

VISION CARE

Doctors of Optometry

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www.drcoopermanoptometry.com

Dear Patient,

Greetings! Thank you for allowing us to take care of your eye care needs. We look forward to providing you with a superior experience in our office. The doctors and staff are friendly, professional, attentive, and thorough. We take pride in our customer service, and enjoy what we do.

In order to best serve your needs, please bring along the following items to your visit:

1. All prescription eyeglasses you have
2. All sunglasses (prescription or non-prescription) you have
3. If you wear disposable contact lenses: the boxes or packages that the contact lenses came in
4. All current vision and medical insurance cards you have

Enclosed are the following items - please fill them out and bring them along with you:

1. "Welcome to Our Office" form
2. "Digital Retinal Photography" form
3. Privacy forms

For additional information on our practice, please go to www.drcoopermanoptometry.com.

The mission of our practice is to provide top quality eye care in a friendly, caring environment. We look forward to meeting you!

Sincerely,

The Doctors and Staff

WELCOME TO OUR OFFICE !

Name _____ Today's Date _____

By what name do you wish to be addressed? _____ Date of Birth _____

Res. Address _____ Res. Phone () _____

City _____ State _____ ZIP _____

E-mail Address (for our electronic newsletters)
(PLEASE PRINT CLEARLY) _____ Cell Phone () _____

Employed By _____ Bus. Phone () _____

Occupation _____ Social Sec. # _____

Has anyone in your family been a patient of ours? (circle one) No Yes (name) _____

In case of emergency, notify / phone # / relationship _____

Vision Insurance _____ Medical Insurance _____ (circle one)
HMO / PPO

Whom may we thank for referring you to our office (family, friend, sign, VSP, yellow pages, etc.) _____

(Circle all items that apply)

MEDICAL HISTORY

| | | |
|---------------------|------|--------|
| Diabetes | Self | Family |
| High Blood Pressure | Self | Family |
| Thyroid | Self | Family |
| Glaucoma | Self | Family |
| Cataracts | Self | Family |
| Other | Self | Family |

VISUAL NEEDS AND ACTIVITIES

| | | |
|----------------|-------------|-------------------|
| Desk Work | Swimming | Softball |
| Computer | Skiing | Reading Music |
| Typing | Snorkling | Sewing / Knitting |
| Reading | Racquetball | Jogging |
| Fishing | Tennis | Shooting |
| Bicycle Riding | Golf | Sailing |
| Other | | |

Medications _____

Estimated hours / day using computer _____

Allergies _____

Do you wear contact lenses / type? _____

Are you pregnant? _____

If so, are you wearing them now? _____

Are you sensitive to sunlight? _____

If not, are you interested in them? _____

Do you wear prescription sunglasses? _____

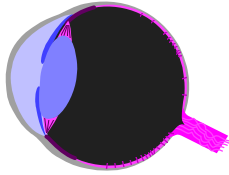
Do you experience glare from lights when night driving? _____

Do you experience itching, burning, grittiness, or other discomfort of the eyes more than just occasionally? _____

Would you like to find out if you are a candidate for laser vision correction? _____

- - PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED - -

Signature _____



Digital Retinal Photography

Our office uses the most advanced testing procedures available to ensure your eye health. The digital retina camera takes a clear picture of the important structures in the back of the eye – the retina, nerves, and blood vessels. It's quick and easy! Here are the benefits:

- **Enhanced Examination** - The details of the retina can be more carefully and deliberately studied. Fine structures are more readily visualized.
- **Early Detection of Changes in the Future** – The photo becomes a permanent part of the medical record, and is used for comparison in future examinations. It is the very best form of baseline documentation.
- **Great for Demonstration** – Our patients have really enjoyed finally seeing what the doctor has been looking at all these years!

Eye conditions such as glaucoma, macular degeneration, diabetic retinopathy, and others can be detected and followed with the digital retina camera.

There are certain findings in the retina that are associated with serious health risks. In a number of our patients, the use of the camera allowed us to detect such structures – we promptly sent those patients to their physician for treatment.

Our doctors highly recommend having a baseline digital retina image taken. The image is presented in the exam room, and the doctor gives an explanation.

The fee for this procedure is \$42.00 for both eyes, and is not covered by vision insurance.

YES, I would like to have digital retinal images taken

NO, I decline to have digital retinal images taken

Patient's Name (Please print)

Date

Notice of Privacy Practices

Effective date of notice: April 14, 2003
Drs. Cooperman and Fineberg Optometry
18449 Brookhurst St., #6
Fountain Valley, CA 92708
Phone (714) 963-2111
FAX (714) 963-4642

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

General Rule

We respect our legal obligation to keep health information, that identifies you, private. The law obligates us to give you notice of our privacy practices.

Generally, we can only use your health information in our office or disclose it outside of our office, without your written permission, for purposes of treatment, payment or healthcare operations. In most other situations, we will not use or disclose your health information unless you sign a written authorization form. In some limited situations, the law allows or requires us to disclose your health information without written authorization.

Uses or Disclosures of Health Information

Examples of how we use information for **treatment** purposes:

- When we set up an appointment for you.
- When our technician or doctor tests your eyes.
- When the doctor prescribes glasses or contact lenses.
- When the doctor prescribes medication.
- When our staff helps you select and order glasses or contact lenses.
- When we show you low vision aids.

We may disclose your health information outside of our office for **treatment** purposes, for example:

- If we refer you to another doctor or clinic for eye care or low vision aids or services.
- If we send a prescription for glasses or contacts to another professional to be filled.
- When we provide a prescription for medication to a pharmacist.
- When we phone to let you know that your glasses or contact lenses are ready to be picked up.

Sometimes we may ask for copies of your health information from another professional that you may have seen before.

We may use your health information within our office or disclose your health information outside of our office for **payment** purposes. Some examples are:

- 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.
- When we prepare bills to send to you or your health or vision care plan.
- When we process payment by credit card and when we try to collect unpaid amounts due.
- When bills or claims for payment are mailed, faxed, or sent by computer to you or your health or vision plan.
- When we occasionally have to ask a collection agency or attorney to help us with unpaid amounts due.

We use and disclose your health information for **healthcare operations** in a number of ways. Health care operations means those administrative and managerial functions that we have to do in order to run our office. We may use or disclose your health information, for example, for financial or billing audits, for internal quality assurance, for personnel decisions, to enable our doctors to participate in managed care plans, for the defense of legal matters, to develop business plans, and for outside storage of our records.

Appointment Reminders

We may call to remind you of scheduled appointments. We may also call to notify you of other treatments or services available at our office that might help you.

Uses & Disclosures without an Authorization

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never happen at our office at all. Such uses or disclosures are:

- A state or federal law that mandates certain health information be reported for a specific purpose.
- Public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the 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, audits by Medicare or Medicaid, or investigation of possible violations of healthcare 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 relating to workers' compensation programs.
- Disclosures to business associates who perform healthcare operations for us and who agree to keep your health information private.

Other Disclosures

We will not make any other uses or disclosures of your health information unless you sign a written **authorization form**. You do not have to sign such a form. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it.

Your Rights Regarding Your Health Information

The law gives you many rights regarding your health information.

- You can ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or healthcare operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to Nancy Jansen, Office Manager at the address or fax shown at the beginning of this notice.

- You can ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using e-mail to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to Nancy Jansen, Office Manager at the address or fax shown at the beginning of this notice.
- You can ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. Primarily, however, you will be able to review or have a copy of your health information within 30 days of asking us. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally required. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we sent you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to Nancy Jansen, Office Manager at the address or fax shown at the beginning of this notice.
- You can ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to Nancy Jansen, Office Manager at the address or fax shown at the beginning of this notice.
- You can get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want), except disclosures for purposes of treatment, payment or health care operations, disclosures made in accordance with an authorization signed by you, and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to Nancy Jansen, Office Manager at the address or fax shown at the beginning of this notice.

Our Notice of Privacy Practices

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time in compliance with and as allowed by law. If we change this notice, the new privacy practices will apply to your health information that we already have, as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office.

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 Nancy Jansen, Office Manager at the address or fax shown at the beginning of this notice. If you prefer, you can discuss your complaint in person or by phone.

For More Information

If you want more information about our privacy practices, call or visit Nancy Jansen, Office Manager at the address or phone number shown at the beginning of this notice.

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge receipt of the **Notice of Privacy Practices** of Dr. James Cooperman and Dr. Barbara Fineberg.

Our **Notice of Privacy Practices** provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our **Notice of Privacy Practices** is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our Privacy Officer at (714) 963-2111.

Name (please print) _____

Signature _____ Date _____
(patient, parent, conservator, guardian)

FOR OFFICE USE ONLY

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained:

Signature of provider representative _____ Date _____

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement

Other (Please specify) _____