DELAWARE EYE INSTITUTE

PATIENT INFORMATION FORM

Name:______________________________Home Phone:____________________

Home Address: ______________________City:______________Zip Code:________

Employer:____________________________Work Phone:____________x_________

Employer Address: ____

Soc. Security#:____________________Date of Birth:______________________

Spouse's Name:___________________Work Phone:________________x________

Family Physician:_________________________________Phone:______________

Friend or relative we may contact in case of an emergency?________________Phone:__________

Who may we thank for referring you to us? ________________________________

Who is financially responsible for co-pay/balance of bill not covered by insurance?____________________

Delaware Eye Institute ("we") are committed to providing you with the best possible care. If you have medical insurance, we want to help you receive your maximum allowable benefits.

INSURANCE: Payment for services is required at the time services are rendered unless payment arrangements have been approved in advance by the doctor. We accept cash, checks, MasterCard or Visa. We will provide you with a receipt for all your office visits. All you need to do is attach it to your insurance form for proper filing. Returned checks and balances older than 30 days may be subject to additional collection fees. We will be happy to discuss your proposed treatment and answer any questions related to your insurance.

HMO: If you are insured through an HMO, we ask that you obtain any authorization required from your primary care physician prior to your visit. Any co-payment required by your insurance plan is required at the time of the visit.

RELEASE OF INFORMATION: We respect our legal obligation to keep health information that identified you private. The Delaware Eye Institute maintains a Patient's Right to Privacy Policy ("Policy") that is displayed in our reception area. You may also request a copy for your records. The Policy describes how we protect your health information and what rights you have regarding it.

Your signature below demonstrates that you understand and agree that: regardless of insurance status, you are ultimately responsible for any balance of your account for services rendered; you authorize payment of medical claims to the provider; you are responsible for all charges not paid by insurance; you authorize the use of this signature on all insurance submissions.

CONTACT LENS PATIENTS: A contact lens fitting is not part of a routine eye exam. If you need a contact lens fitting, we can help you make a separate appointment to have this done.

SIDE EFFECTS OF DILATING DROPS: Dilating drops may cause blurry vision for 4 to 8 hours. Some people experience difficulty walking with blurry vision. Driving and operating machinery should be avoided. To avoid these risks, we recommend that you make arrangements to have someone assist you. Sunglasses are available at checkout. If you need to reschedule your appointment, please see a receptionist

***Medicare Patients Please Complete Other Side**

____
Patient Signature or Authorized Person

Form: 0114-B

PATIENT'S MEDICARE AUTHORIZATION

Patient's Medicare No. ____

I request that payment of authorized Medicare and Medigap benefits be made either to me or on my behalf to Delaware Eye Institute. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, and the indicated Medigap insurer any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 on the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible coinsurance, and non-covered services. Any co-payment not covered by a secondary insurance is your responsibility and we ask you pay this at the time of your visit. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Refraction for eyeglasses is not a covered Medicare service. According to Medicare regulations, non-covered services may be billed to the patient if the services are considered to be Medicare program exclusions. Determination of a refractive state, (HCPCS code 92015) is a program exclusion under Medicare, therefore, patients will be responsible to pay for that portion of the exam if a refraction is done for new glasses.

______________________________ ______________________

(Patient's Signature) (Date)

Form: 0114-B

NAME: ______________________ **DATE:** ______________________

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING:

_____ Headaches
_____ Blurry vision
_____ Double vision
_____ Growths on your eyelids
_____ Floaters or specks in your vision
_____ Difficulty reading
_____ Burning eyes
_____ Cataracts
_____ Glaucoma
_____ Retinal detachment
_____ Macular degeneration
_____ Eye muscle problems
_____ Problems with glare
_____ Growths on your eyeball
_____ Flashes of light
_____ Itching eyes
_____ Watering eyes
_____ Pain in or around eyes
_____ Droopy lids

Are YOU currently under treatment or have YOU been treated for any of the following?

_____ Diabetes
_____ Asthma
_____ High blood pressure
_____ High cholesterol
_____ Heart attack
_____ Stroke
_____ Arthritis
_____ Thyroid problem
_____ Cancer

PLEASE CIRCLE ANY SYMPTOM(S) YOU HAVE HAD IN THE PAST MONTH:

Fever, chills, weight loss, or weakness
Hearing loss, earaches, nasal drainage, sore throat
Short of breath, cough, sputum or wheezing
Nausea, vomiting, diarrhea, abdominal pain, bloody or tarry stools
Difficult or painful urination, urgent or frequent urination
Fainting, headaches, seizures or dizziness
Chest pain, palpitations
Skin lesions, rash
Infectious diseases
Blood disorders
Depression or anxiety

Form: 0118-A

In order to improve patient convenience and reduce our environmental footprint, it is the goal of Delaware Eye Institute to send your appointment reminders and other relevant information via e-mail. Please provide us with your e-mail address below. WE WILL NOT SHARE YOUR E-MAIL ADDRESS WITH ANY OUTSIDE ORGANIZATIONS.

Your Name: ______________________ DOB: _____/_____/________

E-mail address: ____

Please also take this opportunity to tell us about any changes to your address, telephone numbers, insurance coverage, etc. Thank you.

ACKNOWLEDGEMENT OF NOTIFICATION OF PATIENT'S RIGHT TO PRIVACY

I acknowledge that I have been notified of Delaware Eye Institute's and Delaware Eye Surgery Center's Notification of Patient's Rights to Privacy. To allow Delaware Eye Institute and Delaware Surgery Center to discuss your medical condition, treatment plan, appointment dates, etc., with persons involved in your health care, please list them below. You are not required to list anyone. <u>If you have previously completed this form, please take this opportunity to update your record.</u>

I authorize Delaware Eye Institute and Delaware Eye Surgery Center to release health information identifying me to the persons I have listed below:

Name_________________________ Relationship___________________

Name_________________________ Relationship___________________

Name_________________________ Relationship___________________

Pt. Signature___________________________ Date:_________________

Form: 0127-B

PATIENT'S RIGHT TO PRIVACY

DELAWARE EYE INSTITUTE
DELAWARE EYE SURGERY CENTER
18791 John J Williams Highway
Rehoboth Beach, DE 19971
(302) 645-2300

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. An example of how we use or disclose information for treatment purposes is: setting up an appointment for you or getting copies of your health information from another professional that you may have seen before us. An example of how we use or disclose your health information for payment purposes is preparing and sending bills or claims. "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office such as financial or billing audits or internal quality assurance.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for the above reasons, we will not ask you for special written permission.

USES ANDS DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. 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;
- 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;

OVER

•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" who perform health care operations for us and who commit to respect the privacy of your health information.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

APPOINTMENT REMINDERS

We may call, write, or email to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call, write, or email to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, send an email and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form". The content of an "authorization form" is determined by federal law.

If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

•ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations.

•ask us to communicate with you in a confidential way.

•ask to see or to get photocopies of your health information according to federal regulation.

•ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write.

•get a list of the disclosures that we have made of our health information within the past six years if we use it for purposes other then treatment, payment or health care operations.

•get additional paper copies of this Notice of Privacy Practices upon request.

OUR NOTICE OF PRIVACY PRACTICES

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or 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 Privacy Office, C/O Delaware Eye Institute, 18791 John J. Williams Highway, Rehoboth Beach, DE 19971. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, please call or visit the office.

Form: 0208-A