# CENTER FOR SIGHT

**Language Preferred** ☐ English ☐ Spanish ☐ Other_____ **Date:**_____

## PATIENT INFORMATION

First Name:_____Last Name:_____Middle_____

Home Phone:_____Cell Phone_____

Address_____

City:_____State_____Zip_____Driver's License_____

☐ Male ☐ Female **Birthdate:**_____**Social Security:**_____

☐ Single ☐ Married ☐ Widowed ☐ Domestic Partner ☐ Divorced ☐ Separated

**Race:** ☐ White ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or other Pacific Islander **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino

**Employer:**_____**Employer Phone:**_____

Employer's Address_____

Occupation:_____

**In case of an emergency contact:**_____**Relationship:**_____**Phone:**_____

**Primary Care Doctor:**_____**Phone:**_____

## REFERRED BY

☐ Doctor_____ ☐Friend/Family Member_____

☐ Yellow Pages ☐ Insurance ☐ Facebook ☐ Website ☐ Magazine ☐ Newspaper ☐ Other_____

## COMPLETE THE FOLLOWING IF MARRIED

Spouse's Name:_____

Employer:_____Occupation:_____

Employer's Address:_____Phone:_____

## COMPLETE THE FOLLOWING IF PATIENT IS A MINOR

Father's Name:_____Birthdate:_____

Phone:_____Social Security:_____Driver's License:_____

Address:_____

Employer:_____Employer's Phone:_____

Employer's Address:_____

(over)

Mother's Name:_____Birthdate:_____

Phone Number:_____Social Security:_____Driver's License:_____

Address:_____

Employer:_____Employer's Phone:_____

Employer's Address:_____

## INSURANCE INFORMATION

Primary Insurance:_____

Subscriber Name:_____Birthdate:_____Social Security:_____

Policy ID No:_____Group:_____

Secondary Insurance:_____

Subscriber Name:_____Birthdate:_____Social Security:_____

Policy ID No:_____Group:_____

## VISION PLAN

☐ Vision Service Plan (VSP) ☐ Medical Eye Services (MES) ☐ Eye Med ☐ Safeguard ☐ Optum

☐ Vision Benefits of America ☐ Other_____

## FINANCIAL POLICY

The insurance information I have given is accurate. I understand that it is my responsibility to notify Center for Sight if any change in insurance coverage takes place. I realize that by withholding the correct insurance information, including the required authorizations or referrals, I become liable for payment should my claims be denied.

Signature:_____Date:_____
(Patient or Guardian)

**PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST ALONG WITH A PHOTO ID**. If your insurance card requires a referral or claim form, please present it at the time of your visit.

We will bill all insurances as a courtesy to our patients. If you do not have insurance we ask that payment be made at the time of service. We gladly accept MasterCard, Visa, Cash and Checks.

## CLAIMS AUTHORIZATION

I request that payment of authorized Health Insurance benefits (including Medicare) be made on my behalf to Center for Sight for services provided to me by that group. I authorize the holder of medical information about me to release to the Centers for Medicare and MediCaid services and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If a claim form is submitted, my signature authorizes release of the information to the Insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and patient is responsible only for the deductible, coinsurance, and non-covered services. The coinsurance and deductible are based upon the charge determination carrier. I also understand that Medicare will not cover the refraction (measurement for glasses) portion of the examination. Therefore, I accept responsibility for payment.

Signature:_____Date:_____

## CO-PAYMENTS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE

Patient Name:_____ Date:_____

Date of Birth:_____ Primary Care Doctor:_____

Patient Phone Number:_____

Please complete the following sections:

Do you wear glasses: ❑ No ❑ Yes If Yes since what year?_____ Used for Distance / Near
Do you wear Contact Lenses: ❑ No ❑ Yes

Patient's Eye History (past surgeries or eye conditions): ❑ None

_____

_____

Patient's Eye Medication: ❑ None

_____

_____

Patient's Medical History, including ALL operations: ❑ None

_____

_____

Blood Relative Family History:

1. High Blood Pressure: ❑ No ❑ Yes If Yes, what relation?_____
2. Glaucoma: ❑ No ❑ Yes If Yes, what relation?_____
3. Diabetes: ❑ No ❑ Yes If Yes, what relation?_____
4. Macular Degeneration: ❑ No ❑ Yes If Yes, what relation?_____
5. Retinal Detachment: ❑ No ❑ Yes If Yes, what relation?_____
6. Color Blindness: ❑ No ❑ Yes If Yes, what relation?_____
7. Other Eye Condition ❑ no ❑ Yes If Yes, what relation?_____

Please circle all that apply to the PATIENT:

1. Smoking Status: Former Current Never
2. Tobacco Use: Former Current Never

Allergies to Medications and reactions: ❑ No Know Medication Allergies:

_____

_____

_____

Medications, including over the counter medications and vitamin/herbal supplements:

_____

_____

Blood Sugar (If known)_____ Date Last Taken:_____
Hemoglobin A1C_____ Date Last Taken:_____

(OVER)

Patient Name:_____ Date:_____

Please **CHECK YES OR NO;** If YES, circle all that apply to you:

| | | |
|---|---|---|
| ❑ No | ❑ Yes | **Constitutional (general health**): ie: fever, fatigue, night sweats, weight gain/loss, insomnia, weakness. Other:_____ |
| ❑ No | ❑ Yes | **Ear/Nose/Throat:** aches/ringing of ears, hearing loss, nasal congestion, nose bleeds, sinus problems, sore throat, vertigo. Other:_____ |
| ❑ No | ❑ Yes | **Respiratory (lungs):** blood in sputum, cough, shortness of breath, TB exposure, wheezing. Other:_____ |
| ❑ No | ❑ Yes | **Cardiovascular (heart):** calf pain with exercise, chest pain or pressure, irregular/rapid heart rate, leg swelling, palpitations, shortness of breath with exertion. Other:_____ |
| ❑ No | ❑ Yes | **Gastrointestinal (stomach):** increased/decreased appetite, food intolerance, heart burn, jaundice, or trouble swallowing. Other:_____ |
| ❑ No | ❑ Yes | **Genitourinary (urinary tract):** blood in urine, painful urination, urinary urgency, discharge Other:_____ |
| ❑ No | ❑ Yes | **Integumentary (skin):** abnormal change in lesion, change in fingernails or hair, acne, skin rash or skin cancer, sores, warts, hives. Other:_____ |
| ❑ No | ❑ Yes | **Endocrine (glands):** hypo/hyper thyroid, increased thirst, bulging of eyes, heat/cold intolerance, mass in front of neck. Other:_____ |
| ❑ No | ❑ Yes | **Neurological (nerves):** balance/memory problems, dizziness, fainting, vertigo, headaches, weakness, seizures, numbness of extremities, tremors, tingling. Other_____ |
| ❑ No | ❑ Yes | **Psychological:** depression/anxiety, frequent nightmares, hallucinations, low mood, nervousness. Other_____ |
| ❑ No | ❑ Yes | **Musculoskeletal (muscles/bones):** joint/back or muscle pain, stiffness/weakness, night cramps, easily broken. Other_____ |
| ❑ No | ❑ Yes | **Hematological/Lymphatic (blood):** bleeding, blood transfusion, bruising, tender or enlarged lymph nodes. Other:_____ |
| ❑ No | ❑ Yes | **Immunological (immune system):** seasonal allergies, hay fever, joint pain. Other:_____ |

Patient/Guardian Signature:_____

**NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse protected health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of PHI by alterative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of October 1, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information, in person or in writing.

**WRITTEN ACKNOWLEDGEMENT FORM**

I am a patient of Center for Sight.

I hereby acknowledge receipt of Center for Sight's Notice of Privacy Practices.

Name [please print]:_____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of Center for Sight's Notice of Privacy Practices with respect to the patient.

Name [please print]:_____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____