

Welcome to the Eye Doctor's Office

Patients Information

Legal Name: _____
First M.I. Last

Nickname: (Please call me): _____

Circle one: I am: Married Single Widowed Domestic Partner
If Student Circle one: Full Time Student Part Time Student

Address: _____
 City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Age: _____ Sex: M or F

Home Phone: (____) _____ - _____
 Work Phone: (____) _____ - _____
 Cell Phone: (____) _____ - _____

Social Security Number: _____/_____/_____

Your Email is only used for in office professional purposes only, such as; recall, confirming appointments & for our contact lens patients, passwords for ordering contact lenses on online. It will never be shared with any outside persons or sources.

Home Email: _____
 Alternate Email: _____

Circle one of the following that applies to the patient:
I am employed: Full Time Part Time Self Employed Retired
 Homemaker currently not employed

Employer: _____
 Occupation: _____
 Drivers License # _____ State _____ Exp _____

For New Patients
Whom may we thank for referring you?

Spouse or Parent Information (If applicable)	Medical/Health Insurance Card Information
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Name: _____

Relationship to Patient: _____ DOB: ____/____/____

Circle One: I am employed F/T P/T Self Employed Retired Not Employed

Employer: _____

Occupation: _____

Work Phone: (____) _____ - _____ Ext _____

Drivers License # _____ State _____ Exp _____

This office is a medical facility. Your medical insurance may often times cover advanced testing and treatment of the eyes. Diseases of the body can show up in the eyes. If the doctor determines the need for additional medical testing or treatment, the following information will help us file your claim.

Employee Name: _____ DOB ____/____/____ Sex M or F

Company/Employer Name: _____

Relationship to Patient: Self Spouse Child F/T Student Other

Circle One: I am employed F/T P/T Self Employed Retired Not Employed

Insured's ID# _____ Group# _____

SS# _____ Medical Plan Name: _____ Vision Plan Name _____

Acknowledgment of Notice of Privacy Practices

The Federal Law requires that we make every effort to inform you, the patient, of your right related to your personal health information.

Please check only one below

___ **Yes, I have** read or had explained to me by this office the NPP & I wish to continue my care with The Eye Doctor's Office under said terms.

___ **No, I have not** read this office's NPP but, I was given the opportunity to read it upfront and declined. I wish to continue my care with The Eye Doctor's Office under the terms.

___ The NPP **could not be read** due to the emergent nature of the care or other reasons described below.

Comments: _____

Financial Assignment & Release (Signature Required)

* I, the undersigned, assign directly to American Eye Care Centers, Inc. dba: The Eye Doctor's Office, Inc. and/or Dr. Bob Consor all insurance benefits, if any, otherwise payable by me or to me for services rendered.

* I understand that I am financially responsible today for all fees. I also agree that I am financially responsible to reimburse any and all fees for services and materials not collected in full at the date of service or should my insurance or vision plan deny payment for services or materials rendered.

* I further understand that after 60 days from the date my services or claim is filed I agree to pay for any unpaid balances on my account as a result of denial in part or whole from my insurance carrier caused by; unmet deductibles, non covered materials or professional services, my negligence in fulfilling any paperwork, providing any required information requested of me by my insurance carrier or uncollected fees on service day.

* If I fail to reimburse said fees in a timely manner with the above stated office and should the need arise, I agree to pay any and all collection fees, court costs and attorney fees.

* **If you do not inform us you have a vision plan or medical insurance before services are rendered, we will assume no coverage exists.**

* **I agree I am responsible to file my own claim if I discover I have vision or medical benefits after services or products are rendered.**

* **I agree this office with NO EXCEPTIONS will not back file claims, post authorize claims, or refund fees after services are rendered due to lack of notification of vision or medical benefits.**

X _____ / ____/____

Patient or Responsible Party Signature Date Signed

Relationship to Patient

Release of Health Information to Family, Friends and Others

Please check only one below

___ **Yes, I authorize** all persons listed below the ability to receive materials in my absence and/or information on my behalf.

Name: _____ Relationship _____ Date _____

Name: _____ Relationship _____ Date _____

___ **No, I Do Not authorize** any persons the ability to receive materials or information on my behalf. I choose to come myself.

Notice of Privacy Practices

Eye Doctor's Office
And Eye Gallery
6036 Sherry Lane
Dallas, TX 75225
(214) 361-1300

www.theeyedoc.com

Nikki Souadress, Privacy Official

**IN COMPLIANCE WITH THE FEDERAL REGULATIONS OF HIPAA'S PRIVACY RULE,
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND
DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO IT.
PLEASE REVIEW IT CAREFULLY.**

We respect our legal obligation to keep health information that might identify you private. We are obligated by law to provide you with notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reasons we would use or disclose your health information is for treatment, payment, or business operations. We routinely use and disclose your medical information within the office on a daily basis. We do not need specific permission to use or disclose your medical information in the following matters, although you have to right to request that we do not.

Examples of how we might use or disclose health information for treatment purposes might include:

Setting up or changing appointments including leaving messages with those at your home or office who may answer the phone or leaving messages on answering machines, voice mails or emails; prescribing glasses, contact lenses, or medications as well as relaying this information to suppliers by phone, fax or other electronic means including initial prescriptions and requests from suppliers for refills; notifying you that your ophthalmic goods are ready, including leaving messages with those at your home or office who may answer the phone, or leaving messages on answering machines, voice mails or emails; referring you to another doctor for care not provided by this office; obtaining copies of health information from doctors you have seen before us; discussing your care with you directly or with family or friends you have inferred or agreed may listen to information about your health; sending you postcards or letters or leaving messages with those at your home who may answer the phone or on answering machines, voice mails or emails reminding you it is time for continued care.

Examples of how we might use or disclose health information for payment purposes might include:

Asking you about your vision or medical insurance plans or other sources of payment; preparing and sending bills to your insurance provider or to you; providing any information required by third party payers in order to insure payment for services rendered to you; collecting unpaid balances either ourselves or through a collection agency, attorney, or district attorney's office.

Examples of how we might use or disclose health information for business operations might include:

Financial or billing audits; internal quality assurance programs; participation in managed care plans; defense of legal matters; business planning; certain research functions; informing you of products or services offered by our office; compliance with local, state, or federal government agencies request for information; oversight activities such as licensing of our doctors; Medicare or Medicaid audits.

USES AND DISCLOSURES FOR OTHER REASONS NOT NEEDED PERMISSION

In some other limited situations, the law allows us to use or disclose your medical information without your specific permission. Most of these situations will never apply to you but they could.

- When a state or federal law mandates that certain health information be reported for a specific purpose
- For public health reasons, such as reporting of a contagious disease, investigations or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices
- Disclosures to government or law authorities about victims of suspected abuse, neglect, domestic violence, or when someone is or suspected to be a victim of a crime
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative hearings
- Disclosures to a medical examiner to identify a deceased person or determine cause of death or to funeral directors to aid in burial
- Disclosures to organizations that handle organ or tissue donations
- Uses or disclosures for health related research
- Uses or disclosures to prevent a serious threat to health or safety of an individual or individuals
- Uses or disclosures to aid military purposes or lawful national intelligence activities
- Disclosures of de-identified information
- Disclosures related to a workman's compensation claim
- Disclosures of a "limited data set" for research, public health, or health care operations
- Incidental disclosures that are an unavoidable by-product of permitted uses and disclosures
- Disclosures to business associates who perform health care operations for Eye Doctor's Office, Inc. and who commit to respect the privacy of your information
- Unless you object, disclosure of relevant information to family members or friends who are helping you with your care or by their allowed presence cause us to assume you approve their exposure to relevant information about your health

USES OR DISCLOSURES TO PATIENT REPRESENTATIVES

It is the policy of Eye Doctor's Office and Eye Gallery for our staff to take phone calls from individuals on a patient's behalf requesting information about making or changing an appointment; the status of eyeglasses, contact lenses, or other optical goods ordered by or for the patient. Eye Doctor's Office and Eye Gallery's staff will also assist individuals on a patient's behalf in the delivery of eyeglasses, contact lenses, or other optical goods. During a telephone or in person contact, every effort will be made to limit the encounter to only the specifics needed to complete the transaction required. No information about the patient's vision or health status may be disclosed without proper patient consent. Eye Doctor's Office and Eye Gallery's staff and doctors will also infer that if you allow another person in an examination or treatment room with you while testing is performed or discussions held about your vision or health care that you consent to the presence of that individual.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written *Authorization for Release of Identifying Health Information*. The content of this authorization is determined by federal law. The request for signing an authorization may be initiated by Eye Doctor's Office and Eye Gallery or by you as the patient. We will comply with your request if it is applicable to the federal policies regarding authorizations. If we ask you to sign an authorization, you may decline to do so. If you do not sign the authorization, we may not use or disclose the information we intended to use. If you do elect to sign the authorization, you may revoke it at any time. Revocation requests must be made in writing to the Privacy Officer named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your personal health information.

You may ask us to restrict our uses and disclosures for purposes of treatment (except in emergency care), payment, or business operations. This request must be made in writing to Privacy Officer named at the beginning of this Notice. We do not have to agree to your request, but if we agree, must honor the restrictions you ask for.

You may ask us to communicate with you in a confidential manner. Examples might be only contacting you by telephone at your home or using some special email address. We will accommodate these requests if they are reasonable and if you agree to pay any additional cost, if any, incurred in accommodating your request. Requests for special communication requests must be made to the Privacy Officer named at the beginning of this Notice.

You may ask to review or get copies of your health information. There are a very few limited situations in which we may refuse your access to your health information. For the most part we are happy to provide you with the opportunity to either review or obtain a copy of your medical information. All requests for review or copy of medical information must be made in writing to the Privacy Officer named at the beginning of this Notice. While we usually respond to these requests in just a day or so, by law we have fifteen (15) days to respond to your request. We may request an additional thirty (30) day extension in certain situations.

You may ask us to amend or change your health care information if you think it is incorrect or incomplete. If we agree, we will make the amendment to your medical record within thirty (30) days of your written request for change sent to the Privacy Officer named at the beginning of this Notice. We will then send the corrected information to you or any other individual you feel needs a copy of the corrected information. If we do not agree, you will be notified in writing of our decision. You may then write a statement of your position and we will include it in your medical record along with any rebuttal statement we may wish to include.

You may request a list of any non-routine disclosures of your health information that we might have made within the past six (6) years (or a shorter period if you wish). Routine disclosures would include those used your treatment, payment, and business operations of Eye Doctor's Office, Inc.. These routine disclosures will not be included in your list of disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you must pay for them in advance at a fee of {\$25.00} per list. We will usually respond to your written request (made to the Privacy Officer named at the beginning of this Notice) within thirty (30) days but we are allowed one thirty (30) day extension if we need the time to complete your request.

You may obtain additional copies of this Notice of Privacy Practices from our business office or online at our website address shown at the beginning of this Notice.

CHANGING OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change the Notice. We reserve the right to change this Notice at any time. If we change this Notice, the new privacy practices will apply to your existing health information as well as any additional information generated in the future. If we change this Notice, we will post a new Notice in our office and on our website.

COMPLAINTS

If you think that anyone at Eye Doctor's Office, Inc. has not respected the privacy of your health information, you are free to complain to the Privacy Officer named at the beginning of this Notice. We are more than happy to try to resolve any concern you may have in writing or by phone. You may also file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you if you make such a complaint.

Eye Doctor's Office And Eye Gallery, Inc.

6036 Sherry Lane

Dallas, TX 75225

Medicare Authorization

I, _____ request that payment of authorized

(Patients Name as appears on Medicare Card)

Medicare benefits be made either to me or on my behalf to Dr. Bob Consor for any services furnished me by that doctor.

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 authorized release of medical information necessary to pay the claim. If "other health insurance" is indicated on item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.

In the event that I am billed by the Eye Doctor's Office and my financial responsibility is not reimbursed in a timely manner and should the need arise I agree to pay any collections fees, court costs and attorney's fees.

In Medicare assigned cases, the physician or supplier agrees to accept the **charge** determination of the Medicare carrier as the full charge, and **the patient is responsible only for the deductible, 20% Medicare does not cover and non-covered services**. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. The doctor's office will include coinsurance information when submitting Medicare claims, but **since the office does not accept the coinsurance the patient agrees to pay the 20% Medicare does not cover and if the coinsurance reimburses the office it will be immediately reimbursed to the patient.**

X _____

Signature of Patient or Beneficiary

_____/_____/_____

Date

Relationship to Patient