)? ☐ **Yes** ☐**No**
   If yes, explain: _____

   D.) Gastrointestinal problems (e.g. heartburn, diarrhea, vomiting)? ☐ **Yes** ☐**No**
   If yes, explain: _____

   E.) Urinary problems (e.g. blood in urine, pain)? ☐ **Yes** ☐**No**
   If yes, explain: _____

   F.) Skin problems (e.g. rashes, excessive dryness)? ☐ **Yes** ☐**No**
   If yes, explain: _____

   G.) Neurological problems (e.g. numbness, weakness, ☐ **Yes** ☐**No**
   Headache, paralysis)? If yes, explain: _____

   H.) Psychiatric problems (e.g. depression, anxiety)? ☐ **Yes** ☐**No**
   If yes, explain: _____
7. **Do you smoke?*** ☐**Current every day** ☐ **Current some days**
   ☐ **Former: from**_____ **to** _____ ☐ **Never** ☐ **Unknown**
8. **Do you have allergies?*** ☐ **Yes** ☐**No** If yes, explain: _____
9. **Do you drink alcohol?** ☐ **Yes** ☐**No** If yes, how much? _____
10. **Weight:** _____**lbs** **Height:** _____**ft.** _____**in.**

Reviewed by M.D.: _____ **Date:** _____
COMMENTS: _____

PeposeVision INSTITUTE

MidAmerica SURGERY CENTER

PEPOSE VISION INSTITUTE, P.C.

CONSENT FOR DISCLOSURE OF PERSONAL MEDICAL INFORMATION

As a patient I agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby authorize the physicians and staff of Pepose Vision Institute, P.C. to disclose my personal medical information to the following individual(s).

☐ Pepose Vision Institute, P.C. may disclose my medical information only in my presence.
☐ Pepose Vision Institute, P.C. may disclose my medical information when I am not present; this includes telephone calls, fax or mail.
☐ I understand that consent may be revoked by me at anytime by written notice of Pepose Vision Institute, P.C.

Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____
Name: _____ Relation: _____ Phone: _____

☐ Person(s) listed above age 18 or older may pick up prescription when I am not present.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

☐ I have received the Pepose Vision Institute Notice of Privacy Practices.

_____ _____
Patient or Guardian Signature Date

PEPOSE VISION INSTITUTE FINANCIAL POLICIES

We are glad you have chosen us for your vision care. Full payment for all services provided is expected on the day of your visit unless you have health insurance coverage with a plan with which we have a written agreement **and** the service is a covered service under your plan. Your insurance provider **requires us to collect all applicable deductibles and copayments at the time that any medical service is provided**. Such payments, as well as payments for noncovered services, may be paid by cash, check (under $200) or credit card (Visa, MasterCard, Discover). There is a fee of $25 for any checks returned by the bank.

We must have a copy of the front and back of your insurance card(s) along with your driver's license or other photo ID at your initial visit. You may be asked to provide your insurance card at subsequent visits. We will require the name, date of birth, address, telephone number and employer of the family member through whom you are insured. You are responsible for notifying us (1) of any change in address, telephone number, employer or insurance coverage; and (2) whether your insurance coverage requires a referral to our office or pre-certification for any services rendered. Should your insurance deny payment of your medical claim for either reason, you are financially responsible for any outstanding charges for services rendered.

CREDIT CARD POLICY: At your initial visit you are asked to bring a current credit card. We will keep a copy on file to cover any unpaid copays, deductibles, refraction fees or co-insurance. We will guard your financial information as carefully as we guard your medical information. **Unless other arrangements have been made, unpaid balances for copayments, deductibles or co-insurance will be charged to your credit card on file, in increments not to exceed $60 per month.** If there is an overpayment to your account we will issue a refund within 15 business days.

PATIENT INITIALS: _____

REFRACTION POLICY

A refraction is a measurement of lens power necessary to prescribe glasses or other corrective lenses. Most insurance plans, including Medicare, DO NOT cover routine refractions (when no medical eye problem is known or suspected). Insurance companies permit us to charge separately for this refraction since it is not included in your covered eye exam. Upon payment of this fee, you may request a copy of your refraction in order to purchase prescription glasses.

THE FEE FOR THIS SERVICE IS $69

PATIENT INITIALS: _____

AUTHORIZATION OF PAYMENT: I hereby authorize payments to be made directly to PVI and MidAmerica Surgery Center for all sums due for services rendered. Any past due balance sent to an attorney or collection agency is the responsibility of the guarantor and he/she agrees to pay all collection fees and court costs.

_____ _____

Name of Patient (Print) Signature / Date

_____ _____

Name of Responsible Party (Print)
[If not Patient] Signature/ Date

PATIENT QUESTIONNAIRE

LAST NAME*: _____ **FIRST NAME*:** _____ **MI*:** _____

PRIMARY CARE DOCTOR: _____

ADDRESS: _____ **PHONE #:** _____

_____ **SECONDARY #:** _____

_____ **EMAIL**: _____

PHARMACY NAME*: _____ **PHARMACY #:** _____

1. **Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, arthritis, etc)?**
   ☐**Yes** ☐**No** If yes, please explain: _____
2. **Have you ever been diagnosed with any eye disease (glaucoma, cataract, "lazy" eye, retinal detachment)?**
   ☐**Yes** ☐**No** If yes, please explain: _____
3. **Have you ever had surgery?**
   ☐**Yes** ☐**No** If yes, please explain: _____
4. **Do you take any medications?**
   ☐**Yes** ☐**No** If yes, please list: _____
5. **Are you allergic to any of the following drugs (check the box for all that apply)?**
   ☐**Sulfa** ☐**Cipro** ☐**Levequinn** ☐ **Aspirin**
   ☐**Other:** _____
6. **Do you currently have any of the following problems?** ☐ **Yes** ☐**No**
   A.) Chronic Fever, unexpected weight loss/gain, fatigue, If yes, explain: _____
   Ear/nose/throat (e.g. hearing loss, sinus problems, sore throat)

   B.) Heart Problems (e.g. chest pain, irregular heart beat)? ☐ **Yes** ☐**No**
   If yes, explain: _____

   C.) Respiratory Problems (e.g. shortness of breath, wheezing)? ☐ **Yes** ☐**No**
   If yes, explain: _____

   D.) Gastrointestinal problems (e.g. heartburn, diarrhea, vomiting)? ☐ **Yes** ☐**No**
   If yes, explain: _____

   E.) Urinary problems (e.g. blood in urine, pain)? ☐ **Yes** ☐**No**
   If yes, explain: _____

   F.) Skin problems (e.g. rashes, excessive dryness)? ☐ **Yes** ☐**No**
   If yes, explain: _____

   G.) Neurological problems (e.g. numbness, weakness, ☐ **Yes** ☐**No**
   Headache, paralysis)? If yes, explain: _____

   H.) Psychiatric problems (e.g. depression, anxiety)? ☐ **Yes** ☐**No**
   If yes, explain: _____
7. **Do you smoke?*** ☐**Current every day** ☐ **Current some days**
   ☐ **Former: from**_____ **to** _____ ☐ **Never** ☐ **Unknown**
8. **Do you have allergies?*** ☐ **Yes** ☐**No** If yes, explain: _____
9. **Do you drink alcohol?** ☐ **Yes** ☐**No** If yes, how much? _____
10. **Weight:** _____**lbs** **Height:** _____**ft.** _____**in.**

Reviewed by M.D.: _____ **Date:** _____
COMMENTS: _____

Directions to Pepose Vision Institute

Chesterfield Location:

1815 Clarkson Road
Chesterfield, MO 63017
636-728-0111
877-862-2020

I-64/40 to Clarkson/Olive (exit 19B), turn left (40 west) or right (40 east). Take Clarkson Road south 1.3 miles through 3 stoplights and turn right into our parking lot. Our office is a brown brick building.

South County Location:

13134 Tesson Ferry Road
Suite B
St. Louis, MO 63128
314-375-0111

I-270 to Tesson Ferry Road (exit 2), turn left (270N) or right(270S). Take Tesson Ferry Road south 1.9 miles and turn left into the parking lot. Our office is across the street from the firehouse.