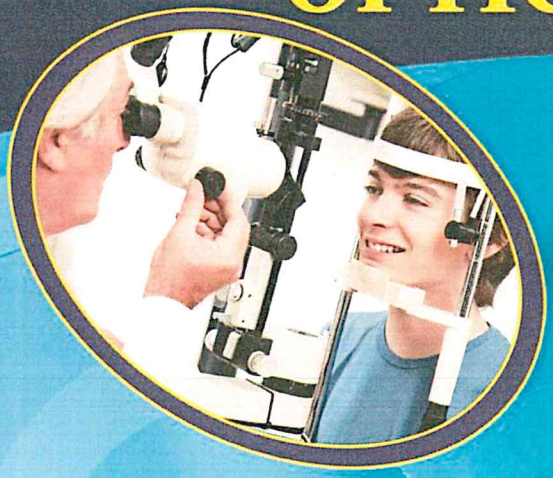
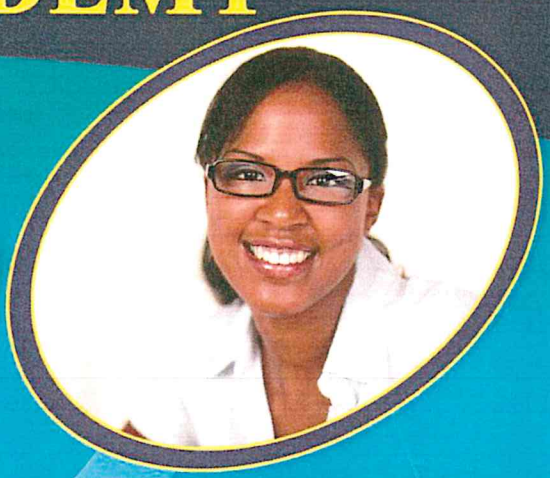
OPTICAL ACADEMY





BOOK YOUR EYE EXAM AND EYE WEAR

WELCOMES ALL!

Hamburg Public Schools

Tuesday, March 24, 2020 @ 2:00pm – 6:00pm

30 Linwood Ave, Hamburg, NJ 07419

Visit the Complete On-Site Optical Shop

Eye Exams – Glasses – Sunglasses – Contacts - Accessories

To Register: Call 1-800-530-2730

Or Register Online By Visiting

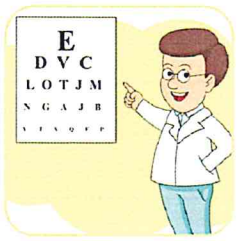
https://www.optical-academy.com/event/hamburg-public-school/

EYE EXAMS $30
CONTACT LENS EXAMS ADD $30

FRAME & LENS STARTING AT $29

WE ACCEPT ALL INSURANCE

1-800-530-2730 www.Optical-Academy.com



The Optical Academy
On-site Vision Team At Your School

#glassestoclasses

ABEER AYOUB
Ophthalmic Dispenser
NY LIC #007472 NJ LIC #31TD00330100

VITTORIO MENA, OD
NJ LIC: 27OA00657300
NY LIC: TUV008546-1

By filling out this form, you are agreeing to allow the Optical Academy Vision Team to provide Comprehensive Eye Exams & Eyewear to your child, if necessary.

SCHOOL NAME:_____ Date of Event_____

Child's First Name:_____ Last Name:_____ Gender: **M / F**

Address:_____ City:_____ State_____ Zipcode_____

Email:_____ Phone Number_____

☐ **CHILD/PATIENT WILL BE USING THEIR INSURANCE BENEFITS:**

Insurance Name:_____ Primary's Name :_____

Insurance ID:_____ Primary's DOB :_____

Patient DOB:_____ Last four # of SSN:_____

☐ **Child/ Patient has no medical or vision insurance & Parent/Guardian will be paying $30 for the Eye Exam. (you can send money with your child to school or call in the payment to 1-800-530-2730)**

- ☐ Allow an Optical Academy Vision Team member to choose eyewear for my child for $29 frame & lens, if they are necessary.
- ☐ Please send the prescription home with Child/Patient.

MEDICAL HISTORY

Does the Child/Patient or anyone in their family have any of the following: (Please Circle)
Diabetes,High Blood Pressure, Thyroid Problems, Heart Disease, Cancer, Glaucoma, Cataracts

Does Child/ Patient experience any of the following: (Please Circle)
Eye Surgery, Seizures, Seeing Double, Red Eyes, Itching, Allergies

Is Child/Patient on any medication? If yes, please list:

_____

_____

HIPPA The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information. Our Legal Duty-Law Requires Us to keep your medical information private and give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information. Notice of Change to Privacy Practices: Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request. Use and Disclosure of Your Medical Information. The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us. For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you. Notifications: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, we will share only the health information that is directly necessary for your healthcare, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you. Acknowledgement of Receipt and General Consent I acknowledge that I have reviewed a copy of Optical Academy, Your Eye Exam in Your School. I further consent to the release of my health information for purposes of treatment, payment and health care operations and as authorized or required by law under the circumstances described in the Notice of Privacy Practices.

HIPPA La privacidad de su información médica es importante para nosotros. Entendemos que su información médica es personal y estamos comprometidos a protegerla. Este aviso le dirá sobre las maneras en que podemos usar y compartir información sobre médica usted .También describimos sus derechos y ciertas obligaciones que tenemos con respecto al uso y divulgación de información médica. Nuestro deber-ley legal nos obliga a mantener su información médica privada y darle este aviso que describe nuestras obligaciones legales, las prácticas de privacidad y sus derechos respecto a su información médica. Notificación de Cambio de Prácticas: Antes de hacer un cambio importante en nuestras prácticas de privacidad: Vamos a cambiar este aviso y hacer el nuevo aviso a pedido. Uso de la divulgación de su información médica. La siguiente sección describe las formas diferentes que podemos usar y divulgar información médica. Se enumerarán No todo uso o divulgación. Sin embargo, hemos hecho una lista de todas las maneras diferente somos permitido utilizar y divulgar información médica. No vamos a utilizar o divulgar su información médica para cualquier fin que no se enumeran a continuación, sin su autorización expresa y por escrito, cualquier autorización especifica por escrito que usted proporcione puede ser revocada en cualquier momento por escrito. Para tratamiento: Podemos usar información médica sobre usted para proporcionarle tratamiento o servicios medicos. Podemos revelar información médica acerca de usted a médicos, enfermeras, técnicos, estudiantes de medicina y demás personas que están tomando el cuidado de usted. También podemos compartir información médica acerca de usted a sus otros proveedores de atención médica para ayudar en su tratamiento. Notificaciones: Podemos utilizar y divulgar información médica para notificar o ayudar a notificar: un miembro de la familia, su representante personal u otra persona responsable de su cuidado. Vamos a compartir información sobre su ubicación, condición general o muerte. Si usted está presente, obtendremos su permiso, si es posible antes de que compartamos, o le damos la oportunidad de negar el permiso. En caso de emergencia, vamos a compartir sólo la información de la salud, que es directamente necesario para su cuidado de la salud, de acuerdo a nuestro criterio profesional. También utilizaremos nuestro juicio profesional para tomar decisiones en su mejor interés de permitir a alguien para recoger medicamentos, suministros médicos, radiografías o médica para usted. Acuse de Recibo y Consentimiento General reconozco que he revisado una copia de la Academia Optica, su examen de la vista en su escuela. Además doy mi consentimiento para la divulgación de mi información de salud para fines de tratamiento, pago y operaciones de cuidado de salud y según lo autorizado o requerido por la ley en virtud de las circunstancias descritas en el anuncio de las prácticas de privacidad.

READ AND SIGN BELOW I UNDERSTAND AND AUTHORIZED OPTICAL ACADEMY AND ITS AFFILIATED DOCTORS TO PROVIDE THE COMPLETE EYE EXAM FOR THE LISTED CHILD/PATIENT. I AUTHORIZED & DIRECT OPTICAL ACADEMY TO BILL & COLLECT PAYMENT FROM ANY MEDICAID, INSURANCE, OR OTHER PAYER. IF I HAVE VISION INSURANCE, I WILL BE BILLED FOR & AGREE TO PAY ANY DEDUCTIBLE AND/OR COPAYS. I ALSO AGREE TO PAY FOR ANY UPGRADES AND/OR ADDITIONAL OPTIONS FOR EYE WEAR FOR MY CHILD. UNLESS I HAVE MADE PRE-ARRANGEMENTS TO ATTEND, AND AM THERE AT THE TIME OF SERVICE, SERVICES WILL BE PROVIDED WITHOUT MY PRESENCE

PARENT/LEGAL GUARDIAN SIGNATURE *(FIRMA DEL PADRE / TUTOR LEGAL)*

DATE *(FECHA)*

PRINT NAME *(IMPRIMIR EL NOMBRE)*

VERSION 04 NJ 06/13