DELAWARE EYE INSTITUTE

PATIENT INFORMATION FORM

Name:____ DOB:____

Mailing Address: ____

City:____________________________________ State:____________ Zip Code:__________________________________

Last 4 of Social Security #:___________________ Home Phone:___________________ Cell Phone:_________________

Email:____

Primary Care Physician:____ Phone:______________________________

Spouse/Legal Guardian:____ Phone:______________________________

Employer:____ Work Phone:___________________________

Employer Address:____

Emergency Contact:____ Relationship:__________________________

Emergency Contact Phone:____

Who may we thank for referring you to us? ____

Who is financially responsible for balance of bill not covered by insurance?___________________________________

PRIVACY PRACTICES ACKNOWLEDGEMENT

Notice of Privacy Practices for Delaware Eye Institute

Our "Notice of Privacy Practices" policy, available at the reception desk and also online at our website, provides detailed information about how we may use and disclose protected health information about you. The details of this policy are in full compliance with all provisions, including those most recently updated, of the Health Insurance Portability and Accountability Act passed in 1996 (HIPPA). Our "Notice of Privacy Practices" states that we reserve the right to change terms within our policy. Should this happen, we will display, and make available, the new policy and its perspective date of implementation. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment or health care operations. We are not required to agree with your restrictions; however, if we do, we are bound by our agreement with you.

By signing below, I acknowledge receipt of "Notice of Privacy Practices" and consent to your use and disclosure of protected health information about me for treatment, payment, and health care operations. I have the right to revoke this consent, in writing, except where the practice has already made disclosures in trust on my prior consent.

PATIENT'S NAME: ____

PATIENT'S DATE OF BIRTH: ____

PATIENT/GUARDIAN SIGNATURE: ____

DATE: ___________ TIME: ________________

NOTICE OF BILLING PRACTICES:

THIS NOTICE DESCRIBES OUR BILLING PRACTICES, PLEASE REVIEW IT CAREFULLY.

At Delaware Eye Institute, you can expect to receive medical services in a professional and caring manner. We are committed to providing you with the highest level of service and quality care. In return, it is your responsibility to provide your insurance information. Please have your photo identification and current insurance information available at your visit to ensure that your claim can be processed promptly.

1. APPOINTMENTS: We request that you keep scheduled appointments and arrive at the appointed time. If you are unable to keep your appointment, please give at least 48 hours notice. [Cancellations of less than 24 hours prior to your appointment, or a No-Show for your appointment, will result in a minimum $35 fee per patient.] We reserve the right to not make additional routine appointments for you should you have any remaining balance for previous treatment you received with our offices. Additionally, any outstanding balance will need to be addressed before checking in for an appointment.

2. CO-PAYS: According to your insurance contract, you are obligated to pay any co-pay (a small fixed amount required by your health insurer), deductible (amount you are liable before your health insurer will make payment), or co-insurance (percentage of total cost of medical expenses after your deductible has been reached) due at the time of service. IF you are unable to pay the co-pay at the time of service, we retain the right to cancel or reschedule your appointment to a time when you are prepared to pay your co-pay. Furthermore, if your appointment is kept without payment of the co-pay at the time of service, we retain the right to levy an administrative charge of $10 to your account in order to defray the cost of securing the co-pay.

3. PRESCRIPTION REFILLS/FORMS: Please request any prescription refills and present any forms that need to be completed at the start of your examination. At that time, we have full access to your complete record and can fulfill your request. We reserve the right to charge the state allowable amount for filling out and completing forms or attorney requests for your various needs (ie, SSI, disability, etc.).

4. REFERRALS: If your insurance plan requires a referral, the referral must be presented before seeing a physician. If you do not have the required referral, we reserve the right to reschedule your appointment or you will have to be willing to be responsible for the entire cost of the examination. You will be presented with a waiver acknowledging your acceptance as self-pay, and payment will need to be made at the time of service.

5. RETURNED CHECKS: Any payment made by check that does not clear our bank account will result in a fee for insufficient funds. Our fee for insufficient funds is $25 and will be added to your account for each bounced check.

6. OTHER INSURANCE: I understand that Delaware Eye Institute participates with multiple insurance plans and that not all Doctors in the Practice participate with all plans or products within the plans. I understand that it is my responsibility to verify with my insurance carrier that my physician currently participates with my plan. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Delaware Eye Institute if I belong to a plan with which Delaware Eye Institute does not participate.

7. NON-COVERED SERVICES: I understand that Delaware Eye Institute contracts with health care service plans related only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. **Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care plan service plan furnishes to the patient**

(i.e. refraction, contact lens fittings) and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Delaware Eye Institute to obtain necessary health care service plan authorizations.

8. FINANCIAL AGREEMENT: I agree that in return for the services provided to me by Delaware Eye Institute, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Delaware Eye Institute for payment. I understand and agree that if my account is delinquent and sent to collections, I may be charged up to 35% in administrative fees. If the account is sent to an attorney to assist with collections, I agree to pay collection expenses and reasonable attorney fees. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Delaware Eye Institute. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Delaware Eye Institute. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill. I further understand and agree that if I ignore statements of attempts to collect past due amounts, I may have my ability to schedule appointments and/or receive future services from Delaware Eye Institute limited including possible dismissal as a patient from the practice.

9. PATIENT STATEMENTS: At Delaware Eye Institute, all accounts are payable within 30 days after you receive your first statement. Credit is extended as a courtesy, and arrangements will be based on demonstrated needs. Payments keep your account current only when arrangements have been made. Please call customer service to set up payment arrangements. As a result of costs associated with sending statements, Delaware Eye Institute does not send statements to patients for balances under $20. Billing statements are suppressed until the patient's balance becomes $20 or more in patient responsibility. As a result, you may receive a statement long after your last appointment or may be asked to pay small balances when presenting for an appointment without having received a statement. Patients should remit small balances owed to Delaware Eye Institute upon receipt of their explanation of benefits from their insurance.

10. PATIENT DISMISSAL: I agree and understand that Delaware Eye Institute may initiate separation and/or dismissal of me as a patient of the practice for any of the following non-exclusive reasons:

(a) Disruptive, aggressive, violent, and/or threatening behavior towards physicians, staff, and/or other patients;
(b) Repeated failure to attend scheduled appointments;
(c) Non-compliance with physician instructions and recommended treatment and/or other erosion of physician/patient relationship; and
(d) Non-payment of past due amounts and/or failure to pay any past due amounts as agreed in any payment arrangement you entered with Delaware Eye Institute. Please note, making payments that are less than an agreed amount per a payment arrangement will be considered and treated as non-payment for purposes of this provision.

Patients who are dismissed from the practice will be notified in writing and will be given 30 days to find alternative vision care. Appointments for emergency visits will be allowed during the 30 days but payment of an emergency visit will be collected at check-in with any additional amounts due collected at check-out.

The physicians and staff at Delaware Eye Institute appreciate your confidence in allowing us to participate in your eye care.

Your signature indicates that you have read, understand and agree to the financial responsibilities policies and procedures of our office.

PATIENT'S NAME: ____

PATIENT’S DATE OF BIRTH: ____

PATIENT/GUARDIAN SIGNATURE: ____

DATE: ____________ TIME: _________________

CONSENT FOR CARE AND TREATMENT:

I understand that Patient, which may be defined as me, my child or a child for whom I have legal responsibility, needs medical care and treatment and I consent to such treatment at Delaware Eye Institute. Treatment provided by medical providers, nurses, and medical assistants at Delaware Eye Institute may include evaluation and management, laboratory and other testing; routine medical, nursing and medical assistant care and procedures. I understand that photos or video of Patient may be taken in connection with such treatment and for operational, and quality improvement.

No Guarantee: I acknowledge that no guarantees or warranties have been made with respect to treatment or services to be provided by Delaware Eye Institute. I understand that all supplies, medical devices and other goods provided to Patient are provided by Delaware Eye Institute AS IS and Delaware Eye Institute disclaims any expressed or implied warranties.

Patient Rights: I understand that a copy of Patient Rights and Responsibilities is available upon request. This information tells me how to register a complaint or grievance that I might have relating to Patient's care at Delaware Eye Institute.

Communicable Disease Testing: I agree that if a Delaware Eye Institute employee or provider is exposed to Patient's blood or other bodily fluid, pursuant to Delaware law, Delaware Eye Institute may test Patient to determine the presence of communicable diseases including Human Immunodeficiency Virus (HIV) and hepatitis. I understand that these test results will be kept confidential.

Specimen Disposal: I acknowledge that Delaware Eye Institute may, in its sole discretion, remove, retain, or dispose of any tissue or body parts removed from Patient.

Text Messaging: I understand that Delaware Eye Institute can provide notifications to my cell phone. These texts are Do Not Reply texts for informational purposes only and are not intended as a form of two-way communication. I acknowledge that standard text messaging rates and fees will apply. Messages may include private health and billing information protected under federal and state law. Messaging utilizes a public telephone network and full encryption and security is not guaranteed, and any person with access to my phone will be able to see these messages unless I take steps to protect my phone with a password or PIN. I will have the ability to opt out of text messages at any time by using the STOP function.

Accessing Pharmacy Information: I agree that if a Delaware Eye Institute employee or provider needs to access my pharmacy information that they have my permission to do so.

PATIENT’S NAME: ____

PATIENT’S DATE OF BIRTH: ____

PATIENT/GUARDIAN SIGNATURE: ____

DATE: ___________ TIME: ________________

NOTICE OF PRIVACY PRACTICES

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.

UNDERSTANDING YOUR HEALTH RECORD

A record is made each time you visit a hospital, physician, or other health care provider. Your symptoms, examination and test results, diagnoses, treatment, and a plan for future care are recorded. This information is most often referred to as your "health or medical record," and serves as a basis for planning your care and treatment. It also serves as a means of communication among any and all other health professionals who may contribute to your care.

Understanding what information is retained in your record and how that information may be used will help you to ensure its accuracy, and enable you to relate to who, what, when, where, and why others may be allowed access to your health information. This effort is being made to assist you in making informed decisions before authorizing the disclosure of your medical information to others.

UNDERSTANDING YOUR HEALTH INFORMATION RIGHTS

Your health record is the physical property of the health care practitioner or facility that compiled it but the content is about you, and therefore belongs to you. You have the right to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your health record. Your rights include being able to review or obtain a paper copy of your health information, and to be given an account of all disclosures. You may also request communications of your health information be made by alternative means or to alternative locations. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information.

UNDERSTANDING YOUR CHOICES

As your health record contains information about you, you have some choices in the way we use and share certain health information. In these cases, you have 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; and 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 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 your information, most sharing of psychotherapy notes. If you give us written permission to share your information in those cases, but later change your mind, you may revoke that authorization in writing at any time. In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

If you have a clear preference for how we share your information in the situations described above, talk to us. Tell us what you want us to do, and we will follow your instructions.

OUR RESPONSIBILITIES

This office is required to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about you. This office is required to abide by the terms of this notice and to notify you if we are unable to grant your requested restrictions or reasonable desires to communicate your health information by alternative means or to alternative locations. This office will notify you promptly if a breach occurs that may have compromised the privacy or security of your information

This office reserves the right to change its practices and effect new provisions that enhance the privacy standard s of all patient medical information. In the event that changes are made, this office will notify you at the current address provided on your medical file. If applicable, this office will post changes on our web site that provides information about our customer service and/or benefits.

Other than for reasons described in this notice, this office agrees not to use or disclose your health information without your authorization.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS:

We will use your health information for treatment. For example: Information obtained by a healthcare practitioner will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record their expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations (example varies by practitioner type). We will also provide your Physician or a subsequent healthcare provider with copies of various reports that should assist them in treating you.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. An **exception** would be an instance in which you have paid for your health care out of pocket, in which case this office must agree to your requested restriction with respect to communications with your health plan.

We will use your health information for regular health operations. For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve quality and effectiveness of the healthcare and service we provide.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we've asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relatives, close personal friends or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

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 that person has this authority and can act for you before we take any action.

Research: We may disclose information to researchers when an institution review board that has reviewed the research proposal, and established protocols to ensure the privacy of your health information has approved their research.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to be extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Medical Examiner/Funeral Director: As required by law, we may disclose your health information with a coroner, medical examiner, or funeral director when an individual dies.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with tracking birth and deaths, as well as with preventing or controlling disease, injury, or disability; including reporting any suspected abuse, neglect, or domestic violence

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals. An inmate does not have the right to the Notice of Privacy Practices.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Including for special government functions such as military, national security, and presidential protective services. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding the health information we maintain about you.

Right to Inspect and Copy. You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a request in writing in order to inspect and/or copy your health information. We will furnish the requested records within 15 days or less from receipt. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If law requires such a review, we will select a licensed healthcare professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend. If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Medical Record Amendment/Correction Form to the Privacy Officer. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. If we deny your request to amend/correct, we will tell you why in writing within 60 days.

In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
b) Is not part of the health information that we keep.
c) You would not be permitted to inspect and copy.
d) Is accurate and complete.

Right to an Accounting of Disclosure. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and healthcare operations. To obtain this list, you must submit your request in writing to the Privacy Officer. It must state a time period, which may not be longer than six years and may not include dates before January 1, 2010. Your request should indicate in what form you want the list (for example, on paper or electronically). We will provide one free accounting of disclosures per year, but we may charge you for the costs of providing the list if you ask for another one within 12 months. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit the Request for Restriction On Use/Disclosure of Medical Information to the Privacy Officer.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information and/or Confidential Communication to the Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Must specify how or where you wish to be contacted.
For more information on how we can use or share your health information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

NOTICE OF PRIVACY AVAILABILITY

This notice will be prominently posted where registration occurs. Patients will be provided a hard copy, if so desired and the notice will be maintained on our Web site (if applicable Web site exists) for downloading.

THIS OFFICE MUST NOTIFY ANY AFFECTED INDIVIDUALS OF BREACHES OF THEIR PROTECTED HEALTH INFORMATION.

TO RECEIVE ADDITIONAL INFORMATION OR REPORT A PROBLEM

If you have questions and would like additional information, you may contact the practice's Privacy Officer at **410-583-1000.** If you believe your rights have been violated, you can file a complaint with the center's Privacy Officer, or with the Office for Civil Rights, U.S. Department of

Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumer/noticpp.html

The address for the Office of Civil Rights is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building Washington, D.C. 20201

Alternative Contact/Preferred Method of Communication Form

Patient Name ____ Date of Birth ____________________

We at __Delaware Eye Institute__ take your medical confidentiality very seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff to speak only with an individual(s) you designate in the event you are not available to receive phone calls or you have an adult member that helps coordinate your medical care. You should not designate your doctor.

As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below:

______I do NOT authorize anyone to receive information regarding my medical care.

______I authorize my physician and the employees of this clinic to speak with:

1. _______________________________ (Name), my ___________________________(Relationship to patient), their phone number is: ________________, regarding my APPOINTMENTS AND ACCOUNT/BILL
2. _______________________________ (Name), my ___________________________(Relationship to patient), their phone number is: ________________, regarding my MEDICAL CARE AND TREATMENT (including Test Results and Lab Results).

Electronic Communication is my preferred method ☐ **yes** ☐ **no**

(In order to electronically communicate with you or anyone you designate; we are required to have your written permission. Communication may be in the following forms: Home Phone/Answering Machine, Cell Phone: Voicemail, Cell Phone Text-Messaging, E-mail, Mail, or Work Phone.)

This authorization will remain in effect unless changed by me while I am a patient at this office. It is my responsibility to notify this office of changes and to complete a new form. Any problems and/or questions concerning this form are to be referred to the Privacy Officer.

I agree that should I desire to revoke this authorization, I will give written notice.

PATIENT'S NAME: ____

PATIENT'S DATE OF BIRTH: ____

PATIENT/GUARDIAN SIGNATURE: ____

DATE: ___________ TIME: ________________

Patient Name: ______________________________ DOB: _________________

Patient Account # ________________________

REFRACTION WAIVER

Planned procedure: Refraction

Fee Quote: $50.00

What is a Refraction? - A refraction is an important measurement that determines the best potential vision of your eyes.

Why is it necessary? - It is necessary to perform a refraction to determine whether eye diseases or refractive errors are responsible for your current visual acuity. A refraction is performed at a new patient visit, an annual visit, a cataract consultation, or anytime there has been a change or decrease in vision.

The purpose of this notice is to help you understand that it may be necessary to have tests performed during the course of your treatment that may or may not be covered by your insurance. Due to the nature of your presenting symptoms/problems it is vital that the physician perform these tests to accurately diagnose or determine a treatment plan.

- Insurance does not pay for all of your health care costs. Your insurance only pays for covered benefits. Some items and services are non-covered benefits and your insurance will not pay for them.
- When you receive an item or services that is not a covered benefit, you are responsible to pay for it, personally or through any other insurance that you may have.

I have been informed of the charges and payment terms for my planned procedure and agree to these terms and conditions.

Patient Signature: ____ Date: _______________

Parent/Legal Representative: ____ Date: _______________

Fee information given and confirmed by _________________________________ Date: _______________

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance carrier, your health information on this form may be shared with them. Your health information which your insurance carrier sees will be kept confidential by your insurance carrier.