Richens Eye

PATIENT INFORMATION

Date_____

Last Name _____ First Name _____ Middle Initial _____
❒Single ❒Married ❒Separated ❒Widowed ❒Divorced Sex: M ❒ F ❒ Ethnicity _____
Birth date_____ Age_____ Social Security #_____-_____-_____
Mailing Address_____ City_____ State____ Zip_____
Phone _____ Email_____
Emergency Contact, please give the name of the person we should contact in case of an emergency:
Name_____ Phone_____ Relationship_____
How did you hear about us?
❒ *Physician*_____ ❒ *Friend*_____ ❒ *Social Media* ❒ *Printed Ad* ❒ *Other*_____

RESPONSIBLE PARTY INFORMATION *(If not the patient)*

Name-Last_____First_____Middle Initial_____
Mailing Address-Street_____City_____State_____Zip_____
Social Security Number _____ - ____ - ____
Employer_____Position_____Work Phone _____
Spouse Name**:** Last_____First_____Middle Initial____

INSURANCE INFORMATION

Primary Insurance: _____ID # _____ Group _____
Subscribers Name: _____ Birth date: _____ Relationship: _____
Secondary Insurance: _____ID # _____ Group _____
Subscribers Name: _____ Birth date: _____ Relationship: _____

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Richens Eye Center all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
Responsible Party Signature _____ Date _____

I acknowledge that I have been offered a copy of the Notice of Privacy Practices. Initial _____

I, agree to allow Richens Eye Center to send me automated text messages to the number I've provided. This will be used as appointment reminders, to fill out preregistration forms, etc. I know I can select "opt-out" on my first text message.

I DO NOT want to receive text messages. *Initial*_____

I agree to pay for all deductible, co-insurance and non-covered services. If a balance remains after 30 days, I will pay interest at the annual rate of 18% (1.5% per month) starting from the date the charges were made. (There will be a $28.00 fee for all returned checks.) I understand that delinquent accounts are turned over to a collection agency. If this account is assigned to an outside agency for collection, I agree to pay all attorney fees, court costs, and a collection agency fee of 40%, which will be added to the outstanding balance of my account with or without suit.
PLEASE NOTE: Refraction (a necessary component of a comprehensive eye exam) is a NON-COVERED service of Medicare and most traditional insurances. There is a $35.00 charge for a refraction.
***Initial*_____**
Signature_____Date_____
Please Print Name _____Relationship to Patient_____

Name: _____ DOB:_____/_____/_____ DATE: _____/_____/_____

Date of last eye exam: _____By Dr.: _____

PRIMARY CARE PHYSICIAN:_____ PHARMACY:_____

Date of last physical exam or office visit:_____

How can we help you today?(Reason for your visit today?_____

Currently wearing glasses?□ Yes □ No Contacts?□Yes □ No Do you drive? □ Yes □ No, at night?□ Yes □ No

Do your eyes itch,burn, or sting? □ Yes □ No, rate itch 1-10____ If "yes" for burn or sting, rate 1-10_____

List Allergies to medications: □ NONE or :_____

Ever a Cigarette/Cigar smoker? □ Yes □ No #pk/day?____ # years?_____ Quit? □ Yes □ No When? _____

Current Marijuana user? □ Yes □ No

Have you ever taken: Flomax, Uroxatrol, Hytrin, Cardura, Proscar, or Saw Palmetto? (circle any/all)

Adult immunizations? Covid 19 No/Yes #1, #2, Date:_____; Influenza No/Yes year:_____;

Pneumovax No/Yes; Zostavax (shingles) No/Yes; Whooping Cough Booster No/Yes, year:_____

****** Please see reverse side to list all medications and previous surgeries***

Please check any of the following that apply to;	Yourself	Mother	Father	Siblings			Yourself	Mother	Father	Siblings
Amblyopoia						High Blood Pressure				
Cataract						High Cholesterol				
Cataract Surgery?(YR?_____)	Eye? Right Left Both					Heart Disease/Stent/MI				
Diabetic Retinopathy				928/304-1325		Valve Repair				
Dry Eye						Cardiac Arrythmia(A fib, ect)				
Floaters						Pacemaker				
Glaucoma										
Herpes Simplex in Eye						Depression				
Herpes Zoster (shingles) of the eye: eyes/face						Multiple Sclerosis				
Keratoconus						Seizure Disorder				
Macular Degeneration						Stroke				
Retinal Degeneration						Shingles (where:_____)				
Retinal Detachment										
Strabismus						Malignant Melanoma				
Uveitis						Malignant Tumor of the Brain				
						Malignant Tumor of the Eye				
						Cancer (type:_____)				
Hearing Loss										
						Diabetes Mellitus (Type 1 & 2)				
Allergy						Pre-Diabetes				
Arthritis (OST/other)						Thyroid Disorder				
Rheumatoid Arthritis						Kidney Disorder				
Osteoporosis						Alchoholism				
Lupus						Drug Addiction				
Sjogren's										
Fibromyalgia						Hepatitis (A/B/C)				
						Sickle Cell Anemia/Trait				
Asthma									*OVER*	
COPD/Emphysema										

PLEASE LIST ALL PRESCRIPTION OVER THE COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING TO INCLUDE: EYE DROPS, ORAL MEDICATIONS, HERBAL SUPPLEMENTS, VITAMINS

Name_____

No Prescription drugs needed ❒

No supplements being taken ❒

Multivitamin? No ❒ **Yes** ❒ **Brand:**_____

Omega 3 supplement? No ❒ **Yes** ❒ **Brand:**_____

Medication/Supplement	Dose	Frequency	Route	Diagnosis/Disease	Prescribing Doctor

Previous Surgeries	RT/LT/BOTH	Year	Surgeon	City

Recent Hospitalization	Year	Doctor	Diagnosis

Richens Eye

NOTICE OF PRIVACY PRACTICES

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

PLEASE READ IT CAREFULLY

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires the proper confidentiality of all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally. 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 the following purposes: treatment, payment and health care operations.

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

- Payment means obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example would include sending your insurance company a bill for your visit and/or verifying coverage prior to 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 references to individually identifiable information.

We may contact you, by phone, email or SMS text message to provide appointment reminders or information about treatment alternatives or other health-related benefits and services. You have the right to "opt out" of communication through these avenues.

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.
- 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 of 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 with 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 inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an account 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 don’t 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 discloser.

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

This notice is effective as of September 16, 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 make the new notice provision effect 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 the office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Contact the Practice Compliance Officer for more information, in person or writing.

PATIENT COMMUNICATION FORM

A. Family and friends. It is the office policy of Richens Eye Center 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 reasonable infer from the circumstance (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitle to receive information regarding your treatment),(iv) in emergence 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 provide to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later, please confirm this in writing, or call our staff.)

Spouse: _____	_____yes	_____no
Parent: _____	_____yes	_____no
Other: _____	_____yes	_____no
_____	_____yes	_____no
_____	_____yes	_____no

Patient printed name: _____

Patient/Parent/Guardian Signature: _____

Date: _____

B. Alternative Communications. You are entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only: _____

_____

(Please fill out back side) 

FOR OFFICE USE

Changes to above were authorized by patient over phone:

Change:	Date:	Staff Initials
_____	_____	_____
_____	_____	_____

Richens Eye

WRITTEN ACKNOWLEDGEMENT FORM

I am a patient of RICHENS EYE CENTER and hereby acknowledge receipt of their 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 RICHENS EYE CENTER'S Notice of Privacy Practices with respect to the patient's name above.

Name [**please print**]:_____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature:_____ Date:_____