# AINAK Vision Care Application Form

| Preferred Date and Time of Appointment: | Referred by*: | School District (if a student; otherwise, N/A)*: |
|---|---|---|
| | | |

## 1. CLIENT INFORMATION*

| First Name: | Last Name: | Middle Initial: |
|---|---|---|
| | | |

| Date of Birth (MM-DD-YYYY): | Language you speak |
|---|---|
| | |
| **Cell Phone:** | **Email Address:** |
| | |
| **Address:** | |
| **Street:** | **City:** |
| | |

| County: | State: | Zip Code: |
|---|---|---|
| | | |

| Gender: (Circle one option) | Male | Female | Other |
|---|---|---|---|

## 2. PARENT OR GUARDIAN INFORMATION* (If Client is under 18; otherwise, X-out below section)

| First Name: | Last Name: | Middle Initial: |
|---|---|---|
| | | |

| Cell Phone: | Email Address: |
|---|---|
| | |
| **Address (if different from above)** | |
| **Street:** | **City:** |
| | |

| County: | State: | Zip Code: |
|---|---|---|
| | | |

**Note: All sections marked with a red asterisk must be filled to qualify for a vision exam**

### 3. VETERAN STATUS, INSURANCE, INCOME ELIGIBILITY, and ETHNICITY*

| | | |
|---|---|---|
| **Are you a Veteran? (Circle one)** | **Yes** | **No** |
| **Do you have insurance (MediCal, Medicaid, Other)? Yes / No (Circle One)** | **If "Other", which one?** | |

| | | |
|---|---|---|
| **Is your annual household income less than $50,000? (Circle one)** | **Yes** | **No** |
| **Housing (Circle one)** | **Rental** | **Own** |

**ETHNICITY (Check the one(s) you identify with; if not listed, add your ethnicity under "Other")**

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other: _____

### 4. ADDITIONAL INFORMATION

**Do you wear eyeglasses? Yes / No. (If yes, bring them for your optometrist appointment.)**

**Do you have any health issues? Yes / No**

**Specify the health issue if "Yes" is selected: _____**

**Primary employer Name and Address: _____**

**(N/A, if unemployed or student)**

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**Signature*: _____ Date: _____**

**Note: All sections marked with a red asterisk must be filled to qualify for a vision exam**

**Please email the completed application including HIPPA and Photo release forms to submit@myainak.org**

ainak
Eyeglasses
Blurry to Sharp Vision
www.myainak.org

# *HIPAA INFORMATION AND CONSENT FORM*

## PATIENT DETAILS

First Name: Last Name:

Middle Name: Date of Birth:

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003.

What this is all about: Specifically, there are rules and restrictions on who may be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
2. It is the policy of this organization to remind patients of their appointments. We may do this by

telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to organization policy and new technology that you might nnd valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in the normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request the change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

**I, _____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.**

**Signature _____**

**Date _____**

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eyeglasses

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**CONSENT TO PHOTOGRAPH, FILM, OR VIDEOTAPE AN INDIVIDUAL FOR NON-PROFIT USE**

**(e.g. educational, public service, or health awareness purposes)**

Name of Patron receiving the services: _____

Name of School (if a student): _____

Check one of the boxes below, sign, and date the form.

☐ I hereby consent to the participation in interviews, the use of quotes, and the taking of photographs, movies, or videotapes of the individual named above. I also grant AINAK the right to edit, use, and reuse said products for nonprofit purposes including use in print, on the internet, and all other forms of media. I also hereby release AINAK and its agents and employees from all claims, demands, and liabilities whatsoever in connection with the above.

☐ I do not consent to participation in interviews, use of quotes, and taking of photographs, movies, or videotapes of the individual named above.

Signature of Parent/Guardian (if the patron is under 18): _____

Date: _____

Signature of Patron (if 18 or over): _____ Date: _____