Bloom Family Eye Surgeons

Child Information

First Name_____ MI_____ Last Name_____ DOB_____

Age_____ SS# _____-_____-_____ Address_____

City_____ State_____ Zip_____ Sex: Male / Female

Pediatrician / Family Doctor_____ Referring Doctor_____
Who does The Child Live with: ☐Both Parents ☐Mother ☐Father ☐Other_____
Do any of your other children see Dr. Bloom? ☐Yes ☐No
If yes, please write the other patient's names_____

Parent Information

☐Mother ☐Stepmother ☐Guardian ☐Foster Parent

Name_____DOB_____ SS#_____-_____-_____

☐Single ☐Married ☐Divorced Home Phone (_____)_____ Cell phone (_____)_____

Email Address_____Work Phone (_____)_____

Employer _____ Occupation _____

☐Father ☐Stepfather ☐Guardian ☐Foster Parent

Name_____ DOB_____ SS#_____-_____-_____

☐Single ☐Married ☐Divorced Home Phone (_____)_____ Cell Phone (_____)_____

Email Address _____Work Phone (_____)_____

Employer_____ Occupation_____

PARENT BRINGING CHILD FOR APPOINTMENT WILL BE RESPONSIBLE FOR CHARGES

Insurance Information

Primary Medical Insurance_____Policy Holder Name_____

Policy Holder DOB_____ Policy Holder Relationship to Patient_____

Secondary Medical Insurance_____ Policy Holder Name_____

Policy Holder DOB_____ Policy Holder Relationship to Patient_____

Authorization: I, with my signature, authorize Bloom Family Eye Surgeons LTD., and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am legal guardian. I also authorize Bloom Family Eye Surgeons LTD., to furnish information to the identified insurance carrier(s) for prior authorization, pre-certification, or payment of health care services. This information may include claims, copies of medical information, faxes and phone calls concerning care provided or proposed. I shall assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the insurance plan, as required by my contract with my insurance plan and state regulation.

Signed:_____ Date:_____ Relationship to Patient:_____

I also authorize and give consent to the identified physician / practice and other health care professional associates with this physician to discuss my care or other relevant information with attorneys, accountants, malpractice carriers, outside consultants, transcription, billing agents, coding specialists as deemed necessary by my physician. This includes all services relating to my medical care, including, hospital services, nursing home services, lab services, radiology services and care directly ordered by my physician. This contact may include ongoing correspondence with referring and consulting physicians for the duration of your care with them as needed for the continuity of care.

I further understand that my contract with my health care insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If I seek care outside of the contract, I am aware that I may be responsible for charges that are incurred.

Patient/Guardian _____ Intial Date:_____

I have reviewed the above information, and there is no change, or changes have been provided
Reviewed ☐ _____/11 ☐ _____/12 ☐ _____/13 ☐ _____/14 ☐ _____/15

****Medical History Questionnaire****
Does the patient currently have problems in the following areas?

	YES	NO		YES	NO
Skin Problems	_____	_____	Headaches	_____	_____
Ears, Nose, Throat	_____	_____	Neck	_____	_____
Respiratory (lungs.breathing)	_____	_____	Cardiovascular (heart)	_____	_____
Gastrointestinal (stomach)	_____	_____	Bones, joints, muscles	_____	_____
Neurological System	_____	_____	Lymphatic (lymph nodes)	_____	_____
Blood Disorder	_____	_____	Allergic/Immunology	_____	_____
Psychiatric	_____	_____	Loss of Vision	_____	_____
Blurred vision	_____	_____	Distorted vision	_____	_____
Double vision	_____	_____	Dry eyes	_____	_____
Red eyes	_____	_____	Itchy eyes	_____	_____
Excess tearing/watering	_____	_____	Glare/light sensitivity	_____	_____

List any medication patient is taking _____

_____

List any major illnesses or injuries_____

_____

List all hospitalizations and what they were for_____

_____

Does the patient have crossed eyes, lazy eye, drooping eyelid, prominent eyes, previous contact lens wearer?_____

_____

Does the patient have any allergies to medications? Yes No
If YES, please list_____

Is patient latex sensitive? Yes No

Family History (parent and/or sibling)

Cataract	Yes	No	Cancer	Yes	No
Glaucoma	Yes	No	Diabetes	Yes	No
Macular degeneration	Yes	No	Heart Attacks	Yes	No
Retinal Detachment	Yes	No	Stroke	Yes	No
High Blood Pressure	Yes	No	Arthritis	Yes	No
Thyroid disease	Yes	No	Blindness	Yes	No

Other_____

Physician Signature_____ Date___ _____

Bloom Family Eye Surgeons, Ltd.
One Children's Plaza
Dayton, Ohio 45404
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy apply to Bloom Family Eye Surgeons Ltd. The Medical Practices of this organization will share personal health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to your personal health information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all personal health information maintained by us. You may receive a copy of any revised notices from the Office Manager of this practice.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

YOUR AUTHORIZATION AND CONSENT: Except as outlined below, we will not use or disclose your personal health information for any purpose unless you have signed a form consenting to or authorizing the use or disclosure. You have the right to revoke that consent or authorization in writing unless we have taken any action in reliance on the consent of authorization.

USES AND DISCLOSURES FOR TREATMENT: With your signed consent, we will make uses and disclosures of your personal health information as necessary for your treatment. For instance, doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to plan a course of treatment for you that may include procedures, medications, tests, etc.

USES AND DISCLOSURES OF PAYMENT: With your signed consent, we will make uses and disclosures of your personal health information as necessary for payment purposes. For instance, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided t you or we may use your information to prepare a bill to send to you or to the person responsible for your payment.

USES AND DISCLOSURES FOR HEALTH CARE OPERATIONS: With your signed consent, we will use and disclose your personal health information as necessary, and as permitted by law, for your health care operations which include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and care of our patients.

FAMILY AND FRIENDS INVOLVED IN YOUR CARE: With your care approval, we may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

BUSINESS ASSOCIATES: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, legal services, etc. At times it may be necessary for us to provide certain parts of our personal health information to one or more of these outside people or organizations that assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

APPOINTMENTS AND SERVICES: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You have the right to request and will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You may request such confidential communication in writing and may send a request to the Office Manager of this practice.

RESEARCH: In limited circumstances, we may use and disclose your personal health information for research purposes. For example, a researcher may wish to compare outcomes of all patients that received a particular drug and will need to review a series of medical records. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements.

OTHER USES AND DISCLOSURES: We are permitted or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization.

- We may release your personal information for any purpose required by law;
- We may release your personal health information as requires by law if we suspect child abuse or neglect; we may also release your personal health information as required by law if we believe you to be a victim of abuse, neglect, or domestic violence;

- We may release your personal health information to the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls;

- We may release your personal health information to your employer when we have provided health care to you at the request of your employer; in most cases you will receive notice that information is disclosed to your employer;

- We may release your health information if required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings;

- We may release your personal health information if required to do so by a court or administrative ordered subpoena or discovery request; in most cases you will have notice of such release;

- We may release your personal health information to law enforcement officials a required by law to report wounds and injuries and crimes;

- We may release your personal health information to coroners and/or funeral directors consistent with law;

- We may release your personal health information if necessary to arrange an organ or tissue donation from you or a transplant for you;

- We may release your personal health information if you are a member of the military required by armed forces services; we may also release your personal health information if necessary for national security or intelligence activities; and

- We may release your personal health information to workers' compensation agencies if necessary for your workers' compensation benefit determination.

RIGHTS THAT YOU HAVE

ACCESS TO YOUR PERSONAL HEALTH INFORMATION: You have a right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your representative. We will charge you per page if you request a copy of the information. We will also charge for postage if you request a mailed copy and will charge for preparing a summary of the requested information if you request such summary. You can obtain an access request form from the Office Manager of this practice.

AMENDMENTS TO YOUR PERSONAL HEALTH INFORMATION: You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request. If any amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain an amendment request form from the Office Manager of this practice.

ACCOUNTING FOR DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION: You have the right to receive an accounting of certain disclosures made by us of your personal health information after April 14, 2003. Requests must be made in writing and signed by you or your representative. Accounting request forms are available from the Office Manager of this practice. The first accounting in any 12-month period is free; you will be charged a fee each subsequent accounting you request within the same 12-month period.

RESTRICTIONS ON USE AND DISCLOSURE OF YOUR PERSONAL HEALTH INFORMTION: You have the right to request restrictions on certain of our uses and disclosures of your personal health information for treatment, payment, or health operations on the consent for you sign when you become a patient. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a treatment by us, we will notify you such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to The Office Manager of this Practice.

COMPLAINTS: If you believe your privacy rights have been violated, you can file a complaint, in writing, with the Privacy Officer, Bloom Family Eye Surgeons, Ltd., One Children's Plaza, Dayton, Ohio 45404. You may also file a complaint with the Secretary of the U.S. Department Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION

If you have questions or need further assistance regarding this Notice, you may contact the Office Manager of this Practice or the Privacy Officer of Bloom Family Eye Surgeons, One Children's Plaza, Dayton, Ohio 45404. As a patient you retain the right to obtain a paper copy of this Notice of Privacy Practices.

EFFECTIVE DATE

This Notice of Privacy Practices is effective April 14, 2003.

ACKNOWLEDGEMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES BLOOM FAMILY EYE SURGEONS, LTD. ONE CHILDREN'S PLAZA DAYTON, OHIO 45404-1898

By signing below, I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices from BLOOM FAMILY EYE SURGEONS, LTD. A copy will be made available upon request.

_____
Patient's Name

_____ _____
Patient/Guardian/Parent Signature Date

_____ _____
Witness Signature Date

Documentation of Failure to Obtain Signed Acknowledgement

On _____ (date), _____ (employee name) presented this Acknowledgement of Receipt of Notice of Privacy Practices form to _____.

The Patient refused to provide a signature when requested.

Bloom Family Eye Surgeons

Michael S. Bloom, MD | **Robert T. Bloom, MD**

One Children's Plaza
Dayton, Ohio 45404
937-641-3020 • 1-800-228-8564 • Fax: 937-226-9605

• Pediatric & Adult Ophthalmology • Adult Strabismus • Laser Vision Correction • Plastic Surgery

Consent to Treatment

I authorize ***Robert T. Bloom, M.D. / Michael S. Bloom, M.D.*** to provide diagnostic and treatment services to my child / self. All rendered services, including dilation drops, will be discussed with me prior to their implementation. The dilation is standard in all children and can last from 3 hours to 24 hours and rarely longer. Your child / self may be sensitive to light and we offer complimentary sunglasses at checkout.

_____ _____

Patient / Parent Signature Date

_____ _____

Physician Signature Date