Little Wood
VISION CLINIC
MATTHEW E. KENT, O.D.

520 N Greenwood St. · Shoshone, ID 83352 · Phone: 208.537.2020 · Fax: 208.537.2010

Patient Information

Last Name:	First Name:	M.I.	Nickname:	Date of Brith:
Male or Female:	Marital Status:	SSN:	Guardian (if applicable):	
Address:	City:	State:	Zip Code:	
Home Phone:	Cell Phone:	Work Phone:	Email:	
Employer (if applicable):		Occupation:		
Employer's Address and Phone:				
Responsible Party (person responsible for paying):		Spouse's Name (if applicable):		
Emergency Contact and Relationship:		Emergency Contact Number:		

Race(s):

□ All Other Races □ American Indian or Alaska Native □ Asian □ Black or African American
□Native Hawaiian or Other Pacific Islander □ White □ Declined

Language:	Ethnicity:
□ English □ Spanish □ Other_____ □ Declined	□ Hispanic or Latino □ Not Hispanic or Latino □ Declined

Insurance Information

If you have insurance, please present your insurance card to be added to your records.

Vision Insurance:	Policy #/Subscriber Name/DOB/SSN:
Medical Insurance:	Policy #/Subscriber Name/DOB/SSN:
Secondary Insurance:	Policy #/Subscriber Name/DOB/SSN:

Financial Agreement and Authorization for Treatment and Services

I authorize treatment and services of the person named above and agree to pay all fees and charges for such treatment and services. I authorize release of information necessary to process any claims for treatment and services received in this office. I further authorize payment for any claims to be made to this office. By signing below, I agree that I am finanically responsible for co-pays, deductibles, and fees not paid for by insurance. Payment on deductibles, co-payments, and non-covered charges are due at the time of service. All balances are subject to a 1.5% charge or $3.00/month whichever is greater. Returned checks are subject to a $20 service fee. I understand that unpaid balances I owe may be turned over to a collection agency for collection. This authorization shall continue and be in force and effect until revoked in writing by me.

XPatient or Guardian Signature _____Date_____

Medicare Patients Only

Medicare patients, please note that the refraction portion of the eye exam is not a covered service by Medicare. You will be personally responsible for the payment of the refraction at the time of service.

XPatient or Guardian Signature _____Date_____

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Vision and General Health History Form

Rev Dec 2019

Name_____ **Date of Birth** _____

Date of last eye exam _____ Name of previous eye doctor _____
Do you use tobacco products? □ Yes □ No Do you have a history of smoking? □ Yes □ No
Do you drink alcohol? □ Yes □ No Do you use other substances? □ Yes □ No

Do you have a PERSONAL history of any of the following?

□ Cataracts □ Age-related macular degeneration □ Glaucoma □ Diabetes □ Diabetic retinopathy
□ Dry eyes □ Floaters/Flashes □ Eye infections/inflammation/allergies □ Iritis or uveitis
□ Retina defects or degenerations □ Other eye problems/surgeries?_____
Do you wear glasses? □ Yes □ No Do you wear contact lenses? □ Yes □ No

Are you interested in laser vision correction? ☐ Yes ☐ No

Do you have a FAMILY history (parents, grandparents, siblings, children) of any of the following?

□ Diabetes □ High Blood Pressure □ Cancer □ Glaucoma □ Hypo or Hyper Thyroid
□ Cataracts □ Retinal Detachment □ Blindness □ Macular degeneration
□ Other significant medical/eye conditions in your family _____

Personal Medical Information: Please **check** if you have no medical conditions. Please **circle** any past or present issues.

Constitutional	□ No problems	developmental disabilities, cancer, fatigue syndrome
ENT	□ No problems	hearing loss, sinusitis, dry mouth, laryngitis
Neurological	□ No problems	M.S., epilepsy, cerebral palsy, tumor, stroke, migraine
Psychiatric	□ No problems	depression, attn deficit, anxiety disorder, bipolar
Cardiovascular	□ No problems	high blood pressure, stroke/CVA, heart disease, vascular disease, congestive heart failure,
Respiratory	□ No problems	asthma, bronchitis, emphysema, COPD, sleep apnea
Gastrointestinal	□ No problems	Crohn's, colitis, ulcer, acid reflux, celiac disease
Genitourinary	□ No problems	kidney disease, prostate disease/cancer, STD, pregnant, nursing
Musculoskeletal	□ No problems	osteoarthritis, fibromyalgia, muscular dystrophy, ankylosing spondylitis, osteoporosis, gout
Skin/Integumentary	□ No problems	eczema, rosacea, psoriasis, cold sores, shingles, cancer
Endocrine	□ No problems	type 2 diabetes, type 1 diabetes, thyroid dysfunction, hormone dysfunction
Hematologic/Lymphatic	□ No problems	anemia, ulcer, high cholesterol
Allergy/Immune	□ No problems	drug allergies, environmental allergies, rheumatoid arthritis, lupus, Sjogren's syndrome

Other conditions, surgeries, or problems you feel are significant _____
_____
Are you allergic to any medications or other substances? If yes, please list □ Yes □ No _____
_____

Your primary medical doctor and phone number: _____

Do you take any medication? □ Yes □ No **Please list any medications you take (or provide a medication list):**
_____
_____

XPatient/Guardian Signature _____ Date _____

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HIPAA Privacy Acknowledgment

I may refuse to sign this acknowledgment and authorization. In refusing, this office may not be allowed to process my insurance claims.

I acknowledge receipt of the Notice of Privacy Practices regarding how Matthew E. Kent, OD, PA dba Little Wood Vision Clinic may use and disclose my protected health information.

I understand that Little Wood Vision Clinic reserves the right to change the Notice of Privacy Practices and that a copy of the revised notice may be provided to me upon my request and is also available on this office's website.

I understand that this office may contact me by mail, email, text, or phone for such things as appointment confirmations, exam recall notifications, order notifications, treatment and billing information, etc.

- Patient/Guardian Signature: _____
- Patient's Printed Name: _____
- Date: _____

Optional Additional Release of Information Request

Sometimes patients would like family members or close friends to have full access to his or her records in order to assist in patient care. This is optional.

I authorize the release of my protected health information (including the diagnosis, records, examination rendered to me, and claims information). This Release of Information will remain in effect until terminated by me in writing. This information may be released to:

Spouse:_____

Child(ren):_____

Other (list relationship):_____

- Patient/Guardian Signature:_____
- Date:_____

Office Use Only: To be completed only when a patient declines to sign acknowledgement.
_____ Check here if patient declined to sign acknowledgement.
Signature of Privacy Officer_____ Date:_____

Authorization to Send and Receive Medical Information by Email/Text

Little Wood Vision Clinic (the "Practice") sends patient information by e-mail and/or text messaging.

RISKS: Transmitting information by e-mail/text, however, has a number of risks that patients should consider before using e-mail/text (the "Risks"). These include, but are not limited to, the following Risks:

1. E-mail/text can be circulated, forwarded, and stored in numerous paper and electronic files.
2. E-mail/text can be immediately broadcast worldwide and be received by many intended and unintended recipients.
3. E-mail/text senders can easily misaddress an e-mail or text.
4. E-mail/text is easier to falsify than handwritten or signed documents.
5. Backup copies of e-mail/text may exist even after the sender or the recipient has deleted his or her copy.
6. Employers and on-line services have a right to archive and inspect e-mails/texts transmitted through their systems.
7. E-mail/text can be intercepted, altered, forwarded, or used without authorization or detection.
8. E-mail/text can be used to introduce viruses into computer systems.
9. E-mail/text can be used as evidence in court.

CONDITIONS: Because of the Risks outlined above, the Practice cannot guarantee the security and confidentiality of e-mail/text communication, and will not be liable for improper use and/or disclosure of confidential information that is not caused by the Practice's intentional misconduct. Thus, patients must consent to the use of e-mail/text for patient information. Consent to the use of e-mail/text includes agreement with the following conditions:

1. All e-mails/texts to or from the patient concerning diagnosis or treatment may be saved as part of the medical record. Because they are a part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, may have access to those e-mails/texts.
2. The Practice may forward e-mails internally to the Practice's staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. The Practice will not, however, forward e-mail to independent third parties without the patient's prior written consent, except as authorized or required by law.
3. Although the Practice will endeavor to read and respond promptly to an e-mail/text from the patient, the Practice cannot guarantee that any particular e-mail/text will be read and responded to within any particular period of time. Thus, the patient shall not use e-mail/text for medical emergencies or other time-sensitive matters.
4. If the patient's e-mail/text requires or invites a response from the Practice, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail/text and when the recipient will respond.

5. The patient should not use e-mail/text for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
6. The patient is responsible for informing the Practice of any types of information the patient does not want to be sent by e-mail/text, in addition to those set out in the preceding paragraph.
7. The patient is responsible for protecting his/her password or other means of access to e-mail/text.
8. The Practice is not liable for breaches of confidentiality caused by the patient or any third party.
9. The Practice shall not engage in e-mail/text communication that is unlawful, such as unlawfully practicing medicine across state lines.
10. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

INSTRUCTIONS: To communicate by e-mail/text, the patient shall:

1. Limit or avoid use of his/her employer's computer.
2. Inform the Practice of changes in his/her e-mail address or text number.
3. Put the patient's name in the body of the e-mail/text.
4. Include the category of the communication in the e-mail's subject line or body of a text message, for routing purposes (e.g., billing question).
5. Review the e-mail/text to make sure it is clear and that all relevant information is provided before sending to the Practice.
6. Inform the Practice that the patient received an e-mail/text from the Practice.
7. Take precautions to preserve the confidentiality of e-mails/texts, such as using screen savers and safeguarding his/her computer password.
8. Withdraw consent only by e-mail or written communication to the Practice.
9. Contact the Practice's Privacy Official at 208-537-2020 with any unanswered questions before communicating with the Practice via e-mail or text message.

PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand the information the Practice has provided me regarding the Risks of using e-mail and text messaging. I understand the risks associated with the communication of e-mail and text between the Practice and me, and consent to the conditions outlined in this document. In addition, I agree to the instructions outlined above, as well as any other instructions that the Practice may impose regarding e-mail or text message communications.

_____ _____

Signature of patient or personal representative Date

_____

Printed name of patient or personal representative