UK HealthCare **UK Advanced Eye Care**

PATIENT DEMOGRAPHIC SHEET (Please complete ALL information)

PATIENT LEGAL NAME:	DATE OF BIRTH:	SEX:	
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
PRIMARY CONTACT PHONE #:	**HOME PHONE:**	**PREFERRED LANGUAGE:**	**RACE & ETHNICITY:**
PRIMARY CARE PHYSICIAN:	**PRIMARY CARE PROVIDER ADDRESS, CITY, STATE, ZIP:**	**PRIMARY CARE PROVIDER PHONE #:**	

EMERGENCY CONTACT INFORMATION

NAME:	RELATION TO PATIENT:	PRIMARY CONTACT PHONE NUMBER(S):

GUARANTOR INFORMATION

PARENT/GUARDIAN NAME:	RELATION TO PATIENT:	PRIMARY CONTACT PHONE NUMBER(S):
DATE OF BIRTH:	**SSN:**	**EMPLOYER:**

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME:	SUBSCRIBER ID:	NAME AND RELATION TO PATIENT:

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME:	SUBSCRIBER ID:	NAME AND RELATION TO PATIENT:

HealthCare

Tarehe ya Kuanza (DOS):

- ★ University of Kentucky A.B. (Chuo Kikuu cha Kentucky A.B.) Chandler Hospital
- ★ UK HealthCare Good Samaritan Hospital
- ★ UK HealthCare Ambulatory Services
- ★ UK Dental and Oral Health Clinics

RUHUSA NA MAKUBALIANO

(Lebo ya Mgonjwa Hapa)

RIDHAA YA MATIBABU: Ninatoa ridhaa kupokea huduma za matibabu kutoka katika University of Kentucky. Huduma za matibabu zinajumuisha mitihani, upimaji, chanjo zifaazo, matibabu kijumla na matibabu ya dawa zinazodhibitiwa. Ninaweza kupimwa HIV (virusi vinavyosababisha ukimwi (AIDS)), hepatitisi na magonjwa mengine. Ridhaa yangu inajumuisha huduma kutoka kwa mawakala, waajiriwa na wafanyakazi wa matibabu wa University of Kentucky. Hakuna aliyenihakikishia kwamba huduma za matibabu zitakuwa na matokeo fulani. Nina haki (i) ya kufanya maamuzi kuhusu huduma ya afya yangu, (ii) ya kukataa huduma za matibabu, na (iii) ya kubatilisha ridhaa hii kwa wakati wowote isipokuwa mahali ambapo huduma za matibabu zimeshatolewa.
Mgonjwa au mzazi, mlezi, mtu anayewajibika aliyeidhinishwa au mzazi mbadala lazima atoe ridhaa.

Picha: Ninakubali kuwaruhusu wahudumu wangu wa afya kuchukua na kutazama picha (kama vile picha au video) kwa ajili ya utunzaji wangu au utambulisho. Ninaelewa na ninakubali kwamba baadhi ya picha hizi zinaweza kuhifadhiwa huku nyingine zikiwa za ufuatiliaji wa muda halisi pekee.

Taasisi ya Mafunzo: Ninaelewa kwamba University of Kentucky inafundisha na kuwapa maarifa madaktari, wauguzi na watoaji wengine wa afya (kituo cha elimu ya matibabu). Madaktari walio katika mafunzo (wenzangu, wakaaji, wanatahini, na wafanyikazi wa nyumbani), wanafunzi wa matibabu na wafunzwa wengine wa matibabu wanaweza kuhusika katika utunzaji wangu kwa usimamizi ufaao wa daktari wangu.

Utafiti: Ninaelewa kwamba mtu kutoka Chuo Kikuu cha Kentucky anaweza kuwasiliana nami katika siku za usoni ili kuniuliza kuhusu afya yangu au kutaka nishiriki katika utafiti.

WAJIBU WA KIFEDHA

Uhakikisho wa Malipo: Ninakubali kwamba ninawajibika kwa University of Kentucky na Kentucky Medical Services Foundation Inc. (KMSF) kwa malipo yanayotokana na huduma zinazotolewa kwa viwango vyao vilivyopo. Ninakubali kwamba bili zote lazima zilipwe kikamilifu zinapoulizwa. Iwapo nitakosa kutimiza makubaliano haya, ninakubali kulipia gharama yoyote ya ukusanyaji au ada ya mwanasheria inayotokana na ukusanyaji wa akaunti zangu. Si University of Kentucky wala KMSF katika kutekeleza haki zozote itafanya katika namna yoyote kuniachilia au mtu yeyote anayewajibikia gharama. Iwapo waliotia sahihi ni zaidi ya mtu mmoja, jukumu hili litakuwa la pamoja na kadhaa. Ninakubali kwamba University of Kentucky au KMSF si mshirika kwa madai yoyote ya mgogoro au upitiaji wa kiwango kimoja, ambayo yanaathiri malipo ya dai lolote lililodaiwa kwa niaba yangu na kwamba malipo yakiombwa kutoka University of Kentucky au KMSF; ninakubali kulipa baki lolote lililosalia. Iwapo hatua yoyote ya kisheria inachukuliwa na University of Kentucky au KMSF kuhusiana na ukusanyaji wa malipo yanayotokana na huduma zilizotolewa, ninakubali kutii (na hivyo basi kutoa ridhaa) sheria na mahali pa hatua kama hiyo au kesi kotini ndani ya Jimbo la Fayette, Commonwealth of Kentucky, na kwamba ninakubali kuondoa upingamizi wowote ninaoweza kuwa nimeusingizia mahali pasipofaa au mkutano usiofaa. Kwa malengo ya ukusanyaji, ninaidhinisha UK HealthCare na kampuni zake zote na mawakala wahusika wa tatu, kuwasiliana nami kupitia simu yangu ya mkononi au simu nyingine yoyote ambayo nimetoa kama maelezo yangu ya mwasiliani, au namba yoyote iliyojukumishwa kwangu ambayo inapatikana kwa umma, kwa kutumia mbinu zinazojumuisha ujumbe wa sauti iliyorekodiwa mbeleni/na mtu au utumiaji wa kipiga simu otomatiki. Zaidi ya hayo, ninaidhinisha UK HealthCare na kampuni zake zote na mawakala washirika wa tatu, kuwasiliana nami kupitia anwani ya baruapepe iliyotolewa au kupitia ujumbe mfupi.

Kushirikisha Faida: Basi ninashirikisha haki zote na upendeleo na kuidhinisha malipo moja kwa moja kwa University of Kentucky na KMSF kwa madai yoyote yaliyodaiwa kwa niaba yangu au kwa niaba ya mtu ambaye nimeidhinishwa kumtilia sahihi kwa faida za bima. Ninakubali kwamba ushirikishaji huu ni wa msingi kwa ushirikishaji wowote unaotolewa baada ya tarehe hii ukijumuisha gharama yoyote inayohusiana na ada ya mwanasheria. Pia ninafahamu kwamba ninawajibika kifedha kwa University of Kentucky na KMSF kwa gharama zisizojumuishwa kwa ushirikishaji huu au hazijalipiwa kwa muda na kampuni ya bima.

Mambo ambayo kila mmoja anahitaji kufahamu kuhusu Ukimwi (AIDS)
Sheria ya Kentucky inahitaji kwamba tukufahamishe kuhusu Ukimwi (AIDS).

HIV (VVU) inasimamia "human immunodeficiency virus," (virusi vya ukimwi) ambavyo ni virusi vinavyoshambulia mfumo wa kinga ya mwili. Virusi vya HIV husababisha ugumu kwa watu walionavyo kupona kutokana na maambukizi na magonjwa mengine. AIDS (UKIMWI) husimamia "acquired immune deficiency syndrome," (Ukosefu wa Kinga Mwilini) ambao ni athari za kiafya zinazotokea iwapo Virusi vya HIV havitibiwi. Kwa matibabu, mtu anayeishi na virusi vya HIV anaweza kuwa mwenye afya na kuishi muda mrefu karibu tu kama mtu asiyekuwa na HIV. Matibabu ya HIV pia yanapunguza sana nafasi kwamba mtu aliye na virusi vya HIV ataambukiza wengine.

HealthCare

Tarehe ya Kuanza (DOS):

- ★ University of Kentucky A.B. (Chuo Kikuu cha Kentucky A.B.) Chandler Hospital
- ★ UK HealthCare Good Samaritan Hospital
- ★ UK HealthCare Ambulatory Services
- ★ UK Dental and Oral Health Clinics

RUHUSA NA MAKUBALIANO

(Lebo ya Mgonjwa Hapa)

HIV **haienezwi** kupitia shughuli kama vile kukumbatiana au kusalimiana mikono au kushiriki glasi ya kunywea. HIV huenezwa **pekee** kupitia damu, maji maji ya ngono au maziwa ya mama.

Hii kwa kawaida hutokea kwa:
- Kufanya mapenzi bila kondomu
- Kushiriki sindano

Mama anayeishi na HIV anaweza kumwambukiza mtoto wake HIV, lakini hii sasa si ya kawaida sana nchini Marekani mradi tu mama anajua kwamba ana HIV na anatibiwa. Pia ni nadra sana kwamba HIV hupitishwa kwa kuongezewa damu au viungo vya kupandikizwa, kwa sababu damu na viungo vyote vilivyotolewa sasa vinapimwa HIV.

Virusi vya HIV vinasambazwa sana na watu wasiofahamu kwamba wana HIV. Hii ndiyo sababu ni muhimu sana kupima HIV angalau mara moja katika maisha yako, na angalau kila baada ya miezi 6 ikiwa unafanya ngono bila kondomu au kushiriki sindano.

Matibabu ya Dawa Zinazodhibitiwa
Sheria za shirikisho na za nchi hudhibiti dawa (dawa za kulevya) zinazodhibitiwa ambazo zinaweza kutumiwa vibaya. Sheria ya Kentucky inahitaji kwamba unatoa ridhaa kwa matibabu yanayotumia dawa hizi kabla ya kuzipata. Magonjwa mengine na majeraha yanaweza kusababisha maumivu. Baadhi ya dawa zinaweza kufanya maumivu kuwa ya kustahimiliwa zaidi. Baadhi ya dawa nyingine zinaweza kuongeza umakini na kupunguza shinikizo la damu. Utumiaji wa dawa hizi unaweza kusababisha kichefuchefu, usingizi,uchovu, kutapika, kuvimbiwa, kukosa usingizi, kukosa hamu ya kula, kuzeeka, kuongezeka kwa unyogovu, kinywa kavu, kuchanganyikiwa, kupumua polepole, na kupoteza uratibu na kufanya kutokuwa salama kuendesha au kutumia mashine. Dawa hizi zinaweza kusababisha utegemezi wa mwili, kumaanisha kwamba kuacha kutumia kighafla kunaweza kusababisha ishara za kutotumia, utegemezi wa kiakili, kumaanisha kwamba kuacha kutumia kunaweza kusababisha kuwa na hamu ya dawa ili kupata athari iyo hiyo na uraibu, kumaanisha unaweza kupata matatizo kulingana na sababu za kimaumbile au nyinginezo. Lazima umweleze daktari wako iwapo una mimba au unazingatia kuwa na mimba.

Wosia Hai
Tafadhali mwambie mtoa huduma wako ikiwa una Wosia Hai, Maagizo ya Mapema, Mamlaka ya Wakili au hati nyingine yoyote inayomruhusu mtu kukufanyia maamuzi ya afya au kuhifadhi matakwa yako kuhusu utunzaji wako. **Una jukumu la kuiambia timu yako ya utunzaji ikiwa una hati za aina hizi.**

Uthibitisho: Ninathibitisha kuwa nimesoma na kuelewa idhini na ruhusa zilizotolewa hapo juu na kwamba mimi ndiye mgonjwa au nimeidhinishwa ipasavyo na mgonjwa kutekeleza hati hii na kukubali masharti yake.

Haki na Majukumu: Nimeshauriwa kuhusu Haki na Wajibu wangu kama Mgonjwa.

KUMBUKA: Huduma za ukalimani **lazima** zitolewe kwa lugha zinazopendelewa kando na Kiingereza.

Mgonjwa au Mwakilishi wa Kisheria

Tarehe / Saa

Uhusiano kwa Mgonjwa

Jina au Kitambulisho cha Mkalimani#
Cyracom (viringisha moja)

Ana kwa ana au kupitia

Notice of Privacy Practices

Effective April 14, 2003
Revised September 23, 2013

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)

We are committed to protecting the privacy of all health information we create and maintain as a result of the health care we provide you. Your "protected health information" (PHI) includes information about your past, present or future health, health care we provide you and payment for your health care contained in the record of care and services provided by University of Kentucky health care facilities. The purpose of this Notice is to explain who, what, when, where and why your protected health information may be used or disclosed, and assist you in making informed decisions when authorizing anyone to use or disclosure your PHI.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

- To request in writing to the treatment area a restriction on the uses and disclosures of protected health information as described in this Notice. We are not required to agree to the restriction you request. We may not be able to comply with your request in certain situations, which include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services and uses and disclosures that do not require your authorization.

- To request in writing a restriction on disclosures for payment or health care operations when paying out-ofpocket in full for health care item or service. We are required to agree to this restriction.

- To obtain a paper copy of this Notice and upon written request submitted to the UK health care facility maintaining the record, inspect and/or obtain a copy of your health record.

- To amend your health record by submitting a written request with the reasons supporting the request to the Medical Records department. We may deny your request if a) the record was not created by us, unless the person that created the record is no longer available to make the amendment; b) the record is not part of the health information used to make decisions about you; c) we believe the record is correct and complete; or d) you would not have the right to inspect and copy the record as described herein.

- To request in writing to the Privacy Officer a written list of disclosures we made of your health information, except that we are not required to account for disclosures for purposes of treatment, payment, operations, directory notification, disaster relief, as allowed under certain circumstances by law or pursuant to your authorization.

- To request in writing to the treatment area that we communicate with you by a specific method and at a specific location. We will typically communicate with you in person; or by letter or telephone.

- To revoke your authorization to use or disclose PHI at any time except, unless your authorization was obtained as a condition of obtaining insurance coverage, and except to the extent your PHI has already been disclosed pursuant to your authorization. Your revocation request must be made in writing to the Medical Records unit of the facility where you originally filed your authorization.

- To be notified of a breach of your unsecured protected health information

- To receive a copy of your medical record in electronic format, if possible.

OUR RESPONSIBILITIES

Maintainthe privacy of your protected health information and provide you with notice of our legal duties and privacy practices with respect to protected health information.

Abide by the terms of the Notice currently in effect. We have the right to change our Notice of Privacy Practices and we will apply the change to all of your personal health information, including information obtained prior to the change.

Post notice of any changes to our Privacy Practices in the lobby and make a copy available to you upon request.

CONTACT FOR QUESTIONS/COMPLAINTS/REQUESTS

Direct your questions, complaints and requests made pursuant to this Notice to: **Privacy Officer, 2333 Alumni Drive, Suite 200, Lexington, KY 40517, (859)323-1184 or (859)323-8002.** You may also file a complaint with the Secretary of Health and Human Services. Filing a complaint will not result in retaliation.

HOW WE MAY USE AND DISCLOSE YOUR PHI

We may use and disclose your PHI for the following purposes:

Treatment: We may use and disclose your protected health information to anyone involved in the provision of health care to you, including for example, University physicians, nurse practitioners, nurses and other medical professionals, including our medical students, residents and volunteers. We may also disclose your protected health information to outside treating medical professionals and staff as deemed necessary for your health care.

Payment: We may use and disclose your protected health information to billing and collection agencies, insurance companies and health plans to collect payment for our services.

Heath Care Operations: We may use and disclose your protected health information for our own health care operations. For example, we may use your protected health information to assess your care in an effort to improve the quality and safety of our service to you; to evaluate the skills, qualifications and performance of our health care providers; to provide training programs to students, trainees and other health care providers. In addition, our accountants, auditors and attorneys may use your protected health information to assist our compliance with applicable law.

Notice of Privacy Practices

Effective April 14, 2003
Revised September 23, 2013

HOW WE MAY USE AND DISCLOSE YOUR PHI

We may use and disclose your PHI for the following purposes:

Business Associates There are some services provided to our organization through contracts with business associates, such as laboratory and radiology services. We may disclose your protected health information to our business associates so that they can perform these services. We require the business associates to safeguard your information to our standards.

Individuals Involved With Your Care: We may disclose your protected health information to family or others identified by you or who is involved in your care or payment for your care. We may also notify a family member, or another person responsible for your care, about your location and general condition, unless you object by contacting the caregiver at the facility providing your care.

Legally Required Disclosures & Public Health: We may disclose your protected health information as required by law, including to government officials to prevent or control disease, to report child, adult or spouse abuse, to report reactions or problems with products, and to report births and deaths.

Heath Oversite Activities We may disclose your protected health information to a federal or state health oversight agency that is authorized to oversee our operations.

Workers Compensation: We may disclose your protected health information for workers compensation or similar programs.

Serious Threats to Health and Safety We may disclose your protected health information if necessary to prevent or reduce the risk of a serious or imminent threat to the health or safety of an individual or the general public.

Law Enforcement & Subpoenas: We may disclose your protected health information to law enforcement such as limited information for identification and location purposes, or information regarding suspected victims of crime, including crimes committed on our premises. We may also disclose your protected health information to others as required by court or administrative order, or in response to a valid summons or subpoena.

Inmates: We may disclose your protected health information to a correctional facility which has custody of you if necessary a) to provide health care to you; b) for the health and safety of others; or, c) for the safety and security of the correctional facility.

Information Regarding Decedents: We may disclose your protected health information regarding a deceased person to: 1) coroners and medical examiners to identify cause of death or other duties, 2) funeral directors for their required duties and 3) to procurement organizations for purposes of organ and tissue donation.

Research: We may also disclose your protected health information where the disclosure is solely for the purpose of designing a study, or where the disclosure concerns decedents, or an institutional review board or privacy board has determined that obtaining authorization is not feasible and protocols are in place to ensure the privacy of your health information. In all other situations, we may only disclose your protected health information for research purposes with your authorization.

Treatment Alternatives We may contact you with information about treatment alternatives or other health related benefits and services that may be of interest to you.

Fund Raising: We may contact you as part of a fund raising effort. You may opt out of fund raising communications by using the contact information listed on the fund raising material you receive

Directory information: We may disclose your name, location and general condition to those persons who ask for you by name or to members of the clergy. You may object to such disclosure by contacting the Registration Office/Desk at the facility from which you received this Notice.

Appointment Reminders: We may use and disclose your PHI to provide a reminder to you about an appointment.

DISCLOSURES REQUIRING AUTHORIZATION

1. **Sale and Marketing of PHI.** We may not sell your PHI or use or disclosure your PHI for marketing purposes without your authorization.

2. **Psychotherapy Notes.** Most uses and disclosures of psychotherapy notes require an authorization.

3. **All other uses and Disclosures.** All other uses and disclosures of your protected health information will only be made pursuant to your written authorization, which you have the right to revoke at any time, except to the extent we have already made disclosures pursuant to your authorization.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice and to make new Notice provisions effective for all your protected health information that we maintain by posting the revised Notice at our facilities, making copies of the revised Notice upon request to the facility or the Privacy Officer, or posting the revised Notice on our website.

Notice of Privacy Practices

Effective April 14, 2003
This Notice was added to September 23, 2013 Version

Section 1557 of the Affordable Care Act (ACA) NOTICE OF NONDISCRIMINATION FOR UK HEALTHCARE PROGRAMS AND ACTIVITIES

The University of Kentucky complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The University of Kentucky does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

The health programs and activities of the University of Kentucky:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified medical interpreters
    - Information written in other languages

If you need these services, contact any employee of a UK health program or activity.

If you believe the University of Kentucky has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Heather Roop, Section 1557 Coordinator, ADA Coordinator and Technical Compliance Officer
Institutional Equity and Equal Opportunity
University of Kentucky
13 Main Building
Lexington, KY 40506-0032

Telephone: (859) 257-8927
Fax: (859) 323-3739
E-mail: heather.roop@uky.edu

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, UK HealthCare Office of Patient Experience or Martha Alexander, Section 1557 Coordinator is available to help.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights' Complaint Portal, available at:

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

or by mail at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Telephone number: 1-800-368-1019
(TDD) number: 1-800-537-7697

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html

UK HealthCare

Notice of Privacy Practices

Effective April 14, 2003
These Taglines Were Added to September 23, 2013 Version

YOUR RIGHT TO AN INTERPRETER

You have the right to an interpreter at no cost to you.

American Sign Language (ASL)
You have the right to an interpreter at no cost to you. Please point to this line. An interpreter will be called. Please wait.

ENGLISH — If you speak English, language assistance services, free of charge, are available to you.

SPANISH — Si usted habla español, tiene a su disposición servicios de asistencia con el idioma sin costo alguno.

CHINESE — 如果您讲汉语普通话，则可以免费向您提供语言协助服务。

GERMAN — Wenn Sie deutsch sprechen, stehen Ihnen kostenlos Sprachhilfen zur Verfügung.

VIETNAMESE — Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị, nếu quý vị nói tiếng Việt.

ARABIC — إذا كنت تتحدث العربية، فتوفر لك خدمات المساعدة اللغوية مجانًا.

SERBO-CROATIAN (SERBIC) — Ukoliko govorite srpski, na raspolaganju su vam besplatne usluge jezične pomoći.

JAPANESE — 日本語を話される場合には、無償の言語支援サービスがご利用いただけます。

FRENCH — Si votre langue est le français, des services d'assistance linguistiques sont mis gratuitement à votre disposition.

KOREAN — 모국어가 한국어일 경우 무료 언어지원 서비스가 제공됩니다.

PENNSYLVANIA DUTCH — Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch.

NEPALI — यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंले बिना कुनै शुल्क भाषा सहायता सेवाहरू प्राप्त गर्न सक्नुहुन्छ।

CUSHITE (OROMO) — Yoo qooqa Oromo dubbatta tahe, tajaajilli gargaarsaa, baasi (kaffaltii malee) siif jira.

RUSSIAN — Если ваш язык — русский, то вам могут быть предоставлены бесплатные услуги переводчика.

TAGALOG — Kung nagsasalita ka ng Tagalog, may magagamit kang mga serbisyo sa lengguahe na walang bayad.

BANTU (KIRUNDI) — Niba uvuga Ikirundi, hari servisi itishurwa yo gusobanura indimi.

Services available in 200+ languages.

UK HealthCare

7-7702

HealthCare

DOS

- University of Kentucky A.B. Chandler Hospital
- UK HealthCare Good Samaritan Hospital
- UK HealthCare Ambulatory Services
- UK Dental and Oral Health Clinics

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date:_____ Time:_____ (Patient Label Here)

I understand that as part of my health care, University of Kentucky and its affiliates originates and maintains health records. These health records describe my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and medical treatment information to my bill
- a means by which a third-party payer (i.e. insurance company) can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

The University of Kentucky and its affiliates' ***Notice of Privacy Practices*** gives a more complete description of how my health information may be used or disclosed. The notice also explains my rights regarding my personal health information, including the right to access my own records and the right to request restrictions as to how my health information is used or disclosed.

I understand it is my responsibility to notify University of Kentucky and its affiliates regarding any restrictions to disclosure of my health information regarding this or any subsequent visit.

I have been provided with a *Notice of Privacy Practices* and have been given the opportunity to review this notice.

_____

Signature of Patient or Legal Representative Date

_____

Witness Date

KENTUCKY EYE EXAMINATION FORM FOR SCHOOL ENTRY

KRS 156.160.8 (g) requires proof of a vision examination by an optometrist or ophthalmologist. This proof shall be submitted to the school no later than January 1 of the first year that a child is enrolled in a Kentucky public school, public preschool, or Head Start.

PLEASE COMPLETE THE IDENTIFYING INFORMATION AND RECORDS

IDENTIFYING INFORMATION

Student Name:_____ Social Security Number:_____ Date of Birth:_____

Parent or Guardian Name:_____

RECORD OF IMMUNIZATION TO BE REPORTED ON IMMUNIZATION CERTIFICATE FORM, EPID 230 CASE HISTORY

Date of Exam:_____

Chief Complaint:_____

Ocular History: Normal ☐ or Positive for:_____

Medical History: Normal ☐ or Positive for:_____ Drug Allergies: NKDA ☐ or Allergic to:_____

Family Ocular and Medical History: ☐ Amblyopia ☐ Strabismus ☐ Glaucoma ☐ Diabetes

Other:_____

Other Pertinent Information:_____

Refraction with cycloplegic? (please indicate one) ☐ YES ☐ NO

	OD	OS
Unaided Acuity	20 / _____	20 / _____
Best Corrected Acuity	20 / _____	20 / _____

	Normal	Abnormal	Not able to Assess
External Exam (eye and adnexa)	☐	☐	☐
Internal Exam (media, lens, fundus, etc)	☐	☐	☐
Neurological Integrity (pupils)	☐	☐	☐
Binocular Function (stereopsis)	☐	☐	☐
Accommodation and convergence	☐	☐	☐
Color Vision	☐	☐	☐

Diagnosis: ☐ Normal ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Strabismus ☐ Amblyopia

Other:_____

Recommendations:

1 Glasses prescribed: ☐ YES ☐ NO

2_____

3_____

Age appropriate and suggested anticipatory guidance (health assessments):

- ☐ Educate (parents/patients) about eye/vision disorders and needed vision care
- ☐ Counsel (parents/patients) regarding eye safety
- ☐ Stress importance of early, preventative eye care
- ☐ Recommend re-examination, as appropriate

Signed:_____ Date:_____

Optometrist/Ophthalmologist

Address:_____ Telephone: ( )_____

UK HealthCare
The Power of Advanced Medicine

UK HealthCare Financial Assistance Application
Programa de Asistencia Financiera

Medical Record Number/No. de Cuenta: _____ Today's Date/Fecha: _____/_____/_____

Date(s) of hospital service provided or to be provided/ Fecha(s) que fue atendido o será atendido: _____/___/___ ---- _____/_____/

A	Patient Name/Nombre del paciente: (Last/Apellido), (First/Nombre), (MI)	Social Security Number/Número de seguro social	Date of Birth/Fecha de nacimiento
Phone/No. de teléfono	Work Ph./No. de teléfono del trabajo	Single/Soltero ☐ Married/Casado ☐ Minor/Menor ☐ Separated/Widowed/Divorced/Viudado ☐	
Address/Dirección (Street/No. y calle) (City/Ciudad) (State/Estado) (Zip/Código postal)			How Long/Cuánto tiempo Yr./Año/s: Mo./Meses:
Employer (Empleador)/Income Source (Fuente de ingresos):	City/State (Ciudad/Estado):	Phone No./No. de Teléfono:	How Long/Cuánto tiempo: Yr./Año/s: Mo./Meses:
B	Spouse(Esposo)/Parent(Padres)/Guardian(Tutor Legal) Name (Last/Apellido),(First/Nombre),(MI)	Social Security Number/ Número de seguro social	Relationship to Patient/ Relación con el paciente:
Phone/No. de teléfono	Address/Dirección:(Street/No. y calle),(City/Ciudad),(State/Estado),(Zip/Código postal)		How Long/Cuánto tiempo: Yr./Año/s: Mo./Meses:
Employer (Empleador)/Income Source (Fuente de ingresos):	City/State (Ciudad/Estado):	Phone No./No. de Teléfono:	How Long/Cuánto tiempo: Yr./Año/s: Mo./Meses:
C	Co-Guarantor/Tutor Legal (Last/Apellido), (First/Nombre), (MI)	Social Security Number/ Número de seguro social	Relationship to Patient/ Relación con el paciente:
Phone/No. de teléfono	Address/Dirección:(Street/No. y calle),(City/Ciudad),(State/Estado),(Zip/Código postal)		How Long/Cuánto tiempo: Yr./Año/s: Mo./Meses:
Employer (Empleador)/Income Source (Fuente de ingresos):	City/State (Ciudad/Estado):	Phone No./No. de Teléfono:	How Long/Cuánto tiempo: Yr./Año/s: Mo./Meses:

D **Household Members – Each Person living in the Household/Integrantes del Hogar – Todas las personas que viven en la casa**

Name/Nombre	Employment Status/¿Trabaja esta persona?	Relationship/ Relación con el paciente	Age/Edad

E **Monthly Gross Family Income*/Salario Mensual del Hogar***

(a) Patient/Paciente: $	(b) Spouse(esposo)/ Co-Guarantor(Tudor Legal): $	(c) Retirement(Retiro)/ Pension(Pension): $	(d) Social Security (Seguro social/discapacitado): $
(e) Child Support (Manutención del hijo): $	(f) Unemployment/Desempleo: $	(g) AFDC / TANF / Welfare: $	(h) Alimony/Manutención del esposo: $
(i) Workers Comp Benefits/ Compensación de trabajadores: $	(j) Rental Property or Lease/ Propiedades de renta: $	(k) Guard (Guarda) / Reserves (Reserva) / Military (Militar): $	(l) Interest (Interés) / Dividends (Dividendos): $

(m) List Other Income / Assistance, Grants, Financial Aid and Scholarships please describe/Otros ingresos/ Asistencia, Favor de notar y describir::

$ _____ $ _____ $ _____

TOTAL (a – m) $ _____ × **12 months (meses)** = **Annual Gross Income/ Salario total anual** **Total Income/ Salario total**: $ _____

F **Countable Resources/Recursos Contables**

	Bank Name/Nombre de Banco	Balance/Value (Valor)
Checking/Cuenta corriente		$
Savings/Cuenta de ahorros		$

Certificate of Deposit/Certificado de Depósito		$
Money Market (Mercado de Valores), Mutual Funds (Fondo Mutuo)		$
Stocks (Acciones), Bonds (Inversiones), Other (Otros)		$

Total Health Bills Owed(Balance de todas las cuentas médicas): $ _____ **Total Resources (Recursos Totales): $** _____

Note Countable resources are reduced by unpaid medical expenses of the family unit to establish eligibility.
Nota Los recursos contables son reducidos por gastos médicos impagados de la familia para establecer elegibildad

University of Kentucky HealthCare●Patient Financial Experience Department●1000 South Limestone Room A101●Lexington, KY 40536 Phone: 855-211-4707●Fax: 859-257-8071

Patient Financial Experience Department Updated: 08/2021

2021 Federal Poverty Guidelines

Household Size	Resource Limit
1	$2,000.00
	$12,880.00
2	$4,000.00
	$17,420.00
3	$4,050.00
	$21,960.00
4	$4,100.00
	$26,500.00
5	$4,150.00
	$31,040.00

*Note: Income limits are effective as of April 1, 2021

All income of a family unit is to be counted. A family unit includes:

a. the individual
b. the individual's spouse who lives in the home
c. a parent or parents, of a minor child, who lives in the home
d. all minor children who live in the home

Related and non-related household member(s) who do not fall into one of the groups listed above are considered a separate family unit. *Countable resources are limited to cash, checking and savings, stocks, bonds, certificates of deposit, and money market accounts *Countable resources may be reduced by unpaid medical expenses of the family unit to determine eligibility

If you have insurance you can only qualify for financial assistance if your Annual Income Limit is 138% or less of the federal poverty level (Medicaid Spend Down and Medicaid copays are excluded). If your limit is over 138% of the poverty level we will be glad to work with you on a payment plan. We offer additional levels of financial assistance to our non-insured patient for those services covered under our financial assistance policy. If you have questions or concerns about your financial assistance applications please call (855) 211-4707

***Are you (the patient) a resident of Kentucky? "Resident" is defined as a person living in Kentucky and who is not receiving public assistance in another state.* Yes ☐ No ☐**

***Are you (the patient) (Please select all that applies)**
☐ BLIND, ☐ DISABLED, ☐ OVER AGE 65, ☐ PREGNANT, ☐ a MINOR CHILD or ☐ have MINOR CHILDREN IN THE HOME?
***If yes, you must contact the Department for Community Based Services in the county of your residence to apply for Medicaid.**

If an individual claims to be permanently and totally disabled, refer the individual to both DCBS to apply for Medicaid and to the Social Security Administration to apply for SSDI/SSI.

***Was the date of service related to an auto accident? ☐ Yes ☐ No**

Comments:
Número de
_____
Limite de 2021
_____
_____

Integrantes de la Familia

	Salario (Limite del Salario Anual)
1	$2,000.00
	$12,880.00
2	$4,000.00
	$17,420.00
3	$4,050.00
	$21,960.00
4	$4,100.00
	$26,500.00
5	$4,150.00
	$31,040.00

*Nota: Los límites de salario son efectivos el 1 de abril de 2021. Todos los ingresos de la unidad familiar deben ser contados. Una unidad familiar incluye:

a) el individuo
b) el/la esposo/a del individuo que vive en el hogar
c) el padre o los padres de un niño menor de edad
d) que vive en el hogar todos los niños menores de edad que viven en el hogar Considerarán a los miembros relacionados y no relacionados de la casa que no califican en uno de los groupos mencionados arriba como una familia separada.. *Los recursos contables son limitados a una cuenta corriente y/o ahorros, acciones, inversions, certificados de depósito y cuentas de mercado de valores *Los recursos contables puede ser reducidos por gastos médicos impagados para determinar elegibilidad.

Si el paciente tiene seguro médico, solo puede calificar por asistencia financiera si su salario anual es el 138% o menos del nivel de pobreza federal (la tarjeta Medicaid Spend down y los co-pays de Medicaid son excluidos). Si su salario anual es más del 138% del nivel de pobreza federal estarémos disponibles para ayudarle con un plan de pagos. Nosotros ofrecemos niveles adicionales a los pacientes sin seguro médico para aquellos servicios cubiertos en nuestra póliza de asistencia financiera. Si usted tiene preguntas o quiere el estatus de su solicitud de asistencia, por favor llamar (855) 211-4707.

¿Usted, el paciente, es residente de Kentucky ? Un "Residente" se difine como una persona viviendo en Kentucky y quien no está recibiendo asistencia pública del otro estado. ☐ Si ☐ No

*** Por Favor ☒ todos que le corresponden. ¿Es el paciente ☐CIEGO, ☐ DISCAPACITADO, ☐ MAYOR DE 65 Años, ☐ EMBARAZADA, ☐UN MENOR DE EDAD o ☐TIENE HIJOS MENORES DE EDAD EN EL HOGAR? Si la respuesta es SI, usted deberá comunicarse con el Department for Community Based Services (DCBS) en el condado que vive para solicitar Medicaid**

Si un individuo confirma que es permanentemente y totalmente discapacitado, por favor referir al individuo a DCBS para aplicar para Medicaid y tambien la Oficina de Administracion del Seguro Social para aplicar para SSDI/SSI

***La fecha del servicio fue debida a un accidente de auto? ☐ Si ☐ No**

Comentarios:
_____
_____
_____

*I (we) hereby authorize the UK HealthCare (UKHC) to verify the information I have provided above. UKHC may verify employment and wages earned by contacting my employer or others. UKHC may obtain a financial credit report. I certify that the information provided on this application is correct and complete to the best of my knowledge and belief. I understand that if I give false information or withhold information in accepting assistance, I may be subject to prosecution for fraud. I understand that a financial assistance application can be completed upon admission or at any time during the collection process up to when litigation begins or my account is transferred to a collection agency. UKHC reserves the right to make every reasonable attempt to collect from insurance companies or other third parties.	*Yo (Nosotros) autorizo a la Universidad de Kentucky HealthCare (UKHC) a verificar la información que he proveído en este formulario. UK podría comunicarse con mi empleador u otros para verificar mi salario. UKHC podría solicitar un reporte de mi crédito. Yo certifico que la información proveída en este formulario es correcta. Yo entiendo que si doy información falsa u oculto información para obtener asistencia financiera, podré ser acusado de fraude. Entiendo que el formulario para asistencia financiera podrá ser completado al ser admitido en el hospital o en cualquier momento durante el proceso de cobranza hasta que el litigio comience o mi cuenta sea transferida a una agencia de cobranza. La UKHC se reserve el derecho de realizar todo intento razonable de cobranza a las compañías de seguro médico o a terceras partes.

Signature (Firma): _____ Date (Fecha) _____UK HealthCare Employee: _____

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