So we can see you promptly and provide faster service at the time of your appointment, please complete the following forms and bring them with you to your appointment.

1. **Welcome to Our Office**
   This form will help Dr. Lambright make the best recommendations for you and your lifestyle.

2. **Privacy Practices and Insurance Billing Policy**
   This form acknowledges that you understand our insurance policy and have received our Notice of Privacy Practices, which is included in this packet.

3. **Contact Lens Informed Consent & Compliance Agreement**
   This form only needs to be signed if you wear contact lenses or are interested in wearing contact lenses.

If you have any questions regarding these forms, please call our office at 860-231-8482. Thank you.

Welcome to Our Office

Name: Last ______________________________ First __________________________ M.I. _____
Address: __________________________ City: ________________ State: _______ Zip: _________
Home Phone: ________________ Business Phone: _______________ Cell Phone: ________________
E-Mail Address: ____
Date of Birth: ________________ Age: ________ Social Security Number: ______________________
Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Other
Employment Status: ❒ F/T Employed ❒ P/T Employed ❒ Self Employed ❒ Unemployed
❒ Retired ❒ F/T Student ❒ P/T Student ❒ Other
Employer: ________________________________ Occupation: _____________________________
How were you referred to our office?
❒ Friend or Family Member _________________________
❒ Family Doctor ________________________________
❒ Ophthalmologist ______________________________
❒ Insurance Company
❒ Internet
❒ Other ___________________

Please take a moment to answer the following questions. This will assist Dr. Lambright in recommending the best possible options to suit your lifestyle.

Do you……(check box if your answer is yes)

❑..wear prescription glasses? How old are they? ❑..1 year ❑..2 years ❑..3+ years
❑..Single Vision ❑..Progressives
❑..Bifocal ❑..Over the Counter Readers
❑..have more than one pair of current prescription eyeglasses?
❑..work at a computer? How much? _____ Hrs/week
❑..spend time outdoors? How much? _____ Hrs/week
❑..participate in sporting activities? __________________________________
❑..have prescription sunglasses?
❑..have any issues with your current eyeglasses?
❑..too heavy ❑..lenses are too thick
❑..uncomfortable ❑..nose pads
❑..want new style ❑..difficult to clean
❑..other ____
❑..plan on purchasing new glasses at the end of today's exam?
❑..only if I have a prescription change
❑..prefer not to wear your glasses at times?
❑..wear contact lenses?
❑..daily disposable ❑.. two week disposable ❑..monthly disposable
❑..RGP (Hard lenses) ❑..Synergeyes (Hybrid lenses)
❑..use contact lens solution? If yes, which brand?______________________________
❑..have interest in a "test drive" of the latest contact lens designs?
❑..want information on Laser Vision Correction surgery?
❑..have children? Ages? ____
❑..have family members in need of eyecare?

Acknowledgement of Receipt of Notice of Privacy Practices
Melissa Lambright, OD

Patient Name: _______________________________________

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The *Notice of Privacy Practices* you have been given describes these uses and disclosures in detail.

I acknowledge that I have received the *Notice of Privacy Practices* from Melissa Lambright, OD.

___________________________________ _____________
Signature **Date**

Insurance/Billing Policy

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not SIGHT,LLC.

If your insurance company has not reimbursed our office in full within 60 days, you will be responsible for the balance and your insurance company will then pay you directly. (If by mistake your insurance company sends the payment check to us, we will of course sign over and forward the check directly to you.)

It is my understanding that I am responsible to obtain any and all referrals that my insurance company requires for services performed by my doctor.

___________________________________ _____________
Signature **Date**

If signing as a personal representative of the patient, describe relationship to the patient.

____
Relationship to Patient

Contact Lens Informed Consent & Compliance Agreement

The contact lens portion of the eye exam is separate from the medical/routine exam performed by the doctor. Every year, your lenses need to be reevaluated to ensure that they are a proper fit and the healthiest option for your eyes. A poor fitting lens can affect the health of your eyes. Most insurances do not cover the cost of our professional time to perform this valuable and necessary service for you. This fee can vary depending on the changes that need to be made to your current contact lenses. Even lenses that seem okay may sometimes need to be changed to maintain good vision and eye health. At the time of your exam, your needs will be determined by the doctor and you will be informed of this fee.

Fees	Services Provided / Type of Contact Lens Examination
$55	Yearly Evaluation – no diagnostic lenses or follow-up visits needed
$80	Spherical contact lens fitting
$110	Toric or RGP contact lens fitting
$160	Bifocal contact lens fitting
$180	Synergeyes contact lens fitting
$200	Irregular Cornea or Post Surgical contact lens fitting
$500	Keratoconic contact lens fitting
$30	Additional fee for insertion and removal training for first time contact lens wearers

Fees include diagnostic lenses and follow-up visits the patient may require within 90 days of the initial fitting.

Specialty Contact Lenses or Custom Lenses (RGP or Synergeyes)

Specialty contact lenses or custom lenses must be paid in full at the time of dispense. These lenses are only able to be exchanged during the fitting process if it is within 90 days of the shipping date of the manufacturer. Once the prescription is finalized, the lenses are non-refundable.

__________**initial and date**

Compliance Agreement

A written copy of your contact lens prescription will be provided to you upon completion of the contact lens medical management services.

By signing below, I acknowledge that I have read and understand this agreement. I agree to wear my contacts no longer than prescribed by the doctor, agree to properly care for my contact lenses as instructed and agree to return for recommended follow-up visits. I understand the current fee and refund policy and my responsibilities as a contact lens wearer.

__________	____________________	____________________
Date	**Patient's Name (Print)**	**Patient's Signature**

Notice of Privacy Practices
Sight

Melissa R. Lambright, OD
17 South Main Street
West Hartford, CT 06107
(860)231-8482

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

General Rule

We respect our legal obligation to keep health information that identifies you, private. The law obligates us to give you notice of our privacy practices.

Generally, we can only use your health information in our office or disclose it outside of our office, without your written permission, for purposes of treatment, payment or healthcare operations. In most other situations, we will not use or disclose your health information unless you sign a written authorization form. In some limited situations, the law allows or requires us to disclose your health information without written authorization.

Uses or Disclosures of Health Information

Examples of how we use information for **treatment** purposes:

- When we set up an appointment for you.
- When our technician or doctor tests your eyes.
- When the doctor prescribes glasses or contact lenses.
- When the doctor prescribes medication.
- When our staff helps you select and order glasses or contact lenses.
- When we show you low vision aids.

We may disclose your health information outside of our office for **treatment** purposes, for example:

- If we refer you to another doctor or clinic for eye care or low vision aids or services.
- If we send a prescription for glasses or contacts to another professional to be filled.
- When we provide a prescription for medication to a pharmacist.
- When we phone to let you know that your glasses or contact lenses are ready to be picked up.

Sometimes we may ask for copies of your health information from another professional that you may have seen before.

We may use your health information within our office or disclose your health information outside of our office for **payment** purposes. Some examples are:

- When our staff asks you about health or vision care plans that you may belong to, or about other sources of payment for our services.
- When we prepare bills to send to you or your health or vision care plan.
- When we process payment by credit card and when we try to collect unpaid amounts due.
- When bills or claims for payment are mailed, faxed, or sent by computer to you or your health or vision plan.
- When we occasionally have to ask a collection agency or attorney to help us with unpaid amounts due.

We use and disclose your health information for **healthcare operations** in a number of ways. Health care operations means those administrative and managerial functions that we have to do in order to run our office. We may use or disclose your health information, for example, for financial or billing audits, for internal quality assurance, for personnel decisions, to enable our doctors to participate in managed care plans, for the defense of legal matters, to develop business plans, and for outside storage of our records.

Appointment Reminder

We may call to remind you of scheduled appointments. We may also call to notify you of other treatments or services available at our office that might help you.

Uses & Disclosures without an Authorization

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 happen at our office at all. Such uses or disclosures are:

- A state or federal law that mandates certain health information be reported for a specific purpose.
- Public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the 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, audits by Medicare or Medicaid, or investigation of possible violations of healthcare 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 or 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 relating to workers' compensation programs.
- Disclosures to business associates who perform healthcare operations for us and who agree to keep your health information private.

Other Disclosures

We will not make any other uses or disclosures of your health information unless you sign a written **authorization form**. You do not have to sign such a form. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it.

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 (except emergency treatment), payment or healthcare 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 Dr. Lambright at the address, fax or e-mail shown at the beginning of this notice.

- You can 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 email 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 Dr. Lambright at the address, fax or e-mail shown at the beginning of this notice.
- You can ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. Primarily, however, you will be able to review or have a copy of your health information within 30 days of asking us. 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 required. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we sent you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to Dr. Lambright at the address, fax or e-mail shown at the beginning of this notice.
- You can ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. 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 that we may write. Once your statement of position and/or 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 of time 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 Dr. Lambright at the address, fax or e-mail shown at the beginning of this notice.
- You can get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want), except disclosures for purposes of treatment, payment or health care operations, disclosures made in accordance with an authorization signed by you, and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to Dr. Lambright at the address, fax or e-mail shown at the beginning of this notice.

Our Notice of Privacy Practices

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time in compliance with and as allowed by law. If we change this notice, the new privacy practices will apply to your health information that we already have, as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office and have copies available in our office.

Complaints

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to Dr. Lambright at the address, fax or e-mail shown at the beginning of this notice. If you prefer, you can discuss your complaint in person or by phone.

For More Information

If you want more information about our privacy practices, call or visit Dr. Lambright at the address or phone number shown at the beginning of this notice.
Effective date of notice: July 25th 2006