Adult Eye Clinic Patient Packet

Our non-profit clinic provides free eye care to qualifying residents of Fairfield, Lexington and Richland counties. Our goal is to provide quality care to as many patients as possible, therefore we ask for your help to make your time spent with us productive.

Appointments

Call to schedule an appointment (803-888-1692) or do a walk-in (Tuesdays &Wednesday mornings 8:45-9:45am, ALL WALK–INS ARE NOT GUARANTEED).

ARRIVE PREPARED

- Read the attached packet for eligibility requirements
- Collect documentation of your proof to qualify
- New Patient Packet **MUST** be completed prior to appointment time
- Complete Health History with accurate Information

ARRIVE ON TIME

You will be required to reschedule your appointment if you arrive more than 15 minutes late or if you do not have your packet complete by that time.

For their safety, do not bring children to the clinic.

WellPartners Adult Eye Clinic

Richland County Health Department

2000 Hampton Street, Suite 3145

Columbia, SC 29204

Phone: 803.888.1690

Hours: Monday—Thursday, 8:30 A.M.— 4:30 P.M

ADULT EYE CLINIC

SCREENING CHECKLIST FOR ELIGIBILITY

To meet eligibility, you must provide the clinic with following items:

1. **Patient Information Packet:**
    - Completely and accurately filled out and signed

2. **South Carolina Photo Identification:**
    - Valid SC ID or driver's license

3. **Documentation to Verify Patient Eligibility:**
    - 18 years or older (your license or ID)
    - A resident of Fairfield, Lexington or Richland County (your license or ID)
    - Low income (≤ 200% of poverty level)
    - No vision insurance

The following are examples of acceptable documentation to verify low income and no vision insurance. (YOU MUST PRESENT AT LEAST ONE OF THE FOLLOWING):

- Check stub(s) for patient seeking treatment
- W-2 form
- Medicaid card
- Verification of SNAP benefits (EBT card)
- Verification of Social Security income, SSI Disability, VA pension or retirement income
- Verification of Unemployment from Employment Security Commission (a printout)
- If you do not work but live in the household with someone that receives any of the above, their income must be verified with above.
- If you live in a household and someone else pays your expenses, you must provide a written statement: specify the amount paid monthly, signed by both you and the person paying expenses.

Richland County Health Department
Wellness Partners
2000 Hampton Street, Suite 3145
Columbia, SC 29204
Phone: 803.888.1692/ Fax: 803.888.1691

EYE CLINIC PATIENT REGISTRATION & HISTORY FORM

Today's Date: _____ / _____ / _____

Name: _____

Address: _____

City/State/Zip Code: _____

Primary Phone: _____

Birth Date: _____ / _____ / _____ **Age:** _____

Do you have Medicaid? ❍ No ❍ Yes
Do you have Medicare? ❍ No ❍ Yes

County: ❍ **Richland** ❍ **Fairfield** ❍ **Lexington**

Race/Ethnicity: African American/Black ❍ Caucasian/White ❍
Hispanic/Latino ❍ Other: _____

Sex: ❍ Male ❍ Female
Date of most recent Eye Exam: _____

Are you a military veteran? ❍ No ❍ Yes
↳ **Military Branch:** _____

MEDICAL HISTORY

Do you have any allergies to medication? ❍ No ❍ Yes if yes, explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications): _____

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

_____

Have you ever had:

Eye Injury	❍ No	❍ Yes			
Crossed eyes	❍ No	❍ Yes	Lazy eyes	❍ No	❍ Yes
Drooping eyelid	❍ No	❍ Yes	Prominent eyes	❍ No	❍ Yes
Glaucoma	❍ No	❍ Yes	Retinal Disease	❍ No	❍ Yes
Cataracts	❍ No	❍ Yes	Eye infection	❍ No	❍ Yes

Are you pregnant or nursing? ❍ No ❍ Yes

Do you wear glasses ❍ No ❍ Yes if yes, how old is your present pair of lenses?

Do you wear contact lenses? ❍ No ❍ Yes if yes, how old is your present pair of lenses?

Type of contact lenses: ❍ Rigid ❍ Soft ❍ Extended Wear ❍ Other

Are they comfortable? ❍ No ❍ Yes

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?

❍ Eau Claire Cooperative Health Center
❍ Richland County DHEC
❍ United Way of the Midlands
❍ Palmetto Health
❍ Providence
❍ S.C. Department of Medical Health
❍ Lexington Free Medical Clinic
❍ Other_____

Family History (Please note if any family history [parents, grandparents, siblings, children – living or deceased) for the following conditions)

Disease/Condition	No	Yes	Unsure	Disease/Condition	No	Yes	Unsure
Blindness	❍	❍	❍	Cancer	❍	❍	❍
Cataracts	❍	❍	❍	Diabetes	❍	❍	❍
Crossed Eyes	❍	❍	❍	Heart Disease	❍	❍	❍
Glaucoma	❍	❍	❍	High Blood Pressure	❍	❍	❍
Macular Degeneration	❍	❍	❍	Kidney Disease	❍	❍	❍
Retinal Detachment/Disease	❍	❍	❍	Lupus	❍	❍	❍
Arthritis	❍	❍	❍	Thyroid Disease	❍	❍	❍

Social History

Do you drive ❍ No ❍ Yes if yes, do you have visual difficulty when driving? ❍ No ❍ Yes
Do you use tobacco products? ❍ No ❍ Yes
Do you drink alcohol? ❍ No ❍ Yes
Do you use illegal drugs? ❍ No ❍ Yes

MEDICAL HISTORY (Do you currently, or have you ever had any problems in the following areas):

System	No	Yes	Unsure	System	No	Yes	Unsure
Constitutional	❍	❍	❍	**Ears, Nose, Mouth, Throat**	❍	❍	❍
Fever, Weight Loss/Gain	❍	❍	❍	Allergies/Hay Fever	❍	❍	❍
Integumentary (Skin)	❍	❍	❍	Sinus Congestion	❍	❍	❍
Neurological	❍	❍	❍	Runny Nose	❍	❍	❍
Headaches	❍	❍	❍	Post-Nasal Drip	❍	❍	❍
Migraines	❍	❍	❍	Chronic Cough	❍	❍	❍
Seizures	❍	❍	❍	Dry Throat/Mouth	❍	❍	❍
Eyes	❍	❍	❍	**Respiratory**	❍	❍	❍
Loss of Vision	❍	❍	❍	Asthma	❍	❍	❍
Blurred Vision	❍	❍	❍	Chronic Bronchitis	❍	❍	❍
Distorted Vision/Halos	❍	❍	❍	Emphysema	❍	❍	❍
Loss of Side Vision	❍	❍	❍	**Vascular/Cardiovascular**	❍	❍	❍
Double Vision	❍	❍	❍	Diabetes	❍	❍	❍
Dryness	❍	❍	❍	Heart Pain	❍	❍	❍
Mucous Discharge	❍	❍	❍	High Blood Pressure	❍	❍	❍
Redness	❍	❍	❍	Vascular Disease	❍	❍	❍
Sandy or Gritty Feeling	❍	❍	❍	**Gastrointestinal**	❍	❍	❍
Itching	❍	❍	❍	Diarrhea	❍	❍	❍
Burning	❍	❍	❍	Constipation	❍	❍	❍
Excess Tearing/Watering	❍	❍	❍	**Genitourinary**	❍	❍	❍
Glare/Light Sensitivity	❍	❍	❍	Genitals/Kidney/Bladder	❍	❍	❍
Eye Pain or Soreness	❍	❍	❍	**Bones/Joints/Muscles**	❍	❍	❍
Chronic Infection of Eye or Lid	❍	❍	❍	Rheumatoid Arthritis	❍	❍	❍
Flashes/Floaters in Vision	❍	❍	❍	Muscle Pain	❍	❍	❍
Tired Eyes	❍	❍	❍	Joint Pain	❍	❍	❍
Endocrine	❍	❍	❍	**Lymphatic/Hematologic**	❍	❍	❍
Thyroid/Other Glands	❍	❍	❍	Anemia	❍	❍	❍
Psychiatric	❍	❍	❍	Bleeding Problems	❍	❍	❍

If you answered <u>YES</u> to any of the diseases/conditions above or you have a condition not listed, please explain: _____

_____

_____

I certify that under penalty of perjury that the information presented on this application is the truth as I best know.

_____ _____

Patient Signature *Date*

WellPartners Adult Eye Clinic
Richland County Health Department
2000 Hampton Street, Suite 3145
Columbia, SC 29204
Phone: 803-888-1692 |Fax: 803.888.1691

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW TO 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; and
- 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 to remind you of scheduled appointments. 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 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 office contact person named 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 office contact person at the address, fax or E Mail 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 E mail to your personal E Mail 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 office contact person at the address, fax or E mail 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 office contact person at the address, fax or E mail 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 office contact person at the address, fax or E mail 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 office contact person at the address, fax or E mail 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 office contact person at the address, fax or E mail 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 and 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 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 office contact person at the address, fax or E mail 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 the office at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of the Midlands Eye Care Clinic Notice of Privacy Practices.

_____

Patient Name (Please print.)

_____ _____

Patient Signature *Date*

WellPartners Adult Eye Clinic
Richland County Health Department
2000 Hampton Street, Suite 3145
Columbia, SC 29204
Phone: 803.888.1692 / Fax: 803.888.1691

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

PATIENT INFORMATION

Name: _____

Address: _____

Phone Number: _____

Patient ID (if available): _____

AUTHORIZATION FOR RELEASE

I authorize the professional office of my optometrist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:
2. To whom may the information be released [name(s) or class(es) of recipients]:
3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):
4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

_____ _____

Patient Signature *Date*

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: _____ Print Name: _____

Source of Authority: _____

MEDIA AUTHORIZATION AND RELEASE

I, _____, of _____
(Name – please print) (Street address)

_____
(City, state and zip)

hereby authorize and consent that United Way of the Midlands and United Way of America, not-for-profit organizations, their legal representatives, successors or assigns, shall have the absolute right to copyright, publish, use, sell or assign any and all quotes, written remarks, stories, photographic images, case studies, or any part thereof, which they have taken from or made of me or in which I may be included in whole or part, whether apart from or in connection with, illustrative or written printed matter, story or news item, press release, motion pictures, television or radio spots, video footage, world wide web published, or for publicity, advertising or any other lawful purpose whatsoever, in conjunction with my own or a fictitious name, or in reproductions thereof in color or otherwise.

I hereby waive all claims for any compensation for such use or for damages.

I hereby waive any right that I may have to inspect and/or approve the finished product or the advertising copy that may be used in conjunction therewith or the use to which it may be applied.

I hereby warrant that I am of full age and have the right to contract in my own name in the above regard. I state further that I have read the above authorization and release, prior to its execution, and that I am fully familiar with the contents thereof.

Date: _____

Signature: _____

Parent/Guardian
Signature: _____
(If subject is a minor)

Project: _____

Email address: _____

Phone number: _____