Welcome To Our Office!

MADISON HEIGHTS EYE CARE, P.C. - OPTOMETRISTS

Thank you for choosing our practice for your eye care. Please complete this form, front and back. If you have questions, please ask for assistance. (*Required Information)

Name* _____ Date _____
First M.I. Last

Mailing Address* _____ City _____ State_____ Zip _____

Physical Address (If different)_____

Nickname _____ Sex* _____ Race* _____ Hispanic / Latino* ( ) Yes ( ) No

Birth Date*_____ SSN*_____ Email address_____

Home Phone* _____ Cell Phone _____ Work Phone _____

Are you: ( ) Minor ( ) Married ( ) Divorced ( ) Widowed ( ) Single

Your Employer _____ Occupation _____

Work Address _____ City _____ Phone _____

Spouse / Parent's Name _____ Work Place _____ Work Phone _____

If student, name of school/college _____

Emergency contact person _____ Phone _____

How did you hear about the office ( ) Previous Patient ( ) Patient Referred ( ) Sign outside ( ) Internet ( ) Other

RESPONSIBLE PARTY

Name of person responsible for payment ( ) Self ( ) Parent ( ) Other _____

Relationship to patient _____ Phone ( ) same_____

Address ( ) same _____

Name of Employer _____

MEDICAL INSURANCE INFORMATION *(Pays on eye exams for diabetes, eye diseases, and emergency visits)*

( ) Insurance Co. ( ) Medicare ( ) Medicaid ( ) None ( ) Other_____

Name of Insured _____ Relationship to patient _____

Insured's Employer _____

DO YOU HAVE A VISION PLAN? *(Pays on routine eye exams, eyeglasses, or contact lenses) We are not in network with vision plans but we can assist you in filing an out of network claim to your plan.*

( ) Yes ( ) No Insurance co. _____

Name of Insured _____ Relationship to patient _____

Insured's Employer _____

OUR FINANCIAL POLICY

- Payments for exams/office visits are due in full at the time of visit. We will file your insurance for covered services. Filing of services does not guarantee payment by your insurance company.
- Glasses and contact lens orders require a 50% deposit before ordering. The balance is due in full when glasses or contacts are delivered. Orders cannot be delivered until fully paid.
- There is a $35 fee for returned checks, $20 fee to complete forms, and an additional $41 fee for after- hours care.

Method of Payment

( ) Cash ( ) Check ( ) Credit Card ( ) Care Credit ( ) Insurance ( ) Vision Plan

I agree that I am responsible for full payment of each service or product which is not covered or fully paid by my insurer. I have read and understand the Financial Policy.

Signature* _____

Name _____

Patient Health Information

Please provide the following information as completely as possible. The information is ***confidential***, and all information is necessary to meet Federal and Insurance requirements.

Date of last eye exam _____ Doctor's name _____ City _____
Do you, or have you ever worn ( ) Eyeglasses ( ) Contact lenses ( ) Drug Store Readers ( ) None
How do you wear them? ( ) Full time ( ) Driving only ( ) Reading only ( ) Computer only
( ) Sports
How old is your eyeglass prescription? _____ Contact lens prescription? _____
Are you interested in ( ) Contact lenses ( ) Laser vision correction

Please check any of the following problems you have with your VISION:

( ) blurred vision at distance	( ) blurred vision at near	( ) double vision
( ) poor night vision	( ) flashes of lights	( ) seeing spots
( ) eye strain on computer	( ) trouble identifying colors	( ) halos around light

( ) other _____

Please check any of the following problems you have with your EYES:

( ) discharge, pus, matter	( ) itching	( ) burning	( ) pain	( ) redness
( ) swollen eyelids	( ) twitching	( ) watering	( ) recent injury	

( ) other _____

Have you or a relative have, or ever had any of the following:

( ) Cataracts	( ) Self ( ) Relative _____	( ) Glaucoma	( ) Self ( ) Relative _____
( ) Crossed Eyes	( ) Self ( ) Relative _____	( ) Macular Degen.	( ) Self ( ) Relative _____
( ) Eye Surgery	( ) Self What for? _____	( ) Other	_____

Do you use tobacco products?* ( ) Yes ( ) No Do you drink alcohol?* ( ) Yes ( ) No

Please check any of the following conditions that you, or a blood relative, presently / previously had. List any medications you take for the condition(s) next to the word "self". Please list the relative.

Asthma/Respiratory condition	( ) Self _____	( ) Relative _____
Blood disorder	( ) Self _____	( ) Relative _____
Cancer	( ) Self _____	( ) Relative _____
Cholesterol	( ) Self _____	( ) Relative _____
Diabetes	( ) Self _____	( ) Relative _____
Heart condition	( ) Self _____	( ) Relative _____
Hepatitis	( ) Self _____	( ) Relative _____
High blood pressure	( ) Self _____	( ) Relative _____
HIV	( ) Self _____	( ) Relative _____
Kidney disorder	( ) Self _____	( ) Relative _____
Thyroid condition	( ) Self _____	( ) Relative _____
Other	( ) Self _____	( ) Relative _____

Additional medications/vitamins _____

Please list anything you are allergic to including medications and non-medications.

_____

Your Physician's Name* _____ City _____

MADISON HEIGHTS EYE CARE, P.C. - OPTOMETRISTS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY. Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice).

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we must carry out in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- 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 or disclosures;
- disclosures to "business associates" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA;
- [specify other uses and disclosures affected by state law].

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for heath care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION

The following are some specific uses and disclosures we may not make of your health information **without** your authorization:

Marketing activities. We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent to such payment.

Sale of health information. We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.

Psychotherapy notes. Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

- Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization.
- You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.

- We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.

- We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right:

- **To request restrictions on the health information we may use and disclose for treatment, payment and health care operations.** We are not required to agree to these requests. To request restrictions, please send a written request to us at the address below.

- **To receive confidential communications of health information about you in any manner other than described in our authorization request form**. You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.

- **To inspect or copy your health information.** You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.

- **To amend health information.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:

    - was not created by us, unless the person that created the information is no longer available to make the amendment,

    - is not part of the health information kept by or for us,

    - is not part of the information you would be permitted to inspect or copy, or

    - is accurate and complete.

- **To receive an accounting of disclosures of your health information.** You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).

- **To designate another party to receive your health information.** If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

Contact Person:

Our contact person for all questions, requests or for further information related to the privacy of your health information is:

Katherine See, O.D.
HIPAA Officer
(434)846-7822

Complaints:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown above. If you prefer, you can discuss your complaint in person or by phone.

Changes to This Notice:

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

Notice Revised and Effective: 7/1/2020

MADISON HEIGHTS EYE CARE, PC - OPTOMETRISTS

5076 S. Amherst Highway
P.O. Box 1000
Madison Heights, VA 24572
(434)846-7822

I. Acknowledgment of Receipt of Privacy Policy

I acknowledge that I received a copy of Madison Heights Eye Care, P.C.'s Notice of Privacy Practices.

Patient Name _____

Signature of Patient or Legal Guardian _____ Date _____

II. Insurance Filing

I request that payment of authorized Medicare/Insurance/Vision Plan benefits be made, on my behalf, directly to Madison Heights Eye Care, PC-Optometrists, for any service furnished to me by that physician/supplier.

I agree that I am responsible for full payment of each service which is not covered or fully paid by my insurer.

Signature of Patient or Legal Guardian _____ Date _____

III. Access to Patient Health Information

Madison Heights Eye Care, PC has permission to discuss my health care and billing information with the following family members or other personal contacts, including spouse, friends, care givers, etc.

NAME	**RELATIONSHIP**
_____	_____
_____	_____
_____	_____

Signature of Patient or Legal Guardian _____

DATE SIGNED: ___/___/_____ EXPIRES: ___/___/_____ OR NEVER
(circle never if desire not to expire)