



**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 \_\_\_\_\_



## 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 disclosure.

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)*** 

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FOR OFFICE USE

Changes to above were authorized by patient over phone:

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



**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: \_\_\_\_\_