WELCOME TO OUR OFFICE

For faster service, please complete the following form prior to arriving at our office.

Appointment Date ____/____/_____

Patient's Name (please print) _____

If a child, name of parent(s) _____

Patient's Birth Date ____/____/_____ Patient's Gender ___ Male ___ Female

Street Address _____

City _____ State _____ Zip Code _____

Preferred Phone (Home / Cell / Work) *circle one*

Home ph# _____ Cell ph# _____ Work ph# _____

e-Mail Address _____

Vision Plan _____ Member ID _____

Health Insurance _____ Member ID _____

How did you find out about our office? _____

I authorize the release of any medical information necessary to provide the most beneficial and complete visual examination. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due at the time services are rendered.

Signature _____ Date ____/____/_____
(Parent or guardian if patient is a minor)

BERLIN EYECARE ASSOCIATES - DR. JOSEPH POTOSKY
204 HADDON AVENUE WEST BERLIN, NJ 08091 PH (856) 768-2515

MEDICAL HISTORY RECORD

For faster service, please complete the following form prior to arriving at our office.

Appointment Date ____/____/____

Patient's name _____ Date of Birth ____/____/____

Street Address _____ City, State, Zip _____

Preferred Ph# (Home / Cell) _____ eMail _____
circle one

**** NEW PATIENTS ONLY ****

Date of last eye exam ____/____/____ Previous eye doctor _____

PERSONAL MEDICAL INFORMATION: Do you have problems with any of these systems? *Check all that apply.*

☐ Allergic/Immunologic ☐ Blood/Lymph ☐ Cardiovascular ☐ Ear/Nose/Throat ☐ Endocrine (Glands)

☐ Gastrointestinal ☐ Genitourinary ☐ Headaches ☐ Mental ☐ Musculoskeletal

☐ Nervous System ☐ Respiratory ☐ Skin

☐ Surgeries *(what type & when)* _____

Are you in good health? ☐ Yes ☐ No **Primary physician's name** _____

Please list any allergies (medications or other substances). If no allergies, please check "None". ☐ None

_____

CURRENT MEDICATIONS

– please list names, dosages (if known) & how often taken. If not currently taking medications please check "None". ☐ None

_____

_____

Do you have a family history of any of the following? *Check all that apply.*

☐ Diabetes ☐ Macular Degeneration ☐ Glaucoma

☐ Cataracts ☐ Retinal Detachment ☐ High blood pressure

Please explain any checked boxes _____

Do you?

Smoke Yes ☐ No ☐ Amt _____

Drink Alcohol Yes ☐ No ☐

Frequency _____

Do you have any of the following? *Check all that apply.*

☐ Dry Eyes ☐ Blurred Vision ☐ Wear Glasses ☐ Wear Contacts ☐ Eye Surgeries ☐ Eye Injuries

Any eye problems at this time? _____

Please sign below to indicate you have reviewed all information above and it is correct to the best of your knowledge.

Signature _____ **Date** _____

Signature of parent or guardian if patient is a minor

NOTICE OF PRIVACY PRACTICES

Note: This Notice of Privacy Practice is provided for educational and informational purposes only. This Notice is not intended as legal advice, and is not provided for adoption or publication by any party. The publication of any such notice may create legal obligations or liabilities, which may vary depending upon the legal status and business operations of different organizations. The form and content of any Notice of Privacy Practices should be determined only upon informed consultation with qualified legal counsel.

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.

This notice is effective 05/10/2022 until further notice

Right to Notice: As a patient, you have the right to adequate notice of the uses and disclosures of your protested health information. Under the Health Insurance Portability and Accessibility Act (HIPPA). Berlin Eyecare Associates can use your protected health information for treatment, payment and health care options.
a) Treatment - We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
b) Payment - We may use and disclose your health information to obtain payment for services we provide you.
c) Health Care Operations - We may use and disclose your health information in connection with our healthcare operations. [Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of health care professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.]

Your Authorization: Most uses and disclosures that do not fall under treatment, payment, health care operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

Emergency Situations: In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your healthcare.

Marketing: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may also use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to you or other people's health or safety.

National Security: We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized Federal officials, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders via telephone, e-mail or letter/postcard.

Your Rights As A Patient: You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or healthcare operations. You have the right to receive confidential communications regarding your protected health information. You have the right to inspect and copy your protected health information. You have the right to amend your protected health information. You have the right to receive an account of disclosures of your protected health information, You have the right to a paper copy of this notice of privacy practices.

Legal Requirements: Berlin Eyecare Associates is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies and any new notice will not be in effect until they are posted to this site, or are available within our office.

Complaints: If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint.

Contact Information: For further information about Berlin Eyecare's privacy policies, please contact:
Berlin Eyecare Associates
204 Haddon Avenue
West Berlin, New Jersey 08091
856-768-2515

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We ask that you sign this form to acknowledge you reviewed/received a copy of our Notice of Privacy Practices.

I have reviewed/received Berlin Eyecare Associates Notice of Privacy Practices.

____

Patient name (please print)

______________________________ ______________

Patient's Signature or Signature of Adult Representative Date

____

e-mail address (optional)
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CONSENT TO OBTAIN MEDICATION HISTORY

Berlin Eyecare Associates has adopted an electronic medical records system in order to improve the quality of our services. With your permission, this system also allows us to collect and review your medication history. A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer. You benefit from this information sharing by enabling us to reconcile your medications more easily, thereby preventing any undesired drug interactions.

To provide this service, we securely connect to a patient's medication history data stored in the databases of community pharmacies and pharmacy benefit managers through software from a certified vendor. We are required to obtain all necessary patient consents prior to electronically accessing a patient's medication history. Please rest assured that we will treat this shared information, like all other Protected Health Information, with the utmost due care, as HIPAA requires.

Please carefully read the information before making your decision.

○ **I GIVE CONSENT to access** my electronic medication history in connection with providing me any health care services, including emergency care.

○ **I DENY CONSENT to access** my electronic medication history for any purpose, *even in a medical emergency*.

_____
Print Name of Patient

_____
Signature of Patient or Patient's Legal Representative

_____
Date