Name_____ Date of Birth_____

Spouse/Parent_____ Age___Male__ Female__Eye Color____

Address_____ Phone Number_____

_____ Work Number_____

Occupation_____ Cell Number _____

Social Security Number_____-___-_____ E-mail _____

Vision Insurance_____ Medical Insurance_____

Medical Physician_____

PAST OCULAR HISTORY

Date of Last Eye Exam_____ Date of Last Pair of Glasses_____
History of Eye Trauma_____
History of Eye Surgery_____

Eye Diseases (Glaucoma, Cataracts, Retinal Detachment, Macular Degeneration)
Please list any that apply:

Do you have dry eyes? Yes/No Blurred vision? Yes/No
*Are you interested in Laser Vision Correction? Yes_____ No_____

PAST AND PRESENT MEDICAL HISTORY

Medication Allergies_____ Environmental Allergies_____
Current Medications_____
Previous Surgeries_____
Eye Medications_____

MEDICAL CONDITIONS (PATIENT)

	Yes No		Yes No
Thyroid disease	_____	Respiratory	_____
Blindness	_____	Fever/Weight Loss	_____
Heart Disease	_____	Muscle/Bone/Joint	_____
Diabetes	_____	Blood/Bleeding Disorder	_____
Kidney	_____	Liver	_____
Hepatitis	_____	Abdominal Problems	_____
High Blood Pressure	_____	Genital / Urinary	_____
Nervous Disorder	_____	Ear/Nose/Mouth/Throat	_____
Psychological Disorder	_____	Cancer	_____
Cholesterol	_____		

SOCIAL HISTORY

Smoking _____
Alcohol _____
Drugs _____

FAMILY HISTORY (RELATIVES, ie MOTHER,FATHER,GRANDPARENTS)

	Yes No		Yes No
Glaucoma	_____	Heart Disease	_____
Cataracts	_____	Hypertension	_____
Crosses/Lazy Eyes	_____	Diabetes	_____
Retinal Detachment	_____	Blindness	_____

MEDICARE, MEDICAID, BLUE CROSS BLUE SHIELD, VSP AND ALL OTHER INSURANCE PATIENTS/NON-INSURANCE PATIENTS:

" I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Administration (for Medicare patients) or to my insurance company and/or it's intermediaries, any information needed for related claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to either myself or to the party who accepts assignment."

In the event of a denial or rejection of this claim by insurance company, I understand that the payment of said claim will be my responsibility.

ALL PATIENTS WITH INSURANCE ARE RESPONSIBLE FOR THE $35.00 REFRACTION FEE IF THAT IS NOT COVERED BY SAID INSURANCES.
I acknowledge that I was offered a copy of the Notice of Privacy Practices.

_____ Date_____
SIGNATURE OF GUARANTOR/PATIENT

I hereby give approval to disclose any or all of my medical information to:

NAME:_____ RELATIONSHIP_____

REFERRED BY: _____

For Doctors Use Only: Date_____ Reviewed by_____ No changes_____
Date_____ Reviewed by _____ No changes_____
Date_____ Reviewed by _____ No changes_____

EXPLANATION OF INSURANCE BILLING

Dear Patient:

We want to inform you of our responsibility in billing you and your health insurance company for today's visit.

If you are here for a preventative exam (sometimes called an annual wellness exam, well visit or routine exam) we must clearly indicate that when we bill your insurance company. The exam code we use indicates that today's visit is for preventative health care, **not** for a **new or recurring or pre-existing** medical problem such as **cataracts, glaucoma, diabetes, macular degeneration, etc.** These are medical conditions and your visit will be billed as such.

If you receive care for a **new** or **recurring** medical problem during a preventative exam, the diagnosis codes we report to your insurance company must reflect that medical problem. We must also document care for this problem in your medical chart along with any letters written to your primary care physician or specialists to whom we may refer you if further treatment beyond our scope is determined to maintain the health of your eyes. Please note that receiving care for a medical problem during today's visit may result in different out-of-pocket expenses for you than you may expect for your preventative exam.

MEDICARE AND MEDICAID PATIENTS ARE RESPONSIBLE FOR THE $25.00 REFRACTION FEE THAT IS NOT COVERED BY SAID INSURANCES. THIS IS THE PRESCRIPTION PART OF YOUR EXAM FOR YOUR LENSES.

Our billing department bills exactly what your doctor has reported for this visit. The billing department cannot change the codes before reporting them to your insurance company. They must reflect the services you received during your visit today.

If you have any questions, please discuss this letter in the exam room with your doctor.

Sincerely,

NOTICE OF PRIVACY PRACTICES

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.

This Privacy Notice is provided to you in connection with your health plan (see list below) from one of the following affiliated insurance companies (collectively referred to as "we" or "us"):

Stonebridge Life Insurance Company

Health Plans: Medicare Prescription Drug Plan

Effective Date: This Notice is effective January 1, 2013

OUR COMMITMENT TO YOUR PRIVACY

Maintaining the privacy of your protected health information is a high priority to us. In conducting our business, we will create records regarding you and the services we provide to you. We are required by law to maintain the confidentiality of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. We will abide by the terms of this Notice of Privacy Practices so long as it remains in effect.

We reserve the right to change our privacy practices and apply the changes to any protected health information received or maintained by us prior to the date of such change. If a privacy practice is materially changed, we will provide you with a revised Notice of Privacy Practices. In the event applicable law prohibits or materially limits the use or disclosure of your protected health information; we will comply with the more stringent law. You may request a paper copy of our most current notice at any time by contacting Customer Service at 1-877-633-7943. If you have requested a copy of this Notice by e-mail or other electronic means, you also have the right to request a paper copy at any time.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Your Authorization. Except as outlined below, we will not use or disclose your protected health information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization.

We May Use and Disclose Your Health Information in the Following Ways:

1. Treatment. We will make disclosures of your protected health information as necessary for your treatment. For instance, a doctor or health care facility involved in your care may request certain of your protected health information that we hold in order to make decisions about your care.

2. Payment. We will make uses and disclosures of your protected health information as necessary for payment purposes. For instance, we may use information regarding your medical procedures and treatment to process and pay claims, to determine whether services are medically necessary or to otherwise pre-authorize or certify services as covered under your health plan. We may also forward such information to another health plan, which may also have an obligation to process and pay claims on your behalf.

3. Health Care Operations. We will use and disclose your protected health information as necessary, and as permitted by law to operate our business including performing quality improvement and assurance, conducting cost-management and business planning, enrollment, underwriting, reinsurance, compliance auditing, rating, and other functions related to your health plan.

4. Family and Friends Involved in Your Care. With your approval, we may disclose your protected health information to designated family, friends, and others who are involved in your care or in the payment for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited protected health information without your approval.

5. Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, actuarial services, legal services, etc. We may use and disclose your protected health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your protected health information.

6. Information Received Pre-Enrollment. We may request and receive from you and your health care providers protected health information prior to the issuance of a certificate or policy of insurance to you and to determine your rates. We will protect the confidentiality of that information in the same manner as all other protected health information we maintain and, if a certificate or policy of insurance is not issued to you, we will not use or disclose the information about you we obtained for any other purpose.

7. Plan Sponsors. We may also use or disclose protected health information to the plan sponsor of a group health plan, if applicable, provided that any such plan sponsor certifies

that the information provided will be maintained in a confidential manner and not used for employment related decisions or for other employee benefit determinations or in any other manner not permitted by law.

8. Health-Related Benefits and Services. We or our business associates may also contact you regarding health-related benefits and services that may be of interest to you.

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES

Your protected health information may be used or disclosed as applicable without your authorization in the following circumstances: for any purpose when required by law; for public health activities as required by law if we suspect child abuse or neglect or believe you to be a victim of abuse, neglect, or domestic violence; as required by law for governmental health oversight agency conducting audits, investigations or civil or criminal proceedings; if required by a court or an administrative ordered subpoena or discovery request (in most cases you will have notice of such disclosure); as required by law for certain law enforcement purposes; about deceased persons to coroners, health examiners, and funeral directors consistent with law; if necessary for organ and tissue donation or transplant; for certain government-approved research purposes; upon reasonable belief to avert a serious threat to health or safety; for specialized government functions (such as military personnel and inmates in correctional facilities); national security or intelligence activities or to workers' compensation agencies if necessary to make a benefit determination.

YOUR PRIVACY RIGHTS

You have the following rights with respect to the protected health information we maintain about you:

1. Confidential Communications. You may request that we communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may wish to receive communications from us at your work location rather than your home. We will evaluate all such requests, however, we must only accommodate your written request if you clearly state that your life could be endangered by the disclosure of all or part of your protected health information. You may obtain a form to request confidential communication by contacting Customer Service at 1-877-633-7943.

2. Access to Your Protected Health Information. You have a right of access to inspect and obtain a copy of much of the protected health information that we retain on your behalf. We may charge a fee for the costs of copying, mailing, postage, labor and supplies associated with your request, but, you will be notified in advance of any such fee. You may obtain a form to request access by contacting Customer Service at 1-877-633-7943.

3. Requesting Restrictions. You have the right to request restrictions on certain uses and disclosures of your protected health information, for treatment, payment, or health care operations by notifying us in writing. Your request must describe in detail the restriction you are requesting. We will evaluate all requests for restrictions; however, we are not required to agree to the restriction, and we retain the right to terminate an agreed to restriction if we believe such termination is appropriate. In the event of a termination by us, you will be notified. You also have the right to terminate, any agreed to restriction by sending a termination notice. You may obtain a form to request a restriction or to terminate an existing restriction by contacting Customer Service at 1-877-633-7943.

4. Amendment. You have the right to request that protected health information maintained about you be amended or corrected. We are not obligated to make all requested amendments, but we will give each request careful consideration. Requests must be in writing, signed by you or your representative and must state the reasons for the request. If an amendment is made, we may also notify others who work with us and have copies of your record if we believe that such notification is necessary. You may obtain a form to request an amendment by contacting Customer Service at 1-877-633-7943.

5. Accounting of Disclosures. You have the right to receive an accounting of certain disclosures made by us of your protected health information. Requests must be made in writing and signed by you or your representative. The first accounting in any 12-month period is free; but we may charge you for additional accountings within the same 12-month period. You will be notified in advance of any fee. You may obtain a form to request an accounting of disclosures by contacting Customer Service at 1-877-633-7943.

6. Complaints. If you believe your privacy rights have been violated, you can file a written complaint. Send your complaint to:

Stonebridge Life Insurance Company
100 Light Street, MS B-3239
Baltimore, MD 21202
ATTN: Medicare Part D Compliance Officer

You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. within 180 days of a violation of your rights. We will not retaliate against you for filing a complaint

REQUEST FOR RELEASE OF MEDICAL RECORDS

From:

_____

PHYSICIAN'S NAME

_____

ADDRESS

_____

CITY STATE ZIP CODE

_____

TELEPHONE FAX (IF APPLICABLE)

I hereby request that my medical records be released to:

To:

_____

PHYSICIAN'S NAME

_____

ADDRESS

_____

CITY STATE ZIP CODE

_____

TELEPHONE FAX (IF APPLICABLE)

_____

PATIENT'S SIGNATURE (IF MINOR, PARENT'S) DATE

COMMENTS:

_____

_____

REQUEST FOR RELEASE OF MEDICAL RECORDS

From:

_____

PHYSICIAN'S NAME

_____

ADDRESS

_____

CITY STATE ZIP CODE

_____

TELEPHONE FAX (IF APPLICABLE)

I hereby request that my medical records be released to:

To:

_____

PHYSICIAN'S NAME

_____

ADDRESS

_____

CITY STATE ZIP CODE

_____

TELEPHONE FAX (IF APPLICABLE)

_____

PATIENT'S SIGNATURE (IF MINOR, PARENT'S) DATE

COMMENTS:

_____

_____