Name:
Chart:
Date:

PEDIATRIC PATIENT INFORMATION Exam Date _____

Child's Last Name _____ First Name _____ M.I. ____
Birth date _____ Present Age _____ Gender _____
Home Address _____ City: _____ State _____ Zip _____
Home Tel. # _____ Cell Phone # _____ Soc. Sec. # _____
Email: _____
PEDIATRICIAN: _____ Referring Doc (if different): _____

Father's Name _____ Mother's Name _____
Soc. Sec. # _____ Soc. Sec. # _____
Employer _____ Employer _____
Work phone (____) _____ Work phone (____) _____
Primary Language: English ___ Other _____ Race _____ Ethnicity _____ Decline Info ___
Person with child today: Mother ____ Father ____ Bro/Sister ____ Guardian ____ Other _____
Is the patient adopted? Yes ____ No ____

Emergency contact person _____ Telephone (____) _____
Primary Insurance Co. _____ ID # _____ Group # _____
Subscriber's Last Name _____ First Name _____ Birth date _____
Subscriber's Social Security # _____ Relationship to Insured _____

Secondary Insurance Co. _____ ID # _____ Group # _____
Subscriber's Last Name _____ First Name _____ Birth date _____
Subscriber's Social Security # _____ Relationship to Insured _____
Motor Vehicle Accident, If Yes, Insurance _____ Claim # _____

Reason for visit _____
☐ Right Eye ☐ Left Eye ☐ Both How long? _____

Previous Eye Care
☐ Glasses
☐ Contact Lenses
☐ Patching
☐ Eye Surgery
☐ **NONE**

Child's Medical History
☐ Asthma
☐ ADD/ADHD
☐ Autism
☐ Cerebral Palsy
☐ Developmental Delay
☐ Diabetes
☐ Down Syndrome
☐ **NONE**

Family History
☐ Glaucoma
☐ Crossed/Turned Eye
☐ "Lazy" Eye
☐ High Myopia
☐ Decreased Vision
☐ Migraine
☐ **NONE**

Other: _____

☐ Prematurity, if yes, Birth Weight _____ Weeks Gestation _____
Current Medications: _____
Current Eye Drops: _____
Drug Allergy: _____

Preferred Pharmacy Name and address _____

SIGNATURE _____ Date _____

Name:
Chart:
Date:

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE INFORMATION

Financial Responsibility:

I have requested medical services from East Coast Eye on behalf of myself and/or my dependents. I understand and agree that I am responsible for the following expenses: any service my insurance carrier deems "non-covered", all coinsurance and/or copayment amounts, all deductibles, any amount that exceeds benefit limits under my insurance plan, and any amount my insurance plan deems not covered because I was not insured on the date of service.

In the event that my account is not paid in a timely manner, it may be turned over to a collection agency for further action. I acknowledge that I may be liable for any and all charges associated with collecting my outstanding balance. This may include collection agency fees and/or court costs.

Assignment of Benefits:

I hereby authorize and direct my insurance carrier(s) including, Medicare, private insurance and any other health/medical plan to issue payment directly to the East Coast Eye for services rendered to me and/or my dependent. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information:

I hereby authorize East Coast Eye to: (1) release any information necessary to insurance carriers regarding services rendered and my medical treatments and (2) process insurance claims generated in the course of examination or treatment. I certify that the information I have reported with regard to my health insurance is correct. If my insurance changes I will promptly notify East Coast Eye. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/ Responsible Party Signature Date

Please complete the second page

Name:
Chart:
Date:

ROUTINE EXAMS

Routine vision exams are not covered by many medical insurance contracts. Insurance companies have determined that nearsightedness, farsightedness, astigmatism, blurry vision and some other conditions that are correctable by glasses and/or contact lenses and the screening for such conditions (*called* refraction) are not considered "medical" problems and are therefore considered "routine" and are not eligible for reimbursement. If your insurance company does not provide for "routine" vision examinations, you are responsible for payment at the time of your visit. If you are unsure of your insurance coverage, please contact your insurance company for clarification.

If we submit charges to your insurance company and they determine at a later date that the charges are not covered under your contract, you will be responsible for payment.

Please sign below to indicate that you understand and agree to these terms. Our staff is available to answer any questions you might have.

_____ Date _____
Signature of patient or parent/guardian if patient is a minor

ATTENTION MEDICAID PATIENTS:

We are NOT MEDICAID participating providers and have the right not to accept you as a patient. If you choose to come to our practice and you have commercial insurance primary (ex: Blue Cross Blue Shield, Aetna, United Healthcare) and Medicaid secondary, you will be financially responsible for the patient portion of the charges. This applies to patients over the age of 18. Your signature acts as your acknowledgement and agreement of this responsibility.

_____ _____
Patient/Responsible Party Signature Date

Name:
Date:

EAST COAST EYE

NOTICE OF PRIVACY PRACTICES

Compliance Officer Denise Waldron, C.O.T ,C.O.E
dwaldron@mdeyedocs.com

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.

How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart [and on a computer][and in an electronic health record/personal health record]. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. **Treatment**. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. **Payment.** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. **Health Care Operations**. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. [*Participants in organized health care arrangements only should add*: We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.]

4. **Appointment Reminders.** We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.]

5. **Sign In Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. **Notification and Communication With Family**. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

Name:
Date:

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7. **Marketing**. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. **Sale of Health Information**. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. **Required by Law**. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. **Public Health**. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. **Health Oversight Activities**. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. **Judicial and Administrative Proceedings**. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. **Law Enforcement**. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. **Public Safety.** We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

15. **Proof of Immunization**. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

16.. **Specialized Government Functions**. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. **Workers' Compensation.** We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

18. **Change of Ownership**. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

19. **Breach Notification**. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use e-mail

Name:
Date:

notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your e-mail address is "digestivediseaseassociates.com" an e-mail sent with this address could, if intercepted, identify the patient and their condition.]

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. **Right to Request Special Privacy Protections**. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. **Right to Request Confidential Communications.** You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. **Right to Inspect and Copy.** You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. **Right to Amend or Supplement**. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. **Right to an Accounting of Disclosures.** You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. **Right to a Paper or Electronic Copy of this Notice.** You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all

Name:
Date:

protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. [*For practices with websites add*: We will also post the current notice on our website.]

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

_____ _____

Patient/ Guardian Signature Date

Name:
Date:

EAST COAST EYE

Authorization for Release of Protected Health Information (PHI)

Patient Information

- **Full Name: _____**
- **Date of Birth: _____**
- **Address: _____**
- **Phone Number: _____**

Recipient Information

- **Name of Individual(s) /Organization to Receive Information**

Name	Relationship to patient	Contact information

Information to Be Disclosed
I authorize the release of the following health information (check all that apply):

- ☐ Entire Medical Record
- ☐ Billing Information
- ☐ Other: _____

Acknowledgment and Signature
I understand that:

- I have the right to revoke this authorization in writing at any time.
- Information disclosed may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I am not required to sign this authorization, and my treatment, payment, or eligibility for benefits will not be conditioned on whether I provide this authorization.

Signature of Patient or Legal Representative:

_____ **Date: _____**