Eye Site of Crestview, PA Office of Dr. Christopher Howard
Patient Registration

Patient Information

Is this your first visit to our office? *
☐Yes ☐No

Title | **First Name*** | **M.I.** | **Last Name *** | **AKA**

Date of birth: * | **Street Address ***

Address Line 2 | **City *** | **State *** | **Zip Code ***

Social Security Number | **Occupation**

Gender *
☐ Male ☐ Female
☐ Other _____

Marital status *
☐ Married ☐ Single
☐ Divorced ☐ Widowed

Ethnicity *
☐ Hispanic or Latino
☐ Non Hispanic or Latino
☐ Decline to Specify

Employment Status *
☐ Employed
☐ Unemployed
☐ Retired
☐ Self-Employed
☐ Active Duty Military
☐ Student

Preferred Language *

Race *
☐ American Indian or Alaska Native
☐ Asian
☐ African American
☐ Caucasian
☐ Native Hawaiian or Pacific Islander
☐ Decline to Specify

How May We Contact You?

Mobile Phone Number | **Okay to leave detailed message?** Yes No | **Is texting okay?** Yes No

Alternate Phone Number | **Okay to leave detailed message?** Yes No

Email Address

Insurance Information

Vision Insurance	Relationship to CH	Cardholder Name	C.H. DOB

Medical Insurance	Relationship to CH	Cardholder Name	C.H. DOB

Secondary Medical Ins	Relationship to CH	Cardholder Name	C.H. DOB

Information Sharing

Primary Care Physician

Preferred pharmacy *

If you have appointed a legal guardian for your health and finances, please list who that is.

Emergency Contact

First Name *

Last Name *

Relationship *

Phone Number *

Completion

I certify that the above information is accurate.

X signature_____

NOTICE OF PRIVACY PRACTICE (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 carefully, but please be aware that without your written consent to this form, we will not be able to file your insurance or correspond with other providers.

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.

Getting a copy of this privacy notice.

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

Getting 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.
- We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Asking us to correct your medical record.

- You can ask us to correct health information about you that you think is incorrect or incomplete.
- We may say “no” to your request, but we will tell you why in writing within 60 days of request.

Requesting 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 or an email address.
- We will say “yes” to all reasonable requests.

Asking us how 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 operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Getting a list of those with whom we’ve shared information.

- You can ask for a list of instances of times that we would share your information for six years prior to the date you ask, who we shared it with, and why. This can include information shared with your insurance company, optical labs, contact lens distributors, and other medical professionals.
- We will include all disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).

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 person has the 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 listed for a contact.
- 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 Ave SW, 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, please talk to us. Tell us what you want us to do in writing, 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.

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 (such as social media posts and giveaways).
- Sale of our information.
- Most sharing of psychotherapy notes.

Our Uses and Disclosures

How do we 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. This is considered continuity of care and does not require authorization.
  Example: A doctor treating you for diabetes or another condition can request an eye exam report.

Run our organization.

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

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 you health information to bill you health insurance plan so it will pay for your services.

How else can we use and share your information?

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

Help with public health and safety issues.

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

- Preventing disease.
- Helping with product recalls.

- Reporting adverse affects/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 law require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy laws.

Respond to organ and tissue donation requests.

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, if requested.
- We will not use or share your information other than as described in this notice unless you tell us we can in writing. If you change your mind at a further time, let us know in writing if you change your mind, including your reasoning.

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, to comply with state and federal privacy laws. The new notice will be available upon request, in our office, and on our website. At this point, you will be required to sign a new agreement at your next appointment.

Patient Name (Please Print): _____

Patient/Guardian Signature: _____

Date: _____

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Eye Site of Crestview, PA – 850-682-1859 – HIPAA Compliance 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 written 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: _____

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

Name of Authorized Representative: _____

Signature of Authorized Representative: _____

Date: _____

Reasoning (Please select an option):

☐ Patient is a minor _____ years of age

☐ Patient is unable to sign because: _____

Authority of representative to sign on behalf of patient:

☐ Parent ☐ Legal Guardian ☐ Court Order

☐ Other _____

My Authorization (Part 1)

I authorize to disclose my health information to the following party:
Eye Site of Crestview, PA to use or disclose (when authorized) my health information.

☐ All of my health information

☐ My health information relating to the following conditions: _____
_____

☐ My health information covering the period of healthcare from:
Date: _____ to _____

☐ Other _____

The purpose of this authorization is that information will only be released at your request.

The Eye Site of Crestview, PA may disclose my health information to the following recipients without request (this would include family, including spouse, close friends, or organizations involved in your care, to include appointment dates and picking up eyewear):
(Please note that parents/legal guardians are automatically included in this list.)

Name/Organization: _____ Phone: _____

Name/Organization: _____ Phone: _____

Name/Organization: _____ Phone: _____

This authorization ends:

- ☐ On Date _____
- ☐ When the following event occurs: _____

  _____
- ☐ When I am no longer a patient of Eye Site of Crestview, PA

Part 2- Revoking

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 party. I do understand that after revoking this authorization, a new authorization may have to be in place before services continue. I understand that uses and disclosures already made 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) 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, if requested. A copy of this authorization is as valid as the original.

Patient/Guardian Signature: _____

Date: _____

My Authorization (Part 3)

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 (except in cases states in the “Help with public health and safety issues” section of the Notice of Privacy Practice agreement).

☐ I consent to have the above information released.

☐ I do not consent to have the above information released.

Patient/Guardian Signature: _____

Date: _____ Time: _____

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

☐ I consent to have the above information released.

☐ I do not consent to have the above information released.

Patient/Guardian Signature: _____

Date: _____ Time: _____

FINANCIAL POLICY & ASSIGNMENT OF BENEFITS

Thank you for selecting Eye Site of Crestview, PA 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 in 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 (AmEx, Discover, VISA, or MasterCard). In the case of divorced parents, the parent bringing the child into the office is responsible for payment at the time of services, unless an agreement is made otherwise. 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, allowing us to keep a copy of these documents.

EYE SITE OF CRESTVIEW 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 your insurance card, if you are provided one, and collect payment of your deductible and/or co-payment at the time of service.

NON-EYE SITE OF CRESTVIEW 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 of 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 pay 80% of their allowable charges after you pay your annual deductible for the calendar year. You are fully responsible for any non-covered services (including refractions priced at $30). 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 adding and transfer all health plan and insurance benefits to ESOC, authorizing payment to ESOC for all benefits 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 "patients" 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/Guardian Signature: _____

Date: _____