CHESAPEAKE EYE PHYSICIANS, PLC

Patient Registration and Medical Review/History Form

PATIENT INFORMATION:

NAME: ____

LAST FIRST MIDDLE INITIAL

ADDRESS: ____

STREET CITY STATE ZIP CODE

STATUS: MALE / FEMALE ___ SINGLE ___ MARRIED ___ DIVORCED ___ WIDOWED ___ SEPARATED

DATE OF BIRTH: ________ /________/_________ AGE: ________ SSN: __________- __________- ___________

HOME PHONE: (______) ___________________ WORK PHONE: (______) __________________ EXT: __________

OCCUPATION: _________________________________ EMPLOYER: ______________________________________

EMPLOYER'S ADDRESS: ____

NEXT OF KIN: _________________________ RELATION: ______________ PHONE: (_______)_______________

IF THE PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

FATHER'S NAME: ____ SSN: _________ - __________- ___________

EMPLOYER'S NAME: ____ WK PHONE: (_______) ________________

MOTHER'S NAME: ____ SSN: _________ - __________ - ___________

EMPLOYER'S NAME: ____ WK PHONE: (_______) ________________

INSURANCE INFORMATION: (PLEASE PRESENT YOUR INSURANCE CARDS AND/OR VALID REFERRAL)

PRIMARY INSURANCE: ____

POLICY NUMBER: _______________________________________ GROUP NUMBER: _________________________

SUBSCRIBER'S NAME: ___________________________________ RELATIONSHIP TO PATIENT: ______________

SUBSCRIBER'S SSN: ________ - ________ - _________ SUBSCRIBER'S BIRTHDATE: _______ / _______ / ________

SECONDARY INSURANCE: ____

POLICY NUMBER: _______________________________________ GROUP NUMBER: _________________________

SUBSCRIBER'S NAME: ___________________________________ RELATIONSHIP TO PATIENT: ______________

SUBSCRIBER'S SSN: ________ - ________ - __________ SUBSCRIBER'S BIRTHDATE: _______ / _______ / _______

AUTHORIZATION FOR MEDICAL CARE AND NOTICE OF PRIVACY PRACTICES:

I here by authorize treatment to the patient by the physician and/or staff of Chesapeake Eye Physicians, PLC. I also authorize release of any medical information necessary to process the insurance and I authorize direct payment of all charges incurred, as well as attorney and collection fees of 33 1/3% should such action become necessary. By my signature, I also acknowledge that I have reviewed the Chesapeake Eye Physicians, PLC's Summary of Notice of Privacy Practices. (A copy of the privacy booklet is available upon request.)

SIGNATURE: ____ DATE: ________________**(over)**

FOR OFFICE USE ONLY:

REVIEWED BACK AND FRONT BY :______________________________ DATE: _______________

MEDICAL REVIEW OF SYSTEMS AND SOCIAL HISTORY: (Please check all that currently apply.)

- ❑ Fever
- ❑ Weight loss
- ❑ Blurred vision
- ❑ Hearing loss
- ❑ Sore throat
- ❑ Cough
- ❑ Rapid heart beat
- ❑ Tobacco use
- ❑ Sinus congestion
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Wheezing
- ❑ Heart burn/upset stomach
- ❑ Joint pain
- ❑ Frequent colds/infections
- ❑ Alcohol use
- ❑ Muscle aches
- ❑ Itching or rash
- ❑ Muscle weakness
- ❑ Dizziness
- ❑ Mood swings/depression
- ❑ Easy bruising/bleeding
- ❑ Headaches
- ❑ Other: ___________________

MEDICAL HISTORY: (Please check all that apply.)

Your Medical History:

- ❑ Diabetes
  Type I or II
  How Long? ____
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Macular Degeneration
- ❑ Arthritis
- ❑ Asthma or emphysema
- ❑ Chicken pox or shingles
- ❑ Congestive heart failure
- ❑ Depression
- ❑ Eye injuries/Surgery
  Type: ____________
  Date: ____________
- ❑ Heart attack
- ❑ Hepatitis
- ❑ High cholesterol
- ❑ HIV or AIDS
- ❑ Hypertension
- ❑ Irregular heart beat
- ❑ Lymphoma or leukemia
- ❑ Migraine
- ❑ Cancer or tumors
  Type: ____________
  Date: ____________
- ❑ Multiple sclerosis
- ❑ Poor circulation
- ❑ Seizure
- ❑ Stomach ulcers or gastritis
- ❑ Stroke
- ❑ Thyroid disorder
- ❑ Other: __________________
- ❑ Other: __________________

Family Medical History: (Blood relation only.)

- ❑ Glaucoma
- ❑ Macular Degeneration
- ❑ Arthritis
- ❑ Asthma or emphysema
- ❑ Cancer or tumors
- ❑ Chicken pox or shingles
- ❑ Congestive heart failure
- ❑ Diabetes
- ❑ Depression
- ❑ Heart attack
- ❑ High cholesterol
- ❑ Hepatitis
- ❑ HIV or AIDS
- ❑ Hypertension
- ❑ Irregular heart beat
- ❑ Lymphoma or leukemia
- ❑ Migraine
- ❑ Multiple sclerosis
- ❑ Poor circulation
- ❑ Seizure
- ❑ Stomach ulcers or gastritis
- ❑ Stroke
- ❑ Thyroid disorder
- ❑ Other:__________________

MEDICAL INFORMATION:

REASON FOR EXAMINATION: ____

MEDICATIONS: ____

____

ALLERGIES TO MEDICATONS: ____

WHO REFERRED YOU TO OUR OFFICE?: ____

WHO IS YOUR MEDICAL DOCTOR?: ___________________________ OFFICE PH: (____) ______________

HOW DID YOU HEAR ABOUT US? ____ Newspaper ____ Mail ____ Doctor ____ Friend ____ OTHER, please specify

Information Regarding Additional Fees Which May Be Incurred During Your Examination

(Please read and initial each line)

__________The co-pay for your exam is an agreement between you and your insurance provider. Our doctors are specialists; therefore, the specialist co-pay will be collected on the day of your visit.

__________If your insurance requires a referral, it is your responsibility to ensure your Primary Care Physician provides a referral prior to your visit. If we do not have a referral upon check-in, you will be asked to sign a waiver stating your understanding of your financial responsibilities without a referral.

__________The refraction is not covered by most insurance policies, but is a necessary procedure in order to help evaluate the health of your eyes and determine your glasses prescription. It is the part of the exam where the technician puts a device, called a phoropter, in front of your eyes and asks, "which is better 1 or 2?" The cost of the refraction is $35.00. **It is the patient's responsibility the day of the exam.**

__________If you are a contact lens wearer, we are required by law to examine the contact lens fit every year, which includes measuring lens size, tear flow, base curve, and power. There is a fee for the contact lens evaluation, **starting** at $60.00, which is separate from the office visit, refraction fee, and your insurance co-pay. Should any problems with the comfort or vision of your contact lenses arise, please visit our office within 90 days of your exam to avoid additional fitting fees.

__________For the safety and health of your eyes, a training session will be scheduled with our opticians to go over insertion, removal and proper care of contact lenses for all **new** contact lens wearers. The fee for this training is $65 and is required prior to releasing contact lens prescriptions to new wearers.

__________There is a $25 fee for no-show appointments that are not cancelled 24 hours in advance.

__________There is a fee for completing forms and testing required for DMV, Disability, FMLA, etc. These fees range from $25-$80. Your insurance will not cover these fees and they are due upon form completion.

__________Vision Plans: If you have a vision plan, it is your responsibility to notify the front office staff, the technician and the doctor that you are here for a routine vision exam under your vision plan or vision benefit. Please understand that vision exams are for routine vision problems (e.g. near or far sighted vision) not for medical conditions. If you have a medical eye condition known or discovered at this "routine vision" exam, you may be asked to make another appointment to be examined for this medical condition. We cannot file claims to both your Vision Insurance and your Medical insurance on the same day. If you do not notify prior to the visit that this exam is for a "routine vision exam" and there is a medical condition, we will file your medical insurance. We will not go back and file this visit under your Vision plan even if your medical insurance paid nothing or applied the fee to your deductible. **You must let us know prior to the exam which plan this claim is to be filed.**

The purpose of this notice is to ensure our patients have a complete understanding of possible charges to avoid any "surprise" fees. Please be aware that the refraction fee, contact lens evaluation fee, contact training fee and insurance co-pay are all separate fees that may not be covered by your insurance. **These fees are all due the day of your examination.** By signing below, you acknowledge and agree to the above terms and conditions for Chesapeake Eye Physicians, PLC.

Thank you in advance for your cooperation.

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PRIVACY PRACTICES ACKNOWLEDGEMENT AND FAMILY AND FRIENDS AUTHORIZATION

The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I am a patient of Chesapeake Eye Physicians, PLC, **OR** I am a parent or legal guardian of ________________________________ [patient name]. I hereby acknowledge that I have read a copy of Chesapeake Eye Physicians' Summary of Privacy Practices and a copy of the Notice of Privacy Practices is available to me, upon request.

Name [please print]: ____

Signature: ____

Relationship to patient: _____________________ Date: _____________________

If you are the legal guardian and the patient is under 18-years, do you have a POA? __________

Family and Friends. It is the office policy of Chesapeake Eye Physicians, PLC not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances, (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below.

Name: ____

Phone: _____________________ Relationship: ____________________________________

Patient Printed Name: ____

Patient/Parent/Guardian Signature:_________________________ Date: ________________

SUMMARY OF PRIVACY PRACTICES

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

Date of Last Revision: September 23, 2013
Effective Date: Immediately

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

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 Administrator. 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 confidential communications

For more information about these rights, please ask the receptionist for a copy of the detailed Notice of Privacy Practices.

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 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 Chesapeake Eye Physicians, PLC maintains 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 alterative means or at alternative locations.
- The right to inspect,copy and 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 Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of September 23, 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 our 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.