

WILKEN FAMILY

EYE CARE

& Distinctive Eye Wear

Stephanie Wilken, OD 651 N. Denton Tap Road, #150
 Bret Wilken, OD Coppell, Texas 75019
972-410-1313

Welcome to Our Office

Name _____ Mid. Init. _____
 Street _____
 City _____ State _____ Zip _____
 Home Phone _____
 Work Phone _____
 Cell Phone _____
 Is it ok to receive texts on your cell phone? Y or N
 Email _____
 Employer (School) _____
 Today's date _____ Date of last exam _____
 Date of Birth _____ Age _____ Sex: M F
 Insurance Provider _____
 Primary Member Name _____
 Primary Member ID# _____ DOB _____
 Primary Member Employer _____

***We bill your insurance based on direct quotation of benefits.**
This does NOT guarantee payment by your insurance company.

Medical History – F=Family, S=Self

Allergies	F	S	Arthritis	F	S
Asthma	F	S	Cancer	F	S
Skin Disorder	F	S	Diabetes	F	S
Eye Diseases	F	S	Heart Disease	F	S
Eye Injury	F	S	High Blood		
Eye Surgery	F	S	Pressure	F	S
Lazy Eye	F	S	Kidney Disease	F	S
Cataracts	F	S	Nerves	F	S
Glaucoma	F	S	Other		

Current Medications (Rx or Over the Counter) (especially for any conditions listed above)

Name of Medication

Antihistamines	Yes	No	_____
Eye Drops	Yes	No	_____
Blood Pressure Meds	Yes	No	_____
Cholesterol Meds	Yes	No	_____
Oral Contraceptives	Yes	No	_____
Other			_____

Drug Allergies _____

HIPPA Privacy Statement

I understand the Notice of Privacy Practices from Wilken Family Eye Care that is attached to the clipboard (copies available):

Name _____ Date _____

What brings you in today?

Do you have any specific concerns?

Do you currently Wear Glasses? Yes No

What would you change about your glasses?

Do you have more than 1 pair? Yes No
 If yes, for what purpose _____

What kind of frames or lenses would you be interested in?

Do you currently wear contacts? Yes No

If **Yes**:

What brand do you wear? _____
 What solution do you use? _____
 How often do you dispose of them? _____
 Do you wear them overnight? _____

If **No**:

Are you interested in contact lenses? Yes No
 Are you interested in a "Test Drive" of the
 latest contact lens technology? Yes No
 Are you interested in contacts to non-surgically
 correct your nearsightedness overnight? Yes No

Do you Experience any the following Symptoms?

Burning	Itchiness	Watery Eyes
Discomfort	Glare or Reflections	Dryness
Headaches	Sensitivity to Light	Poor Night Vision

How did you hear about our Office?

Friend or Relative Yellow Pages Insurance
 Previous Patient (Who? _____)
 Drive By Other _____



Dr. Stephanie Wilken

Dr. Bret Wilken

Financial Policy

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality of vision care. In order to make your visit a smooth transaction, we want to make our financial policies clear before treatment starts.

1. Payment for services is due at the time services are rendered. We require at least ½ down at time of order of all materials. Balance must be paid in full at or before pick up.
2. As a courtesy, we file your insurance for you and accept assignment of benefits. Some insurance companies will not accept assignment of benefits to out of network providers. In this case, you are responsible for payment in full at the time of service.
3. You are responsible for paying all charges not covered by your insurance company, including all deductible, co-insurance and any fees considered above your insurance company's usual and customary fee schedule.
4. We will not carry balances longer than 90 days and will send you monthly statements to notify you of any accrued balances. If it remains unpaid after 90 days a collection service will be employed to collect payment.
5. There will be a \$35 service charge on all returned checks. If the returned check is not paid within 30 days, it will be sent to the Dallas County District Attorney's office.
6. As a courtesy, we call the day before your appointment to confirm the time and day. We will allow one no-show per patient. If it happens a second time, a \$25 no-show fee will be applied.

Authorization

I have read and accept the above Financial Policy. I understand and agree to the terms set forth regarding payment.

Signature of responsible party

Date

NOTICE OF PRIVACY PRACTICES

**Wilken Family Eye Care
Dr. Stephanie Wilken, O.D.
Dr. Bret Wilken, O.D.**

951 N. Denton Tap Rd.
Coppell, TX 75019
972-410-1313
www.WilkenEye.com

Effective date of notice: June 22, 2006

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION 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 come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal 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; for audits by Medicare or Medicaid; or for investigation of possible violations of health care 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 of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the address shown at the beginning of this Notice.

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 health care 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 the address shown at the beginning of this Notice.
- 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 email 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 the address shown at the beginning of this Notice.
- 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. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). 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 available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of

- the extension. If you want to review or get photocopies of your health information, send a written request to the address shown at the beginning of this Notice.
- 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 our 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 the address shown at the beginning of this Notice.
 - 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). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; 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 the address shown at the beginning of this Notice.
 - get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the address 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 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, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or 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 the address 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 Wilken Family Eye Care at the address or phone number shown at the beginning of this Notice.

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Wilken Family Eye Care offers a state-of-the-art digital scanning technology that allows us to view the inside of your eye without the use of dilation drops. The OPTOMAP allows us to evaluate your retina for problems such as macular degeneration, retinal holes, retinal detachments, hypertension, and diabetic retinopathy. The OPTOMAP is safe for kids and adults and allows you the opportunity to see the inside of your eye just as the doctor sees it.

Dilated Exam

vs.

Optomap Exam

- 1.) Blurred near vision for 4-6 hours
- 2.) Light sensitivity for 4-6 hours
- 3.) Longer office visit waiting for drops to take effect
- 4.) No permanent record of retina
- 5.) Only the doctor can see the retina

- 1.) NO blurred vision
- 2.) NO light sensitivity
- 3.) Map takes less than 2 minutes to process
- 4.) Permanent digital image that can be reviewed and compared each year
- 5.) You can see the retina

Early Detection is Crucial!

Our doctors strongly recommend that ALL patients have a thorough examination of their retina every year. **Without the OPTOMAP or a dilated examination, the doctor cannot fully assess the health of your eye.**

There is an additional fee of \$35.00 for the OPTOMAP. This procedure is not covered by insurance. **Dilation may still be required in rare instances.**

_____ I elect to have a digital image of my retinas today (\$35.00)

_____ I prefer a dilated exam of my retinas today (no additional fee) and I have been informed of the side effects listed above

Patient Signature

Date