BROOKRIDGE EYE CARE
5116 S. Broadway
Englewood, CO 80110-6706
(303) 761-3285

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

Patient Name ______________________________ Birth Date ________

I understand that as a part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

☐ **I request the following restrictions to the use or disclosure of my health information:**

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____
Signature (Parent or Guardian if Patient is a Minor) Date ____________

(circle one): Mr. Mrs. Ms. Dr. ____
Last Name First Name MI

Address ______________________________ Apt. # ______ Home Phone ______________

City ______________________ State _____ Zip Code __________ Work Phone ______________

Birth Date ___/___/___ Social Security # ____________________ Cell Phone ______________

Who may we thank for referring you to our office? __________________ Occupation ______________

Email: ____

Primary Member Insurance Information or Person Responsible for Payment (if other than patient)

Member Name ______________________________ Member Date of Birth ___/___/___

Address ______________________________ City ______________ State ________

Zip Code __________ Relationship to Patient ____________ Social Security # ______________

Name of Vision Insurance Carrier ____

When was your last eye exam? ________ What Office or Doctor? ______________________

Circle "P" (patient has this health problem) or "F" (family has this health problem)

Cancer	P	F	Cataracts	P	F	Lazy Eye	P	F
Diabetes	P	F	Glaucoma	P	F	Headaches	P	
Heart Disease	P	F	Macular Degeneration	P	F	Floaters	P	
HIV	P	F	Retinal Detachment	P	F	Allergies	P	
High Blood Pressure	P	F	Eye Surgery	P	F	Dry Eyes	P	
Thyroid Disease	P	F	Eye Injury	P		Other Surgery	P	

Other Health Problems ____
(please list)

Current Medications ____
(please list)

Medications Allergic to ____
(please list)

Currently Pregnant or Nursing? Y/N Interested in LASIK? Y/N

Currently wearing contact lenses? Y/N If Yes, what brand of contact lenses? ______________

Do you work with a computer? Y/N What are you interested in? Contact Lenses/ Glasses

Do you use smoke or drink alcohol? Y/N

Pupil Dilation

Pupil dilation has become the standard of care and is a part of the eye exam. In order to thoroughly determine the health of the eyes, it is recommended that you dilate your pupils. Eye drops are used to enlarge the pupil in order to fully visualize the inside of the eye. Some ocular diseases are only found in the periphery of the eye and a dilated fundus examination is the only way to visualize the periphery. In addition to dilating the pupils, the drops also will blur your near vision and cause some sensitivity to bright light for about 4 to 6 hours. *People usually have no problem driving after pupil dilation.*

I accept pupil dilation _____ I decline pupil dilation _____

I realize that BROOKRIDGE EYE CARE is billing my insurance as a courtesy. I also authorize BROOKRIDGE EYE CARE to exchange any information necessary for treatment, payment and health care operations. I assume responsibility for any fees not covered under my insurance plan.

Signature (Parent or Legal Guardian if under 18) ______________________________ Date ____________