JENNIFER M. GUDAS, O.D.
633 E. 13th St., P.O. Box 365 Winamac, IN 46996
Ph. (574) 946-3944 Fax (574) 946-6843

MEDICAL HISTORY

(PLEASE FILL OUT COMPLETELY)

Last Name:_____ First Name:_____
Address:_____ Home Phone:_____
City:_____ State:_____ Zip:_____ Cell Phone:_____
Birthdate:_____ Sex: Male Female Occupation:_____
Social Security #:_____
Guardian (if applicable):_____ Relationship:_____
E-mail:_____
Communication Pref. (Circle One): Home Cell Text Email

Vision Insurance? Y N Vision Insurance Carrier:_____
Name of Member:_____ Member Date of Birth:_____
Member Social Security # :_____ Member ID#:_____

Health Insurance? Y N Health Insurance Carrier:_____
Name of Member:_____ Member Date of Birth:_____
Member Social Security # :_____ Member ID#:_____

Medical History:

Primary Care Physician:_____

Do you have any allergies, including medication and environmental? Yes or No If yes, please explain_____
_____
List any medications you take (including oral contraceptives, over-the-counter medications, and home remedies)

_____

_____

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

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, retinal disease, eye infections, or eye injury_____

Are you pregnant and/or nursing [ ] No [ ] Yes If pregnant, how many weeks?_____ Due Date:_____

Tobacco Use: [ ]Never Smoked [ ]Former Smoker [ ] Current Everyday Smoker [ ]Current Some Day Smoker
[ ] Current Smokeless Tobacco User

Eye Color:_____ Date and location of last eye exam:_____

Do you wear glasses? [ ] No [ ] Yes If yes, at what age did you start wearing glasses? _____
Glasses Type: [ ] Single vision [ ] Bifocal [ ] Progressives

Do you wear contacts? [ ] No [ ] Yes If yes, what brand do you wear? _____
How often do you dispose of contact lenses? _____

Health History:

Please note any family history for the following conditions:

Disease/Condition	Self	Relative
Blindness	[ ]	[ ]
Cataract	[ ]	[ ]
Crossed Eyes	[ ]	[ ]
Glaucoma	[ ]	[ ]
Macular Degeneration	[ ]	[ ]
Retinal Detachment/Disease	[ ]	[ ]
Heart Disease	[ ]	[ ]
High Blood Pressure	[ ]	[ ]
Cancer	[ ]	[ ]

Disease/Condition	Self	Relative
Kidney Disease	[ ]	[ ]
Lupus	[ ]	[ ]
Thyroid Dysfunction	[ ]	[ ]
Arthritis	[ ]	[ ]
Diabetes Type 1	[ ]	[ ]
Diabetes Type 2	[ ]	[ ]

Other_____

_____

_____

Review of Systems:

	YES		YES
Constitutional:		**Bones/Joints/Musculoskeletal:**	
Fever, Weight Loss/Gain	[ ]	Rheumatoid Arthritis	[ ]
		Muscle Pain	[ ]
Vascular/Cardiovascular:		Joint Pain	[ ]
High Cholesterol	[ ]		
Heart Pain	[ ]	**Integumentary:**	
High Blood Pressure	[ ]	Skin	[ ]
Vascular Disease	[ ]		
		Neurological:	
Ear, Nose, Mouth, Throat:		Headaches	[ ]
Allergies/Hayfever	[ ]	Migraines	[ ]
Sinus Congestion	[ ]	Seizures/Tremors	[ ]
Runny Nose	[ ]		
Post-Nasal Drip	[ ]	**Psychiatric:**	
Chronic Cough	[ ]	Depression	[ ]
Dry Throat/Mouth	[ ]	Dementia	[ ]
		Anxiety	[ ]
Respiratory:			
Asthma	[ ]	**Endocrine:**	
Chronic Bronchitis	[ ]	Thyroid/Other Glands	[ ]
Emphysema	[ ]	Diabetes (Type 1 or Type 2)	[ ]
Gastrointestinal:		**Lymphatic/Hematologic:**	
Chronic Diarrhea	[ ]	Anemia	[ ]
Chronic Constipation	[ ]	Bleeding Problems	[ ]
Genitourinary:		**Allergic/Immunologic:**	[ ]
Genitals/Kidney/Bladder	[ ]		

If you answered yes to any of the above, or have a condition not listed, please explain:_____

_____

_____

_____

Patient Name_____

HIPAA Compliance Acknowledgement of Receipt

I acknowledge that I have received a copy of Jennifer M. Gudas, O.D., P.C. Notice of Privacy Practices.

Signed_____ Date_____

Authorization to Discuss Your Information with Family or Caregivers

To comply with the new HIPAA Federal Privacy Regulations, we must receive your written approval to discuss your case with anyone else, including your family, children, caregivers, etc. By authorizing this, we will be able to, without requiring your presence, discuss your case, answer questions, leave detailed messages, and contact the person(s) listed below in the event of an emergency. If you would like us to answer questions or discuss your case with anyone other than yourself, you must include them below. This authorization is optional and can be withdrawn at any time by you.

Name: _____ Ph.:_____
Relationship: _____
Name: _____ Ph.:_____
Relationship: _____
Name: _____ Ph.:_____
Relationship: _____
Name: _____ Ph.:_____
Relationship: _____

Authorization to File/Refile/Collect from Insurance

I authorize Dr. Gudas to release to my insurance carriers, including Medicare, any information required to file or resubmit my claim. I further authorize all Insurance companies, including Medicare Supplements, to pay Jennifer M. Gudas, O.D., P.C. directly on my behalf. I authorize all Insurance companies, Medicare, Medicaid, and Medicare Supplements to provide any information required to resubmit any denied or incorrectly paid claims. This authorization remains in effect until withdrawn by me.

Signed_____ Date_____

Patient Name_____

Payment Policy

Please check one of the following payment options. By checking this option and signing this form you agree to follow this option as described. If you have any questions please contact our office. Thank you!

SPECIAL NOTES:

A. **PAYMENT IS DUE AT THE TIME OF SERVICE OR WHEN RECEIVING MATERIALS.** If other arrangements are necessary, they must be made **PRIOR** to receiving services.

B. **In the case of separated or divorced parents**, whoever brings the child to their appointment is responsible for the bill.

C. **Insurance Patients** – Due to the increasing complexity and variability of the many different insurance plans today, and because more and more of the plans reimburse the patient directly, we are now asking our patients to pay their bill directly to our office. If the insurance payment comes to our office, we will promptly refund the patient. Also, please make sure we have a copy of your current insurance card.

PLEASE CHECK ONE OF THE FOLLOWING PAYMENT OPTIONS:

___1. **CASH/CHECK/CREDIT CARD** – "I will pay in full when my services are rendered. I will pay 50% today for any materials ordered and the balance when I receive them."

___2. MEDICARE PART B – (TRADITIONAL MEDICARE ONLY! WE DO NOT ACCEPT MEDICARE REPLACEMENT PLANS!)"I will pay in full today for any deductibles and extra charges that I owe." NOTE: Our office is not required to wait for the secondary insurance to pay before billing you directly for the unpaid balance.

___3. VSP, EYEMED, VCP, UMR, PBA – "I will pay in full today for any copays, deductibles and any extra charges that I owe."

___4. MEDICAID – "I understand that if Medicaid does not pay for any of my services or materials, I am responsible and agree to pay for them myself."

___5. OTHER VISION INSURANCE – (INCLUDING MEDICARE REPLACEMENT PLANS SUCH AS ANTHEM, HUMANA, AARP) "I have not previously filed this vision insurance in this office; therefore, we are not familiar with the insurance benefits and payments. I agree to pay for all charges in full when my services are rendered as is stated in Option #1 above and will request that the insurance payment come directly to me. If payment is received by this office they will promptly refund me."

Name of your insurance company: _____

I agree to pay all of my charges as promised. I further agree upon default to pay 1.5% per month (18% per annum) on any unpaid balances along with all costs of collection including reasonable attorney fees. I further agree that any dispute with regard to payment of this debt shall be subject to the laws of the State of Indiana and by my signature am submitting myself to the jurisdiction of the courts of Indiana.

_____ _____

Patient's Signature Date

Patient Name_____

INSURANCE PATIENTS

Your insurance policy is a contract between you and your Insurance Company or employer and it is important for you to be an informed consumer, who understands the specifications of your insurance policy. We contract with many insurance plans and there is no way to fully determine what your specific plan will cover. If you are uncertain about your current insurance policy benefits you should contact your plan to learn the details about your benefits, out-of-pocket fees and coverage limits.

Before your appointment, please be sure our doctor is in-network and the services are covered under your plan. If our doctor is out-of-network, you will be billed for the cost of care. If your insurance carrier is not one with which we participate, you are responsible for payment in full.

Medicare and many other insurance plans consider some services to be "non-covered," in which case you are responsible for payment in full. For example, Medicare and some other insurances do not cover the refractive part of an eye exam. This is the part of the exam where the doctor determines what your glasses and/or contact prescription should be. This is not considered medically necessary, therefore is not covered by insurance. This fee is the patient's responsibility and will be due at the time of service.

You must present a current insurance card at each visit. As a courtesy to you, we will bill your insurance company directly for medical services rendered. However, please be advised that you are nevertheless ultimately financially responsible for payment.

_____ _____

Patient's Signature Date

optomap®
ultra-widefield retinal imaging

Jennifer Gudas, OD

Advanced Screening

By choosing ***Jennifer Gudas, OD***, you have entrusted us, as your physician, to care for your eyes: **We take this responsibility very seriously.**

We pride ourselves on providing our patients with the best possible standard of care. **Because of this, we now perform the optomap® Retinal Exam on all of our patients.** When reviewed, the scan becomes a permanent part of your medical file, enabling the doctor to make important comparisons should potential vision threatening conditions show themselves at a future examination. **The Doctor strongly believes that the optomap Retinal Exam is an essential part of your comprehensive eye exam and prescribes it for all patients once per year.**

It is our belief that an eye exam without this element is incomplete.

Today, we will perform this fast, easy and comfortable screening test as part of your annual comprehensive examination. The $30 co-pay for this procedure is not covered by insurance and will be in-addition to your examination fee or vision plan co-pay.

By choosing to have an optomap®, the doctor may NOT need to dilate your eyes. Any questions you have about the optomap® Retinal Exam can be directed to the doctor when the images are reviewed during your examination.

Thank you for allowing us to monitor the health of your eyes: Remember, they are the only two you have, and that is why we take your eye care seriously.

Sincerely-

The Doctors and staff of ***Jennifer Gudas, OD***

I have read and understand this document:

Sign: _____ Date: _____

Notice of Privacy Practices

Dr. Jennifer M. Gudas, P.C.
633 E. 13th Street, P.O. Box 365
Ph. (574) 946-3944 Winamac, IN 46996 FAX (574) 946-6843

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 of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We use and disclose your protected health information for treatment, payment, and healthcare operations. For example:

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we use your health information when our technician or doctor tests your eyes, when the doctor prescribes glasses or contact lenses, when we provide a prescription for medication to a pharmacist, and when we notify you that your glasses are ready to be dispensed. Your protected health information may also be provided to a doctor to whom you have been referred to ensure that the doctor has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, we use your health information when our staff asks you about health or vision care plans that you may belong to, or about other sources of payment for our services, and when we prepare bills to send to you or your vision care plan.

Healthcare Operations: We may use or disclose, as needed, your protected health information for administrative and managerial functions that we have to do in order to run our office. These activities include, but are not limited to, financial and billing audits, internal quality assurance, personnel decisions, and participation in managed care plans. We may also call you by name in the waiting room when your doctor is ready to see you. Unless you object, we may use or disclose your protected health information, as necessary, to provide you with appointment or recall reminders (such as voicemail messages, postcards, or letter).

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us this authorization, you may revoke it in writing at anytime. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only with your approval.

Other Uses and Disclosures: We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures.

2. PATIENT RIGHTS

You have the right to inspect and copy your protected health information. Except for a few limited situations in which we can legally refuse to permit access or copying, you may review or copy your health information within 30 days of your written request. You may have to pay for photocopies in advance.

You have the right to request a restriction of your protected health information. This means you may ask us in writing not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your written request must state the specific restriction requested and to whom you want the restriction to apply. Your doctor is not required to agree to a restriction that you may request. If your doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate these written requests if they are reasonable, and if you pay us for any extra cost.

You may have the right to have your doctor amend your protected health information. If we deny your written request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payments, healthcare operations and certain other activities, for the last 6 years (or a shorter period if you want), but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

3. QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made regarding your privacy rights, you may submit a written complaint to our office or to the U.S. Department of Health and Human Services. We support your right to the privacy of your health information. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before **April 14, 2003.** We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.