# Dr. Greg A Hare
# Olympic Optical Inc.

## Patient Information

**Date of Birth:**_____ **Todays Date:**_____

**Last Name:**_____ **First Name**_____ **MI**_____
**Address**_____ **City**_____ **St.**_____ **Zip**_____
**Home phone**_____ **Wk. Phone**_____ **Cell phone**_____
**Last 4 of SS#**_____ **Marital Status**_____ **Spouse Name**_____
**Employer**_____ **How did you hear about us?**_____
**Email address**_____

## Person Responsible for Account (if different than above)

**Name**_____ **Relationship to patient**_____
**Your Address**_____ **City**_____ **St.**_____ **Zip**_____
**Home Phone**_____ **Cell Phone**_____ **Work phone**_____
**Vision Insuranc?**_____ **What Insurance Company?**_____
**Subscriber ID #**_____ **Group#**_____ **Employer**_____

## Insurance information

**Name of Insurance Company**_____ **Medical or Vision**_____
**Subscriber ID#**_____ **Group#**_____ **Employer**_____
**Relationship to Subscriber**_____ **Subscriber Date of Birth**_____

## Secondary Insurance (if Applicable)

**Name of Insurance Company**_____ **Medical or Vision**_____
**Subscriber ID#**_____ **Group#**_____ **Employer**_____
**Relationship to Subscriber**_____ **Subscriber Date of Birth**_____

## NOTICE: Please read before signing.

**By signing this document I understand that I may be seeing Dr. Hare without verification of Benefits from my Insurance Company or a referral from my Primary Care Physician and that I will be financially responsible for payment of all service and merchandise received from Olympic Optical & Dr. Hare from this day forward. I also understand that Olympic Optical staff bill my Insurance only as a courtesy to me.**

**Signature**_____ **Date**_____

Name _____ Date of Birth _____

## Medical Information

How is your general health? _____

Do you have problems with any of the following systems (circle those that apply).

| | | |
|---|---|---|
| Gastrointestinal | Nervousness | Endocrine (glands) |
| Ears/Nose/Throat | Urinary | Blood/Lymph |
| Cardiovascular | Muscles/Bones | Allergic/immunity |
| Respiratory | Integumentary (Skin) | Headaches |
| High Blood Pressure | Eyes | Mental |

Please explain _____
Diabetes Yes/No Type _____ Date of Diagnosis _____
Allergies to medication? Yes/No Which? _____ Reactions _____
Other health problem(s) _____
Have you had any operations? If so what kind _____

## Family History (Circle all that apply)

| | |
|---|---|
| High Blood pressure | Macular Degeneration |
| Diabetes | Retinal Detachment |
| Glaucoma | Cataracts |

## Personal Eye Information

Do you have any eye condition or problems? Yes/No If so what kind? _____
Have you had any eye operations? Yes/No If so what type? _____
Have you had any eye injury? Yes/No If so what kind? _____
Do you have glaucoma? Yes/No Cataracts? Yes/No Dry Eyes? Yes/No
Do you wear glasses? Yes/No Contact lenses? Yes/No
If you wear Contact lenses, what Brand are you wearing? _____

Is there anything special you would like us to know about you or your eyes? _____

# Olympic Optical
# Gregory A. Hare O.D.

## Privacy Policy

## NOTICE TO ALL PATIENTS

**Right to Notice; As a patient, you have the right to adequate notice of the uses and disclosure of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPPA). Olympic Optical, Inc., P.S. can use your protected health information for treatment, payment and health care operations. A) Treatment - We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. B) Payment – We may use and disclose your health information to obtain payment for services we provide you. C) Health care operations – We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification of certification, licensing or credentialing activities. Your authorization: most uses and disclosures that do not fall under treatment, payment, and health care operations will require your written authorization. Upon signing you may revoke your authorization (in writing) through our practice at any time. Emergency Situations in the event of our incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your healthcare. Marketing – We will not use your healthcare information for marketing communications without your written authorization. Required by Law we may also use or disclose your health information when we are required to do so by law. Abuse or Neglect – We may disclose your health information to appropriate if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health or safety. National Security – We may disclose the health of Armed Forces personnel to the military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances. Appointment Reminder- We may use or disclose your health information to provide you with appointment reminders via phone, e-mail or letter. Your rights as a Patient – You have the right to restrict the disclosure of your protected health information (in writing).The request for restriction may be denied if the information is required for treatment, payment or health care operations. You have the right to receive confidential communications regarding your protected health information. You have the right to amend your protected health information. You have the right to receive an account of disclosures of your protected health information. You have the right to a paper copy of this notice of privacy practices.**

**Legal Requirements Olympic Optical Inc., PS. is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are available within our office. Complaints – If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint. Contact Information – For further information about the Olympic Optical privacy policy, please contact Rose Hare at the following address or phone number:**

**Olympic Optical, Inc. P.S. 2500 W. Sims Way Suite 203, Port Townsend, Wa. 98368 (360) 379-6477.**

**I, _____ have been given the opportunity to view the Olympic Optical Privacy Policy and I understand my rights as a patient.**

**SIGNATURE_____ DATE_____**