WELCOME TO THE GAFFNEY EYE CLINIC

BARRY M. GAFFNEY O.D. P.A.
JEREMY H. GAFFNEY O.D.
DANIEL G. GAFFNEY O.D.

DATE_____

PATIENT'S NAME MR ☐ MISS ☐ MRS ☐ MS ☐ _____

DATE OF BIRTH_____AGE_____

SOCIAL SECURITY NUMBER_____

MAILING ADDRESS_____

CITY_____STATE____ZIP_____HOME PHONE( )_____

EMPLOYER_____ WORK PHONE( )_____

OCCUPATION_____HOW LONG_____ CELL PHONE ( )_____

E-MAIL ADDRESS_____

NAME OF SPOUSE_____PARENTS(IF CHILD)_____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE_____

PRIMARY CARE
PHYSICIAN_____

INSURANCE INFORMATION (VISION & HEALTH)

INSURANCE COMPANY_____

POLICY #_____GROUP #_____

SUBSCRIBER NAME (MEMBER)_____

BIRTHDATE_____SS#_____

ARE YOU PLANNING TO GET NEW GLASSES ON THIS VISIT? YES ☐ ***NO*** ☐

MEDICAL HEALTH HISTORY

Name: _____ Birthdate: _____ Age: _____ Date: _____

❖ PAST EYE HISTORY

Last eye exam:_____ Name and location of Eye Doctor: _____Type of treatment: _____

Do you wear: Glasses? ☐ Yes ☐ No Last Worn: _____Contact Lenses? ☐ Yes ☐ No Last Worn: _____

Have you ever been diagnosed with any of the following eye problems:

DISEASE/CONDITION	SELF YES	NO	EXPLAIN
Injury	☐	☐	_____
Surgery	☐	☐	_____
Disease	☐	☐	_____
Blindness	☐	☐	_____
Cataract	☐	☐	_____
Strabismus	☐	☐	_____
Lazy Eye (Amblyopia)	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Other_____	☐	☐	_____

MEDICATIONS: **NONE** ☐

Family Medical History Has anyone in your blood related family (parents, grandparents, siblings, children ;(living or deceased) ever been diagnosed with any of the following conditions:

DISEASE/CONDITION	YES	NO	RELATION
Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
Nerve Condition	☐	☐	_____
Thyroid Disease	☐	☐	_____

EYE PROBLEMS	YES	NO	RELATION
Blindness	☐	☐	_____
Cataract	☐	☐	_____
Strabismus	☐	☐	_____
Lazy Eye (Amblyopia)	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Other	☐	☐	_____

Name and Location of Medical Doctor: _____ Dr.'s Phone: _____

Name and Location of Specialist Doctor:_____ Dr.'s Phone: _____

Last Medical Exam: _____

Do you have allergies to medications? ☐ Yes ☐ No If yes, explain: _____

Do you have allergies to non-medication items? ☐ Yes ☐ No If yes, explain: _____

List major injuries, surgeries and /or hospitalizations you have had: _____

_____

_____

Social History: This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. Yes, I would prefer to discuss my social History information with my doctor. (Check Box) ☐

Employer or School: _____ Occupation/School _____

What Hobbies or avocations do you have? _____

Do you use tobacco products? ☐ Yes ☐ No If yes, type/amount/how long: _____

Do you drink alcohol? ☐ Yes ☐ No If yes, type/amount/how long: _____

Do you use illegal drugs? ☐ Yes ☐ No If yes, type/amount/how long: _____

REVIEW OF SYSTEMS

NO Medications ☐
Medications:

Constitution None_____
☐ Developmental Disability: _____
☐ Fatigue: _____
☐ Trauma: _____
☐ Weightloss/Gain: _____
☐ Other : _____

Integumentary None _____
☐ Eczema: _____
☐ Psoriasis: _____
☐ Rosacea: _____
☐ Other : _____

Neurological None _____
☐ Headache: _____
☐ Migraine: _____
☐ Multiple Sclerosis: _____
☐ Seizures: _____
☐ Stroke Damage: _____
☐ Other : _____

Ear, Nose, And Throat None _____
☐ Dry Throat/Mouth: _____
☐ Hearing Loss: _____
☐ Sinus Drainage: _____
☐ Other: _____

Respiratory None _____
☐ Asthma: _____
☐ Bronchitis: _____
☐ Emphysema: _____
☐ Lung Cancer: _____
☐ Other : _____

Gastrointestinal None _____
☐ Crohn's: _____
☐ Diarrhea: _____
☐ Hiatal Hernia: _____
☐ Reflux: _____
☐ Ulcer : _____
☐ Other : _____

Endocrine None _____
☐ Hormonal: _____
☐ Thyroid: _____
☐ Diabetes: _____ **A1C:** _____

First Diagnosed: _____ Last Check-Up: _____
Family With: _____
☐ Other: _____

Cardiovascular None_____
☐ Heart Disease: _____
☐ Hypertension: _____
☐ Stroke: _____
☐ Vascular Disease: _____
☐ Other: _____

Hematological/Lymphatic None _____
☐ Anemia: _____
☐ Cholesterol: _____
☐ Leukemia: _____
☐ Triglycerides: _____
☐ Other: _____

Psychiatry None _____
☐ Alzheimer's: _____
☐ Depression: _____
☐ Nerve Condition: _____
☐ Panic Disorder: _____
☐ Psychosis: _____
☐ Other: _____

Genitourinary None _____
☐ Genital: _____
☐ Kidney Ailments: _____
☐ Urinary Tract Infection: _____
☐ Other: _____

Musculoskeletal None _____
☐ Ankylosing Spondylitis: _____
☐ Fibromyalgia: _____
☐ Muscular Dystrophy: _____
☐ Osteoarthritis: _____
☐ Other: _____

Allergic/Immunologic None _____
☐ Drug Allergy: _____
☐ Environmental Allergy: _____
☐ Lupus: _____
☐ Rheumatoid Arthritis: _____
☐ Sarcoid: _____
☐ Other: _____

_____ _____
Doctors Signature Date

INFORMATION REGARDING DILATING EYE DROPS

DILATION IS THE STANDARD OF CARE TO ALLOW THOROUGH EVALUATION OF EYE TISSUE FOR A NUMBER OF EYE CONDITIONS. The use of dilation drops temporarily increases the size of your pupils, which allows an eye physician to more accurately investigate the health of your eyes. Dilation drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your physician to predict how much your vision will be affected, and because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself. For a short time, wearing sunglasses may be a necessary comfort. Adverse reactions, such as acute angle-closure glaucoma, may also be triggered and/or diagnosed by the dilating drops. Call our office immediately if you experience excessive pain, discomfort, nausea, or any other untoward symptoms. Thank you for your assistance during this important procedure.

By signing this form I hereby acknowledge that I am aware of the above information and authorize my physicians and/or their assistants to administer dilating eye drops to assist in the optimum evaluation of my eyes. My acknowledgement and authorization shall be without expiration, but I am aware that (as all other diagnostic or treatment procedures) AT ANY TIME I MAY ELECT TO NOT HAVE THIS IMPORTANT PROCEDURE BY SIMPLY INFORMING THE TECHNICIAN AND/OR PHYSICIAN. If I elect to not use dilating drops for my examination, I also hereby affirm that I am aware that my decision may reduce the ability of my physician to optimally care for my eyes.

X_____ _____

Signed by Patient Date

(or person authorized to sign for patient)

Name:

Dry Eye Center of Central Florida

Basic Dry Eye Questionnaire

Office Hours by Appointment

Address: **2002 S. Alexander St.**
Plant City, FL 33563

Do you ever experience:

Gritty or Sandy Sensation?	☐ Never	☐ Slight	☐ Moderate	☐ Severe
Pain or Soreness?	☐ Never	☐ Slight	☐ Moderate	☐ Severe
Fluctuating Vision?	☐ Never	☐ Slight	☐ Moderate	☐ Severe
Occasional Tearing?	☐ Never	☐ Slight	☐ Moderate	☐ Severe
Blurred Vision While Reading?	☐ Never	☐ Slight	☐ Moderate	☐ Severe
Discomfort in Windy Conditions?	☐ Never	☐ Slight	☐ Moderate	☐ Severe
Discomfort in air conditioned areas?	☐ Never	☐ Slight	☐ Moderate	☐ Severe
Itching?	☐ Never	☐ Slight	☐ Moderate	☐ Severe

Barry M. Gaffney, O.D., P.A.
Jeremy H. Gaffney, O.D.
2002 S. Alexander Street
Plant City, FL 33563-8410
Ph. 813-754-3593
Fax. 813-754-5464

Member
American Optometric Association

NOTICE OF PRIVACY PRACTICES

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 AUTHORIZATION 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;
- [specify other uses and disclosures affected by state law].

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.

Psychotherapy notes. Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATIONFOR 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. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also 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.** We are not required to agree to these requests. 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.** You must make such requests in writing to the address below. However, 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.** You must make such requests in writing to the address below. 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. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:
  - was not created by us, unless the person that created the information is no longer available to make the amendment,
  - is not part of the health information kept by or for us,
  - is not part of the information you would be permitted to inspect or copy, or
  - is accurate and complete.
- **To receive an accounting of disclosures of your health information.** You must make such requests in writing to the address below. 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 and may not include dates before April 14, 2003. 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:

Debra Williams	**2002 S. Alexander Street**
Name	Address

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 E mail 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: 09/23/2013

NF 5/2013

GAFFNEY EYE CLINIC

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I _____ _____
Patient Name Parent or Guardian Name if Minor

Acknowledge that I have received a copy of the Notice of Privacy Practices from
DR. BARRY M. GAFFNEY OD PA / DR. JEREMY H. GAFFNEY OD.

By signing this form, I authorize ***BARRY M. GAFFNEY OD PA / JEREMY H. GAFFNEY OD***
To release my Medical and Billing Information to the listed individuals: I am aware that I can revoke the authorization for any individual at any time, but must do so in writing.

The following individuals have my authorization to access my Protected Health Information, and to pick up : Prescriptions, Glasses , Contact Lenses, Etc..

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

Gaffney Eye Clinic may leave appointment information on my voicemail:

Home ☐ Yes ☐ No

Work ☐ Yes ☐ No

Cell ☐ Yes ☐ No

Email ☐ Yes ☐ No **Email:** _____

_____ _____
Signature of Patient **Date**

_____ _____
Signature of Parent or Guardian if Minor **Date**