MILLS OPTOMETRY, LLC
9350 MARSHALL DR.
LENEXA, KS 66215

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____, (print name) have received a copy of this office's Notice of Privacy Practices. I understand that 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 health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

_____

Patient Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the Acknowledgment**
- ☐ **An emergency situation prevented us from obtaining Acknowledgment**
- ☐ **Other (Please Specify)** _____

_____

_____

Staff signature **Date**

Welcome! Please take a few minutes to fill out this form as completely as you can.
If you have any questions, we will be glad to assist you!

Please print legibly. Thank you.

Name: _____ Age: _____ DOB: _____ SSN: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
H. Phone: _____ C. Phone: _____ E-mail: _____
Employer/Occupation: _____ Computer Use (hours per day): _____
Vision Insurance Plan: _____ Insurance ID #: _____
Last Eye Exam: 1yr 2 yrs 3+yrs ago or 1st eye exam Previous location or Dr. Name: _____
Whom may we thank for referring you (First & Last Name)? _____

I am here for:	**I am experiencing:** (Please check all that apply.)		**I have worn:**
☐ Annual Eye Exam	☐ Distance Problems	☐ Itchy Eyes	☐ Glasses
☐ Diabetic Health Check	☐ Near problems	☐ Tired Eyes	☐ Contacts
☐ Glasses	☐ Headaches	☐ Floaters or spots	☐ never worn glasses/contacts
☐ Contact Lenses	☐ Double Vision	☐ Flashes of Light	
☐ Eye Infection/Injury	☐ Dry Eyes	☐ Vision Black Outs	

Are you pregnant? Yes or No Are you nursing? Yes or no
Please list any allergies to medications: _____
_____
Are you using any eye drops (Rx or Over the Counter): _____
List all medications you are taking (Rx or Over the Counter): _____
_____

Do you, your grandparents, parents or siblings have: (Please check the ones that apply.)

	Self	Family		Self	Family
Diabetes	____	____	Cataracts	____	____
High Blood Pressure	____	____	Glaucoma	____	____
Heart Disease	____	____	Blindness	____	____
Thyroid	____	____	Eye Injury	____	____
Respiratory Problems	____	____	Eye Surgery	____	____
Cancer	____	____	Macular Deg.	____	____
Migraines	____	____	Other _____		

Please initial the statements below that are applicable to you:

FEE: Dr. Julia E. Mills is an **Independent Doctor of Optometry** and is **not affiliated with Costco.** I understand that the examination/office visit fee and/or contact lens fitting fee is due at the time of service and is **not** refundable. **Initials**_____

EYE EXAM: The fee for the eye exam is $68. After obtaining the glasses prescription (Rx) you have 60 days to come in for a follow-up visit, if needed, at no extra cost. After the 60 days, there is a $35 office visit charge. **Initials**____

CONTACT LENSES: The contact lens exam fee is between $103 and $123, depending on the disorder of refraction. This exam includes a contact and glasses Rx, a trial pair of lenses, and a follow up visit, if needed, within 60 days of the exam. A follow-up visit after the 60 day period is $35. **Only** when your Rx is finalized can you purchase contacts lenses. **Initials**_____

OFFICE VISIT: The fee for an eye-related medical office visit, such as an eye injury, eye infection or any other eye condition is $35-$190. Each subsequent visit is $35. If a removal of a corneal foreign body is necessary, there is an additional $40 fee. **Initials**____

INSURANCE: Insurance is not a guaranteed form of payment. I am responsible for what my insurance does not cover. **Initials** _____

DILATION: I understand that the doctor may recommend dilation to fully examine the health of my eyes. Dr. Julia E. Mills may not be held responsible for any condition(s) that goes undetected as a result of me refusing the dilation. **Initials**_____

____ Yes, I agree to a dilation, if necessary. ($10 fee) ____No, I decline the dilation.

Patient or Guardian signature (if guardian, please also print name): _____ Date: _____

Mills Optometry, LLC
9350 Marshall Dr.
Lenexa, KS 66215
913.227.3706

Others Involved in My Healthcare

Patient Name: _____

ID Number _____

You, Dr. Julia E. Mils, ***MAY discuss*** all aspects of my healthcare with:

Print Name	Relationship
Print Name	Relationship
Print Name	Relationship
Print Name	Relationship

As the patient, you may also request that any part of your Private Health Information (PHI) not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You, Dr. Julia E. Mills, ***MAY NOT*** discuss any aspect of my health care with the following person/people, unless it is needed to provide emergency treatment.

Print Name	Relationship
Print Name	Relationship
Print Name	Relationship
Print Name	Relationship

Date: _____

_____
Signature of Patient or Legal Representative
(You have the right to rescind any part of this authorization with written notice.)