

TO OUR PATIENTS

We would like to thank you for the opportunity to become your Eye Care Specialist. We have set up an appointment for you for _____AM/PM on _____ with Dr. Cartwright / Dr. Lopez.

We are committed to providing the highest level of eye care available in the area. To accomplish our level of excellence we would like to give you some information on what to expect during your exam;

Please allow on average two (2) hours for your appointment. During this time, our technicians will be performing extensive history taking, dilation (if needed), testing and face to face time with the physician.

Sincerely,

Medical Eye Associates Management

WELCOME TO OUR OFFICE

Today's Date: _____ Soc. Sec # _____

Patient's Name: _____ / _____
(First) (MI) (Last) (Preferred Name)

Marital Status: S M D W Date of Birth: ____/____/____ Age: _____ Sex: F M

Address: _____

City, State and Zip Code: _____

Home#: (____) _____ Cell#: (____) _____ E-mail: _____

Spouse's Name: _____ Phone#:(____) _____

Employer: _____ Work#: (____) _____

Have you been seen by another eye doctor? Yes / No For this similar condition? Yes / No

Referred By: _____ Phone#:(____) _____

Family Physician Name: _____ Phone#:(____) _____

Insurance Information

Principal Insurance Name: _____

Insurance Policy Holder's Name: _____ Date of Birth: ____/____/____

Insurer's Social Security: _____ Ins ID#: _____

Secondary Insurance Name: _____

Insurance Policy Holder's Name: _____ Date of Birth: ____/____/____

Insurer's Social Security: _____ Ins ID#: _____

Emergency Contact

In case of emergency, please contact: _____ Phone#:(____) _____

Relationship to you: _____ Address: _____

Name of family member NOT residing with you: _____ Phone#:(____) _____

Relationship to you: _____ Address: _____

PLEASE NOTE: PAYMENT IS EXPECTED AT TIME OF SERVICE

- € I certify that the information I provided is correct. I authorize the release of medical information necessary to process insurance claims to Medicare or any other insurance company. I authorize payment of medical payments to Eye Center Inc. for any services rendered to me by any doctor of the Eye Center Inc.
- € I understand that my insurance is a contract between my insurer and myself. I am responsible for understanding the terms of my policy, including deductibles, co-pays, coinsurance and referrals. I am responsible for obtaining any required referrals, and in absence of such, I will be held responsible for the cost of the service provided.
- € I authorize use of this form on all my insurance submissions. I understand **I am responsible** for my bill. I permit a copy of this authorization to be used in place of the original.
- € I understand **I am subject to be charged a \$25 (twenty-five dollars) cancellation/no show fee** for canceling my appointment without giving 24-hour notice.
- € I understand **I am subject to be charged a \$100 (one-hundred dollars) cancellation/no show fee** for canceling my laser appointment without giving 48-hour notice

Signature of Patient or Legal Guardian (Signature on file for payment authorization)

Date

NOTE: ANY UNPAID BALANCES FROM PREVIOUS VISITS, OR NON ALLOWED CHARGES/NON-COVERED SERVICES MUST BE PAID IN FULL TODAY. I request that authorized Medigap benefits (if applicable) be made on my behalf to Medical Eye Associates. I authorize Medical Eye associates to contact the State Ins. Commissioner on my behalf in which state my insurance company domiciles to collect their payment. SIGNING THIS FORM CERTIFIES YOUR AGREEIANCE WITH ALL THE STATEMENTS ABOVE. If you disagree with any statement, please discuss with us before signing.

Advanced Notice of Patient Responsibility for Non-Covered Services

PLEASE NOTE: If a refraction test is needed to determine a prescription for your glasses, a fee of \$40.00 is collected at the time of visit. This test is covered by vision insurance only. **Refraction test is not covered by medical insurance.**

Patient

Date

EYE DROPS

In order to perform a thorough evaluation of the health of your eyes, it is sometimes necessary to dilate the pupils with eye drops. Please be advised of the potential for significant decrease in vision after dilating drops and driving may be difficult.

Patient

Date

ASSIGNMENT OF MEDICAL/SURGICAL BENEFIT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____ hereby irrevocably assign and transfer payment of any and all medical benefits to which I may be entitled for services provided by Mont J. Cartwright, MD and Brian T. Burry, OD pursuant to contact of health insurance, group health insurance, Medicare, Medicaid, no fault automobile insurance, or any type or form of insurance whatsoever, and authorize payment of said benefits directly to the aforementioned physician and or supplier. This assignment shall be binding upon my heirs, executors and administrators.

I understand that I am financially responsible for any unpaid balance reflecting insurance deductibles, coinsurances and non-covered services.

I authorize to release, to my insurance company, of any medical or other information which may be necessary to process claims for services provided to me by the above-named physician and/or supplier.

I authorize the release of pertinent medical records to the physician who referred me, as well as to my primary care physician, upon request.

All photos taken are the property of Medical Eye Associates; they may be used for insurance authorizations, educational purposes, and medical publications. Original photos cannot be released. This authorization will certify that I give full consent to have photograph(s) taken, whether still or motion and to have said photograph(s) or portions thereof published. Photograph(s) taken for a specific purpose may be used for multiple purposes, including publications and advertising.

A photocopy for this authorization shall serve in the place and stead of this original.

DATE

PATIENT'S OR AUTHORIZED PERSONS SIGNATURE

WITNESSED BY: _____

PATIENT INFORMATION DISCLOSURE

AUTHORIZATION

Please list below the names of persons who are authorized to receive information from Medical Eye Associates, Doctors Surgery Center, and American Optical concerning your diagnoses, treatment, and prognosis for purposes other than treatment and payment. When authorized persons request healthcare information pertaining to you, they will be required to present a photo I.D. When authorized persons inquire via telephone, your name, date of birth and social security number will be verified. Authorized names shall remain on file until you request removal.

NAME **RELATIONSHIP TO PATIENT**

Patient Signature

Date

Patient Name

Acct#: _____

INSURANCE TERMINOLOGY FOR PATIENTS

PARTICIPATING PROVIDER:	Any doctor who agrees to accept the Medicare allowable (not the Medicare payment) as payment in full.
MEDICARE ALLOWABLE:	The amount Medicare allows for a particular charge which may be equal to or less than the doctor's charge.
MEDICARE PAYMENT:	Medicare pays 80% of the allowable amount after the \$ 183.00 deductible has been met.
MEDICARE DEDUCTIBLE:	Medicare requires that you pay the first \$ 183.00 they have allowed for charges submitted on an annual basis.
MEDICARE CO-PAYMENT:	What's left after Medicare pays their 80% of the allowable. You are responsible for the 20% balance due under co-payments.
OUT-OF-POCKET EXPENCE:	Medicare requires that you pay \$ 183.00 deductible, plus 20% of the allowable amount.
SUPPLEMENTAL INSURANCE:	You may purchase a separate insurance policy that may pay your out-pocket expense (Medicare deductible and co-payment) in part or in full, depending on the terms of your policy.

Patient Signature

Date

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full-length Notice follows this summary.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your Protected Health Information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices that follows this summary):

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and ensure all our patients receive quality care
- For research
- To avert a serious threat to health or safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request

For more information about these rights, please see the detailed Notice of Privacy Practices that follows this summary.

NOTICE OF PRIVACY PRACTICES

Updated 8/13/2016

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 personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal 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 Protected Health Information by alternative 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 you're 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 Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of 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.

Signed: _____ Date: _____

Witness: _____ Date: _____

PATIENT STATEMENT

I _____, certify that I am not a member of any Health Maintenance Organization (HMO) that does not have a participating provider agreement with Medical Eye Associates, Doctors Surgery Center and American Optical.

I also certify that if I enroll in any Health Maintenance Organization (HMO) that Medical Eye Associates, Doctors Surgery Center and American Optical does not have a participating provider agreement with, I take full responsibility for the entire amount of any charges with either of the above-named provider.

Patient: _____ Date: _____

Witness: _____ Date: _____

INFORMED CONSENT OF TREATMENT

Patient's Name/ID#: _____ DATE: _____

I, _____ (name of patient), agree and consent to health care services offered and provided by, Medical Eye Associates a health care provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to perform.

If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of the above-named individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Signature: _____ Date: _____

Relationship to Patient (if applicable): _____

Dear patient,

For your convenience and safety, we are introducing a computerized prescription program that will improve both, the accuracy and the convenience of prescribing medications. This program will allow for the electronic transmission of most of your prescriptions directly to your pharmacy of choice and will eliminate your waiting time. In most cases, it will also accommodate the transmission of your prescription of your prescription to mail order pharmacies.

To implement this new program we need to collect some information from you on the pharmacies of your choice. We will define one pharmacy as your main pharmacy, however, you may also provide the information for additional pharmacies to be used as an alternative. In addition, if you have a mail order benefit program, please provide that information by selecting appropriate box below.

We understand that you may not have the complete pharmacy information with you today. Please provide any information possible regarding the location (street, city, phone and fax) as any information provided will be helpful.

Patient Name: _____ Date of Birth: _____

MAIN PHARMACY

Name (i.e. CVS, Walgreens etc.): _____

Street Name & City: _____

Phone: _____ Fax: _____

ADDITIONAL PHARMACIES YOU WOULD LIKE TO KEEP ON FILE

Name (i.e. CVS, Walgreens etc.): _____

Street Name & City: _____

Phone: _____ Fax: _____

Name (i.e. CVS, Walgreens etc.): _____

Street Name & City: _____

Phone: _____ Fax: _____

Medco CareMark Express Scripts Pharmacare Other

Please list your allergies: _____