EYE SITE OF CRESTVIEW, P.A.
DR. CHRISTOPHER HOWARD

DATE: _____ **PERSONAL REGISTRATION INFORMATION** **PLEASE PRINT CLEARLY**

PATIENT INFORMATION

NAME: _____ AKA: _____ DATE OF BIRTH _____

SOCIAL SECURITY NUMBER: _____ GENDER: M F MARITAL STATUS: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

OCCUPATION/EMPLOYER: _____ DRIVERS LICENSE NO. _____

ETHNICITY: _____ PREFERRED LANGUAGE: _____

RACE: _____

INSURANCE

PRIMARY INSURANCE CO: _____ PHONE NO: _____

INSURED NAME: _____ INSURED DOB: _____ SS# _____

PLAN TYPE: _____ GROUP #: _____ INSURED ID #: _____

INSURED DRIVERS LICENSE NO: _____ RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE CO: _____ PHONE NO: _____

INSURED NAME: _____ INSURED DOB: _____ SS# _____

PLAN TYPE: _____ GROUP #: _____ INSURED ID #: _____

INSURED DRIVERS LICENSE NO: _____ RELATIONSHIP TO PATIENT: _____

HOW MAY WE CONTACT YOU?

HOME PHONE: _____ ☐ROUTINE ☐OK TO LEAVE DETAILED MESSAGE

WORK PHONE: _____ ☐ROUTINE ☐OK TO LEAVE DETAILED MESSAGE

CELL PHONE: _____ ☐ROUTINE ☐OK TO LEAVE DETAILED MESSAGE

EMAIL: _____ ☐ROUTINE ☐OK TO LEAVE DETAILED MESSAGE

The more available you are to us, the more quickly we can provide you with important scheduling changes, visit reminders, labaratory results, peri-operative instructions, answers to your questions, etc.

EYE SITE OF CRESTVIEW, P.A.
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INFORMATION SHARING

NAME: _____ DATE: _____

PHARMACY / PHYSICIANS / HEALTH CARE PROVIDERS

We believe it is in your best interest for us to know all the health care providers involved in your care, so that we may communicate relevant information in a timely fashion. Please list below all of your regular physicians and health care providers (including complementary health care providers such as chiropractor, naturopath, dietician, and acupuncturist) with whom you are willing for us to communicate.

PROVIDER'S NAME	SPECIALTY	TELEPHONE NUMBER

FRIENDS AND FAMILY

Your privacy is very important to us. We can not share any information (including confirming appointment date and time) with anyone, including a spouse or care-giving child (unless they are your legal guardian) without your express permission. Please list below all persons with whom you will allow us to fully discuss your medical issues.

NAME	RELATIONSHIP	TELEPHONE NUMBER

LEGAL GUARDIAN

If you have appointed a legal guardian for your health and financial issues, please tell us who that is.

Guardian's Name: _____

X _____
Signature of Patient or Legal Guardian

EYE SITE OF CRESTVIEW, P.A.
DR. CHRISTOPHER HOWARD

FINANCIAL POLICY & ASSIGNMENT OF BENEFITS

Thank you for selecting Eye Site of Crestview, PA (ESOC) for your care. To prevent any confusion over financial responsibility for medical and surgical services provided, we supply you with the following information:

The patient, guarantor, or the person bringing the patient (if the patient is a minor), is responsible for payment of services at the time of office visit, test, or procedure. Payment may be made by cash, personal check (NSF charge: $25), Care Credit, or credit card (American Express, Discover, VISA, or MasterCard). In the case of divorced parents, the parent bringing the child to the office is responsible for payment at the time of service. Bills provided at each visit contain all the information needed for you to submit requests to your insurance carrier.

If your insurance plan requires a referral from your primary care physician, it is your responsibility to bring the referral with you and present it at the registration desk at the time of your visit. Federal law and insurance contracts require us to ask for your insurance card and driver's license to check in for identification purposes.

ESOC CONTRACTED INSURANCE COVERAGE

If you have coverage through an insurance company that has a contract with the doctor you are seeing, we are required to ask for a copy of your insurance card and payment of your deductible and/or co-payment at the time of service.

NON-ESCO CONTRACTED INSURANCE COVERAGE

If you have coverage through an insurance company that does not have a contract with the doctor you are seeing, we will ask for a copy of your insurance card but payment for services will be due at the time of your visit. We will be happy to file for your possible reimbursement.

MEDICAID

If you have Medicaid coverage, you must provide a current Medicaid card at the time of your visit. You must pay for non-covered services at the time of your visit.

MEDICARE

Office visits to a doctor are covered under Part B of the Medicare program. Medicare pays 80% of their allowable charges after you pay the annual deductible for the calendar year. You are fully responsible for any non-covered services. As a courtesy, if you have supplemental insurance, we will be glad to file this for you.

"I have read the above information and agree that regardless of insurance status, I am responsible for the account balance for all services rendered to the individual listed as "patient" below including disclosed, non-covered medical services. Further, I irrevocably assign and transfer all health plan and insurance benefits to Eye Site of Crestview, PA (ESOC), authorizing payment to ESOC for all beneftis payable to "patient" including health plan benefits, ERISA benefits, insurance payments, payments pursuant to the Social Security Act and other medical benefits to which "patient" may be entitled. ESOC may pursue collection of such benefits in "patient's" name or in the name of ESOC. Finally, I authorize the release of medical information necessary to process "patient's" claims. A photocopy of this agreement shall be considered as effective and valid as the original."

Patient's Name (please print):_____Date:_____

Patient's Signature: X_____

If applicable, Printed Name of Guardian or Responsible Party: X_____

Signature of Guardian or Responsible Party: X_____

Notice of Privacy Practices

Effective 2019

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the persona has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of our information
- Most sharing of psychotherapy notes

In the case of fund-raising:

- We may contact you for fund-raising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways:

Treat you

- We can use your health information and share it with other professionals who are treating you.
  Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run or practice, improve your care, and contact you when necessary.
  Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.
  Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gove/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Patient Name (Please Print):_____

Patient Signature:_____

Date:_____

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Eye Site of Crestview, PA - 850-682-1859 - HIPAA Complaince Officer - Deborah Hulion

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient Name (Please Print):_____

Date of Birth:_____

SSN:_____

I. My Authorization

I authorize the following using or disclosing party:

Eye Site of Crestview, PA to use or disclose the following health information.

[ ]All of my health information

[ ]My health information relating to the following treatment or condition:

_____

[ ]My health information covering the period of healthcare from:

Date: _____ To Date: _____

[ ]Other:_____

The above party may disclose this health information to the following recipient:

Name/Organization:_____

Phone:_____

Fax:_____

Email:_____

The purpose of this authorization is (check all that apply):

[ ]At my request

[ ]To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.

[ ]To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.

[ ]Other:

_____

_____

_____

This authorization ends:

[ ]On (Date):

[ ]When the following event occurs:

_____

_____

[ ]When I am no longer a patient of Eye Site of Crestview, PA

II. My Authorization

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Patient Signature:_____

Date:_____

If the patient is a minor or unable to sign please complete the following:

[ ]Patient is a minor: _____ years of age

[ ]Patient is unable to sign because:

_____

Name of Authorized Representative:_____

Signature of Authorized Representative:_____

Date:_____

Authority of representative to sign on behalf of patient:

[ ]Parent [ ]Legal Guardian [ ]Court Order

[ ]Other:

_____

II. My Authorization

This medical record may contain information about physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment. Separate consent must be given before this information can be released.

[ ]I consent to have the above information released.
[ ]I do not consent to have the above information released.

Signature of Patient or Authorized Representative:_____

Date:_____ Time: _____

IV. Additional Consent for HIV/AIDS

This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. Separate consent must be given to have this information released.

[ ]I consent to have the above information released.
[ ]I do not consent to have the above information released.

Signature of Patient or Authorized Representative:_____

Date:_____ Time: _____