SHARON N. SPOONER, M.D.

HISTORICAL INFORMATION

Date: _____

1. Patient Name: _____ Sex: _____ Age: _____
2. Date of Birth: _____ Hospital: _____
3. Name of Pediatrician: _____
   Address of Pediatrician: _____
4. History filled out by: Mother _____ Father _____ Other _____
5. **ALLERGIES:** _____
6. Brief description of patient's eye problem, including date of onset and previous treatment and operations:
   _____
   _____
7. Glasses since age: _____ Last change in glasses: _____
8. How many brothers: _____ How many sisters: _____ does patient have? _____
9. What is the birth order of the patient: _____
10. Please indicate the birth weight of patient: _____
11. When the mother was pregnant with the patient:
    A. How long was the pregnancy - _____ weeks.
    B. Did she take any medications prescribed, or over the counter? Yes _____ No _____
    C. Was she exposed to any toxins? Yes _____ No _____ Don't recall _____
       If yes, list name and which months
    D. Age of mother at birth _____ yrs. Father _____ yrs.
    E. Was the mother ill during the pregnancy?
       Yes _____ No _____ Don't recall _____ If Yes, please explain:
       _____
    F. Were there any problems with delivery? Yes _____ No _____ Don't recall _____ If so, please explain:
       _____
    G. Was the patient given oxygen after birth? Yes _____ No _____ Don't recall _____ If so, please explain:
       _____
12. Has the patient had any health problems: Yes _____ No _____ Don't recall _____ If so, please explain:
    _____
13. Has the patient had any childhood diseases? Yes _____ No _____ Don't recall _____ If so, please explain:
    _____
14. Is the patient currently on any medication? Yes _____ No _____
    If yes, please list name and dosage: _____
15. Is there any family history of eye diseases:

cataracts	Yes _____	No _____
strabismus (eyes not straight)	Yes _____	No _____
glaucoma	Yes _____	No _____
retinal detachment	Yes _____	No _____
refractive error (need for glasses)	Yes _____	No _____

If yes, please give diagnosis and family member:

Family member	Diagnosis
_____	_____
_____	_____
_____	_____
_____	_____

SHARON N. SPOONER, M.D.

PATIENT'S INFORMATION FORM

Date: _____

Name of Patient: _____ Birthdate: _____

Home Address (please write legibly): _____ Place of Birth: _____

City: _____ State: _____ Zip: _____ Home Phone: (_____) _____

RESPONSIBLE PARENT: ____ MOTHER ____ FATHER _____ OTHERS (PLS. SPECIFY) _____

Name: _____ Cellphone:(_____) _____

Occupation: _____ Business Phone: (_____)_____

Employer: _____

Employer's Address: _____

Name of Alternative Legal Guardian:

Name: _____ Home Phone:(_____) _____

Home Address (please write legibly): _____ Cellphone:(_____) _____

City: _____ State: _____ Zip: _____ Home Phone: (_____) _____

Occupation: _____ Business Phone: (_____)_____

Employer: _____

Employer's Address: _____

FOR EMERGENCY NOTIFICATION

Nearest Relative or Friend: _____

Telephone: (Home) (_____) _____ (Work) (_____) _____ (Cellphone) (_____) _____

Patient Referred by: _____

Name of Insurance Co.: _____ Policy No.: _____

Address : _____ Group No.:_____

Subscriber's Name: _____ Relationship to Patient: _____

Payment is expected in the office at the time of the visit. Insurance will be billed for any laboratory, surgeries or hospital stays; any portion not paid by your insurance will be the responsibility of the patient or responsible party.

Date: _____ Signed: _____

NOTICE OF PRIVACY PRACTICES

(MEDICAL)

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one of more health care providers. An example of this would include a physical examination.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are requires to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____, 20 _____ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA
Or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

SHARON N. SPOONER, M.D.
2222 SANTA MONICA BLVD. SUITE 401
SANTA MONICA, CA 90404
Telephone (310) 453-0471
Fax (310) 453-0473

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: