Hollywood Park EYE STUDIO

Dr. Anna McKinney | Therapeutic Optometrist

WELCOME TO OUR OFFICE

Patient's Full Legal Name:_____ ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

Preferred Name:_____

Date of Birth:_____/_____/_____ **Patient's SSN:**_____-_____-_____

Address:_____

Street City State Zip

Home Phone:_____ **Cell Phone:**_____

Work Phone:_____ **Email:**_____

Preferred method of contact: ☐ Home ☐ Cell ☐ Work ☐ Email

Employer/School:_____

Spouse's Name:_____

Responsible Party:_____

How did you find us? ☐ Location ☐ Provider List ☐ Friend:_____

☐ Other:_____

Current Medications:_____

_____

Medication allergies? ☐ No ☐ Yes (please list):_____

Please indicate which applies:

Currently wear contacts ☐ No ☐ Yes

Interested in contacts ☐ No ☐ Yes

Interested in LASIK ☐ No ☐ Yes

Frequent headaches/migraines ☐ No ☐ Yes

Experiencing dry eyes ☐ No ☐ Yes

Eye strain with digital device use ☐ No ☐ Yes

Currently pregnant ☐ No ☐ Yes

Currently breastfeeding ☐ No ☐ Yes

Tobacco/cigarettes ☐ No ☐ Yes

Alcohol ☐ No ☐ Yes

Other substances ☐ No ☐ Yes (please specify):_____

Medical History (please specify self or family):

High Blood Pressure:_____

High Cholesterol:_____

Diabetes:_____

Cancer:_____

Ocular History (please specify self or family):

Glaucoma:_____

Retinal Detachment:_____

Cataracts:_____

Macular Degeneration:_____

Previous eye injuries/surgeries? ☐ No ☐ Yes (please provide type/date):_____

Other eye conditions?_____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. **FULL PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.**

I HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS TO MY INSURANCE COMPANY.

Signature:_____ Date:_____

Print Name:_____

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SMS PATIENT CONSENT

Patient Name: _____

Mobile Phone Number: (_____) _____ - _____

Patient Consent for SMS Text Notifications

By checking the box and signing below, you authorize **Hollywood Park Eye Studio** to send automated text messages (SMS) to the mobile number provided above.

1. Types of Messages Covered:

- **Appointment Reminders:** Alerts regarding upcoming eye exams or follow-up appointments.
- **Product Pick-up Notifications:** Alerts when your ordered prescription eyeglasses, contact lenses, or other optical goods are ready for pickup.

2. Privacy and Security Disclosures (HIPAA & Texas HB 300 Notice):

- Standard text messaging is an unencrypted method of communication. While our internal platform is secure, there is an inherent risk that unencrypted SMS messages could be intercepted by unauthorized third parties once they leave our network.
- To protect your privacy, **Hollywood Park Eye Studio** will limit the information sent via text to the absolute minimum necessary (e.g., no specific medical diagnoses, vision conditions, or detailed account balances will be sent via SMS).

3. Terms and Freedom to Opt-Out:

- Consent is entirely optional and is not a condition of receiving treatment, exams, or purchasing products from our practice.
- Message and data rates may apply depending on your mobile carrier plan. Message frequency varies based on your appointment schedule and product order status.
- **You can opt out at any time.** To stop receiving text messages, simply reply **STOP** to any text message we send.

[ ] **YES, I CONSENT** to receive automated text messages for appointment reminders and product notifications at the mobile number provided above. I acknowledge that I understand the security risks of standard SMS text messaging stated above.

[ ] **NO, I DO NOT CONSENT** to receive text messages. (Please notify me via telephone/voice call instead).

Patient / Guardian Signature: _____

Date: _____ / _____ / 20_____

Effective date of notice:___01/01/2025_____

NOTICE OF PRIVACY PRACTICES
Hollywood Park Eye Studio

Anna McKinney, O.D.
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San Antonio, TX 78232
P 210-545-4772
F 210-545-5350
staff@HPEyeStudio.com
Office Manager: Jackie Palmer

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

We respect our legal obligation to keep health information that identifies you privately. 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; personal 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 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 in our office at all. Such uses or disclosures are:

- When a stat 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 heath 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 our 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 unavoidable by-product of permitted uses or disclosures;

- 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 or write to remind you of scheduled appointments, or that it is time to make a routine appointment. 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 mail you an appointment reminder on a post card, and/or leave you a reminder message on your phone.

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 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 (expect 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 obtain 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 requesting it (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 are allowed one 30-day extension for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or receive 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 heath information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from your request. We will send the corrected information to persons who we know received the wrong information, as well as anyone specified by you. 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 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 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 additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you initially received one electronically or in paper form. 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.