PATIENT REGISTRATION

PLEASE COMPLETE ALL BLANKS OR WRITE “NONE”

FULL NAME OF PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RESPONSIBLE PARTY (IF MINOR): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT MAILING ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT PLACE OF EMPLOYMENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT OCCUPATION/PAST IF RETIRED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WORK PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT DL#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT MARITAL STATUS: S M W D PATIENT SEX: M F

SPOUSE NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PARENT/GUARDIAN NAME (IF MINOR): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT OTHER THAN SPOUSE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ REFERRED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PREVIOUS EYE DOCTOR:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LAST EYE EXAM:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHARMACY NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHARMACY PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT RACE: (you may check more than one) PATIENT ETHNICITY:

American Indian or Alaska Native Not Hispanic or Latino

Asian Hispanic or Latino

Black or African American

Native Hawaiian or other Pacific Islander

White

 I WEAR GLASSES I WEAR CONTACT LENSES soft hard CURRENT BRAND OF CONTACTS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE THE CONTACT LENSES YOU ARE CURRENTLY WEARING COMFORTABLE? Yes No

**PAYMENT IN FULL FOR PROFESSIONAL SERVICES RENDERED IN THE OFFICE IS DUE AT THE TIME OF THE VISIT**

**MEDICARE PATIENTS ARE RESPONSIBLE FOR THEIR DEDUCTIBLE AND 20% COINSURANCE THAT MEDICARE DOES NOT PAY.**

**A REFRACTION IS A NON-COVERED PROCEDURE WITH MEDICARE AND MOST OTHER HEALTH INSURANCES. THIS IS PAYABLE AT THE TIME OF SERVICE.**

INSURANCE INFORMATION

COMPANY NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PATIENT I.D. NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP NUMBER \_\_\_\_\_\_\_\_\_\_

COMPANY ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_

COMPANY PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IS THIS MEDICAID OR CHIPS? Y N

PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT REPRESENTATIVE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIPAA OMNUBUS RULE

**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION AND RELEASE FORM**

You may refuse to sign this acknowledgement and authorization. In refusing we may not be allowed to process your insurance claims.

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original**. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITYS IN THE FUTURE.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE **PRINT** YOUR NAME PLEASE **SIGN** YOUR NAME

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LEGAL REPRESENTATIVE DESCRIPTION OF AUTHORITY

Your comments regarding Acknowledgements or Consents: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

 First Name Only Proper Sir Name Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient’s records):

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT AND BILLING INFORMATION** VIA:

 CELL PHONE CONFIRMATION TEXT MESSAGE TO MY CELL PHONE

 HOME PHONE CONFIRMATION EMAIL CONFIRMATION

 WORK PHONE CONFIRMATION ANY OF THE ABOVE

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** TO BE CONVEYED VIA:

 CELL PHONE CONFIRMATION TEXT MESSAGE TO MY CELL PHONE

 HOME PHONE CONFIRMATION EMAIL CONFIRMATION

 WORK PHONE CONFIRMATION ANY OF THE ABOVE

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUNDRAISING EFFORTS OR NEW HEALTH INFO** ON BEHALF OF THIS HEALTHCARE FACILITY VIA:

 PHONE MESSAGE ANY OF THE ABOVE

 TEXT MESSAGE NONE OF THE ABOVE (opt out)

 EMAIL

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

**OFFICE USE ONLY:**

AS PRIVACY OFFICER, I ATTEMPTED TO OBTAIN THE PATIENT’S (OR REPRESENTATIVES) SIGNATURE ON THIS ACKNOWLEDGEMENT, BUT DID NOT BECAUSE:

 IT WAS EMERGENCY TREATMENT I COULD NOT COMMUNICATE WITH THE PATIENT THE PATIENT REFUSED TO SIGN

 THE PATIENT WAS UNABLE TO SIGN BECAUSE OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE OF PRIVACY OFFICER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL INFORMATION**

**MEDICAL HISTORY:**

1. MEDICAL ALLERGIES:
2. PAST MEDICAL HISTORY:
3. PAST SURGICAL HISTORY:
4. CURRENT MEDICATIONS (NAME AND PURPOSE):

**FAMILY HISTORY: PLEASE NOTE RELATION TO YOURSELF**

BLINDNESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CANCER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CATARACTS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DIABETES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 MACULAR DEGENERATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HEART DISEASE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 GLAUCOMA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HIGH BLOOD PRESSURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 RETINAL DETACHMENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ KIDNEY DISEASE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 CROSSED EYES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ARTHRITIS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 LUPUS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_THYROID DISEASE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CURRENTLY PREGNANT OR NURSING

**SOCIAL HISTORY:**

 DRIVES: DOESN’T DRIVE DOESN’T USE TOBACCO USES TOBACCO

Driving Difficulties: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type/Amt/How Long:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DRINKS ALCOHOL DOESN’T DRINK ALCOHOL DOESN’T USE ILLEGAL DRUGS USES ILLEGAL DRUGS

Type/Amt/How Long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type/Amt/How Long:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been exposed to or infected with: Gonorrhea Hepatitis Syphilis HIV

**REVIEW OF SYSTEMS: PLEASE CHECK ALL THAT APPLY TO YOU:**

|  |  |  |
| --- | --- | --- |
| **1) EYES:*** VISION LOSS
* BLURRY VISION
* DISTORTED VISION
* DOUBLE VISION
* DRYNESS
* REDNESS
* MUCOUS DISCHARGE
* GRITTY FEELING
* ITCHING
* BURNING
* EXCESS WATERING
* LIGHT SENSITIVITY
* EYE PAIN/SORENESS
* CHRONIC INFECTION
* STIES
* FLASHES
* FLOATING SPOTS
* TIRED EYES
* CATARACTS
* DIABETIC RETINOPATHY
* GLAUCOMA
* MACULAR DEGENERATION
* RETINAL DETACHMENT

**2) GASTROINTESTINAL:*** COLITIS
* CROHN’S DISEASE
* ULCERS
* CONSTIPATION
* DIARRHEA
 | **3) CONSTITUTIONAL:*** FEVER
* WEIGHT LOSS/GAIN
* FATIGUE
* TRAUMA

**4) INTEGUMENTARY (SKIN)*** ECZEMA
* ROSACEA
* PSORIASIS

**5) NEUROLOGIC*** HEADACHES
* MIGRAINES
* SEIZURES
* MULT. SCLEROSIS

**6) ENDOCHRINE*** NON INSULIN DIABETES
* INSULIN DIABETES
* THYROID DISFUNCTION
* HORMONAL DISFUNCTION

**7) RESPIRATORY*** ASTHMA
* BRONCHITIS
* EMPHYSEMA

**8) CARDIOVASCULAR*** HEART DISEASE
* HYPERTENSION
* HYPERCHOLESTEROLEMIA
 | **9) EARS/NOSE/THROAT*** ALLERGIES
* SINUS CONGESTION
* RUNNY NOSE
* POST NASAL DRIP
* CHRONIC COUGH
* DRY THROAT/MOUTH

**10) ALLERGIC/IMMUNE*** DRUG ALLERGIES
* SEASONAL ALLERGIES
* LUPUS
* ARTHRITIS

**11) LYMPHATIC/HEMATOLOGIC*** ANEMIA
* BLEEDING PROBLEMS
* LEUKEMIA

**12) MUSCULOSKELETAL*** FIBROMYALGIA
* MUSCULAR DYSTROPHY
* OSTEOARTHRITIS
* ANKYLOSING SPOND

**13) GENITOURINARY*** KIDNEY PROBLEMS
* BLADDER PROBLEMS
* STD’s
 |

**REFRACTION POLICY**

Refraction is the process of determining the eye’s refractive error, or need for corrective spectacle and/or contact lenses. It is an essential part of an eye examination, but it is NOT a covered service by Medicare or most medical insurances. Our office fee for refraction is $25.00 and this fee is collected in addition to the patient’s co-pay.

**REFUND POLICY**

All exam fees are NON-REFUNDABLE. All contact lens fitting fees are NON-REFUNDABLE.

**ACKNOWLEDGEMENT**

I have read the above information and understand that the refraction is a non-covered service. I also understand that office visits and/or contact lens fittings are NOT refundable services. I accept full financial responsibility for the cost of these services. The co-pay is separate from and not included in the refraction fee.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature (parent or guardian for minor)  Date

**OPTICAL POLICIES**

Lenses will be made in accordance with the recommendations of ANSI 280-1999 to meet the Doctor’s prescription.

Any problems with the glasses must be reported **IN PERSON** within 30 days of glasses being picked up.

Advanced Eye Care cannot make any changes to your lenses after 30 days.

There will be a $30.00 restocking fee if frames are returned.

If glasses are not picked up within 30 days of your being called, they will be returned to the manufacturer with **NO REFUND.**

Contact lenses can only be returned if the box is unopened with 30 days. There will be a restocking fee of $15.00 for contacts that are returned.

We will be HAPPY to adjust your glasses at no charge. However, we are **NOT** responsible for any damage to frames or lenses.

Sorry, no refunds or exchanges on frames, unless the frame itself is to be found defective.

A/R and scratch coating, polycarbonate lenses are under warranty for 1 year (depending on insurance) and covered only for normal wear and tear.

*I have read, understood and agree to the optical policies of Advanced Eye Care.*

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Advanced Eye Care

Optical Department