East Ridge Eye Center

Date _________________ Referred by ____

Full Name ____ SS#: ____________________

Address_____________________________________City_________________State____ Zip______

Home Ph _______________ Work Ph_________________ Cell Ph_________________ AGE _______
Email address ____________________________ May we contact you via email regarding balances, lab/test results, appointment reminders, etc? If yes, sign here________________________________
If no, sign here ____
Date of Birth ____/____/______ Marital Status _______________________ Sex: M F
Employer ____
Complete Address____

Spouse Information
Full Name ____ SS# _____________________
Date of Birth ____/____/______ Work Ph ___________________ Cell Ph ___________________
Employer ____
Employer Address ____

In Case of Emergency, please notify ________________________________ Relationship ___________
Address ____ Phone _________________

General Consent for Treatment:

We need your permission for our physician to examine you, provide treatments, and perform diagnostic studies as necessary. If more invasive procedures are deemed necessary, the risks & benefits of those invasive treatments will be explained to you. When you agree to proceed with an invasive treatment, you will be asked to sign a more detailed consent.

*I give general consent to be treated by East Ridge Eye Center.

Signature____ Date _____________________

Financial Policy/Assignment of Benefits/Promise to Pay

I hereby authorize East Ridge Eye Center., to release to my insurance carrier(s) any information required to process insurance claims on my behalf.

Promise to Pay: I agree to be responsible for payment for professional services rendered to me or on my behalf by East Ridge Eye Center. If this promise to pay is collected by an attorney, by suit or otherwise, I agree to pay all attorneys' fees, interest at the legal rate, and all costs of collection. I understand that payment is due at the time services are rendered unless other arrangements are made, including, but not limited to, deductible, co-pays and co-insurance.

Signature____ Date _____________________

*****IF PATIENT IS A MINOR PLEASE FILL OUT BACK OF FORM*****

MINOR'S INFORMATION

Father's Information

Full Name ____

Address (if different from minor child) ____

Home Phone ________________ Date of birth____/____/______ SS# _____________________

Employer ____

Address ____

Work Phone ___________________________ ext ___________

Mother's Information

Full Name ____

Address (if different from minor child) ____

Home Phone ________________ Date of birth____/____/______ SS# _____________________

Employer ____

Address ____

Work Phone ___________________________ ext ___________

Legal Guardian Information (if applicable) Relationship to patient _______________________

Full Name ____

Address ____

Home Phone ________________ Date of birth____/____/______ SS# _____________________

Employer ____

Address ____

Work Phone ___________________________ ext ___________

NOTICE OF FINANCIAL RESPONSIBILITY:

Please be aware that whoever accompanies the minor child and signs the Financial Policy/Assignment of Benefits/Promise to Pay (located on the other side of this form) assumes financial responsibility for this minor patient for all services rendered, regardless of whether or not you are normally financially responsible for this minor.

I understand that I am financially responsible for any and all services rendered by East Ridge Eye Center on behalf of this minor child.

____ ____________________

Signature of Responsible Party Date

____

Relationship to Minor Patient

Name of Person(s) Accompanying Minor Today (please print): Relationship to Minor:

____ _______________________

____ _______________________

____ _______________________

Dilated Eye Exam

In order to perform a complete ocular examination, your eyes will be dilated. Dilation is accomplished by placing drops in your eyes.

Dilation will make the pupils large so the doctor can visualize the optic nerves and peripheral retina more clearly.

Dilation will last approximately 6-8 hours on an adult, and up to 24 hours on a child dependent upon the drops needed and used.

Your eyes will be more sensitive to bright light and your near vision will be blurred. Sunglasses are recommended. The office will supply disposable sunglasses for your convenience.

If you need an excuse for work/school, one will be provided to you upon request. The excuse will state the time you were here and will release you to return to work/school the same day.

Please direct any questions to the technician that works with you during your appointment.

Thank you for choosing East Ridge Eye Center for the care of your eyes.

____

Patient Signature

____

Date

Failure To Notify Of Insurance Changes

***** Warning *****
If you present an expired, old, out-of-date or terminated insurance card, insurance companies consider it fraudulent.

If you fail to notify us of any insurance changes and a claim is sent to the insurance company that you have previously reported to us, there will be a $50.00 processing fee to re-file with another insurance company. This fee along with any outstanding balances is to be paid prior to re-filing with the corrected insurance company.

I understand the importance of notifying East Ridge Eye Center of any insurance change and agree to do so.

____
Patient Signature

____
Date

____
Witness

MEDICAL HISTORY QUESTIONNAIRE

Name: ______________________________ Date: ______________

Date of **birth**: ______________ Date of **last eye exam**: ______________

List any **medications** you currently take (prescription and over-the-counter):

____

____

Do you have **allergies** to any medications? ☐ Yes ☐ No

If YES, list the medications:

____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):

____

____

List any **surgeries** you have had (cataract, tonsillectomy, appendectomy):

____

____

Do you *currently* have any problems in the following area? If "YES", please provide information.

	Yes	No	Explanation of Problem
EYES (Glaucoma, cataract, retinal disease, etc.)			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
GENERAL/CONSTITUTIONAL			
Fever			
Weight loss			
Other			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			

Do you *currently* have any problems in the following area? If "YES", please provide information.

	Yes	No	Explanation of Problem
CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL			
(Stomach ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple sclerosis, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (Cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, Lupus, Sjogrens, etc.)			

FAMILY HISTORY M=mother F=father S=sibling GP=grandparent

DISEASE	**Yes**	**No**	**RELATIONSHIP TO PATIENT**
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current occupation: ______________________

Education (high school, vocational school, college degree): ______________________

Marital Status (married, divorced, single, widowed): ______________________

Living arrangements: ______________________

Do you drive? ☐ Yes ☐ No

Do you have visual difficulty when driving? ☐ Yes ☐ No

Do you have problems with night vision? ☐ Yes ☐ No

Have you ever tried to wear contact lenses? ☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No

If YES, how long have you worn contact lenses?

Do you currently wear glasses? ☐ Yes ☐ No

If YES, how long have you had your current prescription?

Do you drink alcohol? ☐ Yes ☐ No If "YES": occcasional 1 per day 2-3 per day 4+ per day

Do you smoke? ☐ Yes ☐ No If "YES": occasional 1/2 pack/day 1 pack/day 1+ pack/day

Have you ever had a blood transfusion? ☐ Yes ☐ No

History reviewed. ☐ No changes ☐ Additions as noted above

Physician's signature: ______________________ Date: ______________________

East Ridge Eye Center

Notice of Privacy Practices for Protected Health Information

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!

Our office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of uses of your health information for treatment purposes are:
- A nurse or medical assistant obtains treatment information about you and records it in a health record.
- During the course of your treatment, the physician determines he will need to consult with another specialist in the area. He will share the information with such specialist and obtain his/her input.

Example of use of your health information for payment purposes:
- We submit requests for payment to your health insurance company. The health insurance company or business associate helping us obtain payment requests information from us regarding your medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:

We may obtain services from business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such business associates as necessary to obtain these services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the doctor's office. You have the following rights with respect to your Protected Health Information

1. Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office—we are not required to grant the request but we will comply with any request granted;
2. Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;
3. Right to inspect and copy your health record and billing record (a fee will apply)—you may exercise this right by delivering the request in writing to our office; appeal a denial of access to your protected health information except in certain circumstances;
4. Right to request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office. (The physician or other health care provider is not required to make such amendments); you may file a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
5. Right to receive an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
6. Right to confidential communication by requesting that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office, and,

If you want to exercise any of the above rights, please contact **Teri Reneau, 423-894-1453, 932 Spring Creek Road, Chattanooga, TN 37412**, by telephone or in writing, during normal hours. She will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

The office is required to:
- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.
- Accommodate your request for an accounting of disclosures.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact **Teri Reneau, Office Manager, 423-894-1453.**

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to **Teri Reneau.** You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address is **200 Independence Avenue, SW, Washington, D.C. 20201** and e-mail address is **www.hhs.gov.**
- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

<u>The Following is a List of Other Uses and Disclosures Allowed by the Privacy Rule</u>

Patient Contact
We may contact you to provide you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you. We may contact you as part of a fund raising effort.
Notification – Opportunity to Agree or Object
If you are present and able and do not object, or if you are not present, able, or in an emergency using our professional judgment we may:
Disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care. This will allow them to pick up a filled prescription, etc.
Use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.
We may use and disclose your protected health information to assist in disaster relief efforts.

Notification - Opportunity to Agree or Object Not Required

<u>PUBLIC HEALTH ACTIVITIES</u>
Controlling Disease - As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
Child Abuse & Neglect - We may disclose protected health information to public authorities as allowed by law to report child abuse or neglect.
Food and Drug Administration (FDA) - We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.
Provider Note: Health care providers working for an Industry performing medical surveillance or evaluating whether the individual has a work related injury or illness may disclose PHI pertaining to the work related injury or illness to the employer if the employer needs the findings in order to comply with OSHA regulations.

VICTIMS OF ABUSE , NEGLECT, OR DOMESTIC VIOLENCE
We can disclose protected health information to governmental authorities to the extent the disclosure is authorized by statute or regulation and in the exercise of professional judgment the doctor believes the disclosure is necessary to prevent serious harm to the individual or other potential victim.
OVERSIGHT AGENCIES
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities to include audits, civil, administrative or criminal investigations: inspections; licensures or disciplinary actions, and for similar reasons related to the administration of healthcare.
JUDICIAL/ADMINISTRATIVE PROCEEDINGS
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, or as directed by a proper court order or administrative tribunal, provided that only the protected health information released is expressly authorized by such order, or in response to a subpoena, discovery request or other lawful process.
LAW ENFORCEMENT
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by court order, including laws that require reporting of certain types of wounds or other physical injury.
CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS
We may disclose your protected health information to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.
ORGAN PROCUREMENT ORGANIZATIONS
Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs, eyes, or tissue for the purpose of donation and transplant.
RESEARCH
We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
THREAT TO HEALTH AND SAFETY
To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.
FOR SPECIALIZED GOVERNMENTAL FUNCTIONS
We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.
CORRECTIONAL INSTITUTIONS
If you are an inmate of a correctional institution, we may disclose to the institution or it's agents the protected health information necessary for your health and the health and safety of other individuals.
WORKERS COMPENSATION
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Other Uses and Disclosures
- Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization which you may revoke except to the extent information or action has already been taken.

Website
- If we maintain a website that provides information about our entity, this Notice will be on the website. **Effective Date: N/A**

Acknowledgement of Receipt of East Ridge Eye Center's Medicare Deductible Policy

Patient Name:

____

I acknowledge that I have received a copy of   East Ridge Eye Center's Policy regarding Medicare Deductibles.

____
Signature of Patient, or Personal Representative

____
Date

____
Relationship to Patient

Patient Name: ________________________________

_____ I hereby give permission for the staff of East Ridge Eye Center to discuss any of my past, present or future information including but not limited to medical, financial, insurance, personal or any other matters with the following designated person(s):

Person:	Relationship:
___________________________	________________
___________________________	________________
___________________________	________________
___________________________	________________
___________________________	________________

____
Patient Signature

____
Date

____
Witness

_____ I do not give permission for any information to be made available at this time.

____
Patient Signature

____
Date

____
Witness

Signature on File, Assignment of Benefits, Financial Agreement

____ ____________________

Beneficiary Name (print) Medicare number

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1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to East Ridge Eye Center for services furnished to me by East Ridge Eye Center. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the 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 other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. East Ridge Eye Center accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

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2. MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to East Ridge Eye Center, if possible, or otherwise to me.

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3. RELEASE OF INFORMATION: East Ridge Eye Center may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease. or HIV, to any person or corporation (1) which is or may be liable or under contract to East Ridge Eye Center for reimbursement for services rendered, and (2) any health care provider for continued patient care. East Ridge Eye Center may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

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4. OTHER INSURANCE: I understand that East Ridge Eye Center maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office, and that East Ridge Eye Center has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by East Ridge Eye Center if I belong to a plan that does not appear on the above-mentioned list.

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5. NON-COVERED SERVICES: I understand that East Ridge Eye Center contracts with health care service plans (i.e. HMOs, PPOs) state items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services which are determined by the health care service plans not to be covered. Examples of non-covered include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with East Ridge Eye Center to obtain necessary health care service plan authorizations.

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6. I agree that in return for the services provided to the patient by East Ridge Eye Center, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to East Ridge Eye Center for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to East Ridge Eye Center. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to East Ridge Eye Center. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill* **.** If you fail to notify us of any insurance changes and a claim is sent to the insurance company that you have previously reported to us, there will be a $50.00 processing fee to re-file with another insurance company. This fee along with any outstanding balances is to be paid prior to re-filing with the corrected insurance company. I understand the importance of notifying East Ridge Eye Center of any insurance changes and agree to do so.

____ ______________

Beneficiary Signature or Authorized Party Date