Name:_____ Date:_____

Are you taking any kind of medication now? (This includes prescription, over-the-counter or herbal medicatior
☐No ☐Yes If yes, please list below.

PLEASE LIST ALL MEDICATIONS CURRENTLY BEING USED

NAME, DOSE, AND HOW OFTEN	Problem being treated	Prescribing Doctor

Are you allergic to ANY medication? ☐No ☐ Yes If yes, please list below.

Name of Medication	Type of Reaction

Have you ever been diagnosed with a major health problem? (Ex. diabetes, glaucoma, cancer)
☐ No ☐ Yes If yes, please list diagnosis and year the diagnosis was made.

_____ _____
_____ _____

Surgeries and Hospitalizations
Have you ever had an operation on ANY part of your body including the eyes?
☐No ☐Yes If yes, please list any operations and the date performed.

_____ _____
_____ _____

Family History
Are there any problems that seem to run in your family such as macular degeneration, glaucoma, retinal diseases, etc.? ☐No ☐Yes If yes, list problems and what family member(s) has this problem.

_____ _____
_____ _____

Social History
What is or was your occupation? _____ ☐Check here if you are retired.
Marital Status: _____

Have you ever used tobacco in any form? ☐No ☐Yes If yes, please complete the following:
How many cigarettes per day? _____ Other (list type and how many) _____
From year _____ To year _____

Over

Have you ever used alcohol in any form? ☐ No ☐Yes If yes, please complete the following:
Beers per week:_____ Wine glasses per week:_____ Other per week: (list type)_____

Hobbies:_____

Living setting: ☐Alone ☐Spouse ☐Children ☐Mother ☐Father ☐Nursing Home
☐Assisted Living ☐Other_____

Review of Systems List any problems you have or have had recently in the following areas.

General Health: (fever, weight loss or gain, problems sleeping, fatigue, weakness, etc.)

☐No ☐Yes If yes, please list the problem(s):_____

Eyes: problems that have not been corrected by glasses (visual loss, double vision, blurred vision, etc.)

☐No ☐Yes If yes, please list the problem(s):_____

Cardiovascular: (chest pain, irregular heartbeat, swelling of ankles, blacking out or fainting. etc.)

☐No ☐Yes If yes, please list the problem(s):_____

Respiratory: (shortness of breath, coughing up blood or sputum, wheezing, etc.)

☐ No ☐Yes If yes, please list problem(s):_____

Gastrointestinal: (trouble swallowing, heartburn, nausea, vomiting, diarrhea, abdominal pain, blood in stool, constipation, etc.) ☐ No ☐Yes

If yes, please list the problem(s):_____

Genital/Urinary: (frequency of pain with urination, blood in urine, sexual dysfunction, abnormal periods, testicular pain or masses, etc.) ☐ No ☐Yes

If yes, please list the problem(s):_____

Neurological: (fainting, seizures, paralysis of limbs, speech difficulty, memory loss, pain or numbness, etc.)

☐ No ☐ Yes If yes, please list the problem(s):_____

Emotional Problems: (nervousness, tension, mood swing, depression, etc.)

☐ No ☐ Yes If yes, please list the problem(s):_____

Musculoskeletal: (swollen joints, joint pain, etc.) ☐ No ☐ Yes If yes, please list the problem(s):

_____

Integumentary: (skin rashes, skin masses, itching, etc.) ☐ No ☐ Yes If yes, please list the problem(s):

_____

CUMBERLAND EYE CARE
57 Fairfield Boulevard
Crossville, TN 38558

COOKEVILLE EYE SPECIALISTS, PL
1059 Neal Street
Cookeville, TN 38501

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCL AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your health information is personal to you, and we are committed to protecting the information about you. This Nc Privacy Practices (or "Notice") describes how we will use and disclose protected health information ("PHI"), which is information and that we receive or create related to your health care.

OUR DUTIES

We are required by law to maintain the privacy of your health information, and to give you this Notice describing our legal duties and p practices. We are also required to follow the terms of the Notice currently in effect.

HOW WE MAY USE AND DISCLOSE INFORMATION ABOUT YOU

We may use and disclose personal and identifiable health information about you for a variety of purposes. All of the types of uses and disclosures of information are described below, but not every use or disclosure in a category is listed.

Required Disclosures. We are required to disclose health information about you to the Secretary of Health and Human Services, upon request, to determine our compliance with HIPAA and to you, in accordance with your right to access and right to receive an accountin disclosures, as described below.

For Treatment. We may use health information about you in your treatment. For example, we may use your medical history, such as a presence or absence of diabetes, to assess the health of your eyes.

For Payment. We may use and disclose health information about you to bill for our services and to collect payment from you or your insurance company. For example, we may need to give a payer information about your current medical condition so that it will pay us f eye examinations or other services that we have furnished you, or to obtain prior approval for a service.

For Health Care Operations. We may use and disclose information about you for the general operation of our business. For example, auditors or other consultants to review our practices, evaluate our operations, and tell us how to improve our services. Or, we may use a disclose your health information to review the quality of services provided to you.

Business Associates. There are some services provided in our organization through contracts with business associates. We may disclos your health information to those business associates so they can perform the tasks that we hire them to do. However, we require the bus associates to take precautions to protect your health information.

Notification of Family. We may use or disclose information to notify or assist in notifying a family member, personal representative, or person responsible for your care of your location and general condition.

Communication With Family. We may disclose to a family member, other relative, close personal friend or any other person you identif health information relevant to that person's involvement in your care.

Research. Consistent with applicable law we may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health informat

Funeral Director, Coroner, and Medical Examiner. Consistent with applicable law we may disclose health information to funeral directo coroners, and medical examiners to help them carry out their duties.

Organ Procurement Organizations. Consistent with applicable law, we may disclose health information to organ procurement organizati or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Food and Drug Administration (FDA). We may disclose to the FDA health information relative to adverse events, product defects, or pc marketing surveillance information to enable product recalls, repairs, or replacement.

Public Policy Uses and Disclosures. As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability, including child abuse and neglect.

Victims of Abuse, Neglect or Domestic Violence. We may disclose your health information to appropriate governmental agencies, such adult protective or social services agencies, if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

Health Oversight. In order to oversee the health care system, government benefits programs, entities subject to governmental regulation civil rights laws for which health information is necessary to determine compliance, we may disclose your health information for oversig activities authorized by law, such as audits and civil, administrative, or criminal investigations.

Court Proceeding. We may disclose your health information in response to requests made during judicial and administrative proceedings such as court orders or subpoenas.

Law Enforcement. Under certain circumstances, we may disclose your health information to law enforcement officials. These circum include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court ord reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding susp victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Inmates. If you are an inmate, we may release protected health information about you to a correctional institution where you are incarc or to law enforcement officials in certain situations such as where the information is necessary for your treatment, health or safety, or th health or safety of others.

Threats to Public Health or Safety. We may disclose or use health information when it is our good faith belief, consistent with ethical a legal standards, that it is necessary to prevent or lessen a serious and imminent threat or is necessary to identify or apprehend an individ

Specialized Government Functions. Subject to certain requirements, we may disclose or use health information for military personnel a veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for governm programs providing public benefits.

Workers Compensation. We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Other Uses. We may also use and disclose your personal health information for the following purposes:

- To contact you to remind you of an appointment, by phone, letter or postcard;
- To describe or recommend treatment alternatives to you; or
- To furnish information about health-related benefits and services that may be of interest to you.

PROHIBITION ON OTHER USES OR DISCLOSURES

We may not make any other use or disclosure of your personal health information without your written authorization. Once given, you m revoke the authorization, in writing, at any time. Understandably, we are unable to take back any disclosure we have already made with y permission.

INDIVIDUAL RIGHTS

- You have the right to ask for restrictions on the ways we use and disclose your health information for treatment, payment and hea care operation purposes. You may also request that we limit our disclosures to persons assisting your care or payment for your c We will consider your request, but we are not required to accept it.
- You have the right to request that you receive communications containing your protected health information from us by alternati means or at alternative locations. For example, you may ask that we only contact you at home or by mail.
- Except under certain circumstances, you have the right to inspect and copy medical, billing and other records used to make decisi about you. If you ask for copies of this information, we may charge you a fee for copying and mailing.
- If you believe that information in your records is incorrect or incomplete, you have the right to ask us to correct the existing information or add missing information. Under certain circumstances, we may deny your request, such as when the information i accurate and complete.
- You have a right to receive a list of certain instances when we have used or disclosed your medical information. We are not required to include in the list uses and disclosures for your treatment, payment for services furnished to you, our health care operations, disclosures to you, disclosures you give us authorization to make and uses and disclosures before April 14, 2003, amo others. If you ask for this information from us more than once every twelve months, we may charge you a fee.
- You have the right to a copy of this notice in paper form. You may ask us for a copy at any time.
- To exercise any of your rights, please contact us in writing. When making a request for amendment, you must state a reason for making the request.

CHANGES TO THIS NOTICE

We reserve the right to make changes to this notice at any time. We reserve the right to make the revised notice effective for personal healt information we have about you as well as any information we receive in the future. In the event there is a material change to this notice, the revised notice will be posted. In addition, you may request a copy of the revised notice at any time.

COMPLAINTS/COMMENTS

If you have any complaints concerning our privacy practices, you may contact the Secretary of the Department of Health and Human Services, at 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201 (e-mail: ocrmail@hhs.gov). You also may contact us at Cumberland Eye Care/Cookeville Eye Specialists, PLLC, Attn: Privacy Officer, 57 Fairfield Boulevard, Crossville, TN 38558.

YOU WILL NOT BE RETALIATED AGAINST OR PENALIZED BY US FOR FILING A COMPLAINT.

To obtain more information concerning this notice, you may contact our Privacy Officer at (931) 484-3344.

This notice is effective as of April 14, 2003.

CUMBERLAND EYE CARE
M. Stewart Galloway, M.D.
Patient Registration Form

Date: _____ New Patient _____ Update _____

Email

Patient Name:		SSN:
Address:	City:	Zip Code:
Home Phone:	Spouse's Name:	
Date of Birth:	Martial Status (circle one) Married Single Widowed Divorced	Sex: M F
Employer:	Work Phone:	
Emergency Contact (other than parent or spouse):	Phone:	
Referring Doctor:	Family Doctor:	

PLEASE PROVIDE INSURANCE CARDS TO BE COPIED AT TIME OF VISIT

Does your insurance require a referral from your primary care physician? Yes No

Is this a Workers Compensation Case? Yes No

Primary Insurance

Name: Member's Name:

Member's Date of Birth: Relationship to Patient:

Secondary Insurance

Name: Member's Name:

Member's Date of Birth: Relationship to Patient:

Responsible Party's Info (if other than self)

Name: SSN: Relationship to patient:

Address: Date of Birth: Phone:

I authorize M. Stewart Galloway, M.D., of Cumberland Eye Care, to treat the patient and to release any information acquired in the course of the examination and treatment to secure payment of claims and benefits. I understand that Cumberland Eye Care policy requires payment at time of service unless other arrangements are made. I authorize payment directly from my insurance company to Cumberland Eye Care and/or M. Stewart Galloway, M.D. I agree to be responsible for any deductibles, copays, coinsurances and services rendered that are not covered by my insurance plan.

Signature of Patient or Responsible Party: X _____ Date: _____

I have received Cumberland Eye Care's Notice of Privacy Practices.

Signature of Patient or Responsible Party: X _____ *Date:* _____

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