Patient Information Sheet

Today's Date:		**Soc. Sec. #:**	
Last name:	**First:**	**Middle:**	
Birthdate: / /	**Age:**	**Sex: Male:_____**	**Female:_____**
Mailing Address:			
City:	**State:**	**Zip:**	
Email Address:		**Cell Phone #: ( )**	
Home Phone #: ( )		**Work Phone #: ( )**	

Communication Preferrence: ____Email ____Phone ____Postal ____Text

Prefered Language: _____English _____Spanish

Race: ____American Indian/Alaska Asian ____Native Hawaiian/Pacific Islander ____White

____ Black/African American ____Hispanic ____Other

Ethnicity: ____Hispanic/Latino ____Native Hawaiian/Other Pacific Islander ____Not Hispanic or Latino

Marital Status: _____ Single _____ Married _____ Widowed _____ Separated/Divorced

Occupation: ____ Employed ____ Homemaker ____ Child/Student ____ Retired ____ Disabled

Employer:	**Position:**		
Business Address:	**City:**	**State:**	**Zip:**

In Case of Emergency Whom Should We Contact? **Phone #:**

I Give permisssion to the staff of Spectrum Eye Center to disclose personal Health information (including written, verbal or copied) regarding my eye exam visits to the following people :

Name:	**Phone #:**	**Relationship to pt:**
Name:	**Phone #:**	**Relationship to pt:**

I understand that I have the right to revoke or change this authorization by written request at any time I desire.

Name of Person Responsible for Account:			
Relationship to Patient:		**Phone #:**	
Mailing Address:	**City:**	**State:**	**Zip:**
Employer:	**Work #:**		

Insurance Information

Medical Primary Insurance	Medical Secondary Insurance	Vision Insurance

ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES

I have received a copy of Spectrum Eye Center's Notice of Privacy Practices. I have read and understand it.

Please Print Patient Name	Patient or Parent/Guardian Signature

Privacy Policy: We, the Staff and Management of Spectrum Eye Center, are vigilant to protect patient confidentiality. No information regarding our patients is shared or distributed with any other person or organization without the patients' signed authorization. Any questions or comments may be directed to our Privacy Compliance Officer.

Your official signature is required on the reverse side of this form. All patients under the age of 18 are considered minors and must have a parent or legal guardian to sign and be present during the office visit. Thank you for choosing Spectrum Eye Center.

Signature on File, Assignment of Benefits, Financial Agreement

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Spectrum Family Eye Center, for services furnished me by Spectrum Family Eye Centers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for 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 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Spectrum Family Eye Centers accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Spectrum Family Eye Centers, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Spectrum Family Eye Centers may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Spectrum Family Eye Centers for reimbursement for services rendered, and (2) any health care provider for continued patient care. Spectrum Family Eye Centers may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **OTHER INSURANCE:** I understand that Spectrum Family Eye Centers maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. And that Spectrum Family Eye Centers has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Spectrum Family Eye Centers if I belong to a plan that does not appear on the above-mentioned list.

5. **NON-COVERED SERVICES:** I understand that Spectrum Family Eye Centers contracts with health care service plans (i.e., HMOs, PPOs) that state 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 service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Spectrum Family Eye Centers to obtain necessary health care service plan authorizations.

6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Spectrum Family Eye Centers, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Spectrum Family Eye Centers for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. 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 Spectrum Family Eye Centers. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Spectrum Family Eye Centers. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.*

_____

Patients Printed Name

_____ _____

Signature of Patient or Legal Guardian for minors Date

Spectrum Family Eye Center

NOTICE OF PRIVACY PRACTICES

Effective date of notice: September 23, 2013

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. Examples of how we use or disclose information for treatment purposes are: setting up an appointment; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; referring you to another doctor or clinic for eye care or other services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records. We routinely use your health information inside our office for these purposes without any special permission.

USES AND 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 include but are not limited to:

- 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;
- disclosure to a medical examiner to identify a deceased person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses and disclosures to prevent a serious threat to health or safety;
- disclosures relating to worker's compensation programs;
- disclosures related to inmates;
- disclosures relating to military, national security and intelligence activities or for the protection of the President;
- 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 you have identified as being involved in your eye care.

OTHER USES AND DISCLOSURES

We will obtain your written authorization if we would like to disclose your protected health information for the following reasons: 1) for marketing purposes, including subsidized treatment communications; 2) disclosures that constitute the sale of your health information; and 3) other uses and disclosures not described in this Notice. The content of an "authorization form" is determined by Federal law. You may initiate the process if you would like your information sent to someone else. You will need to supply us with a properly completed "authorization form". If we initiate the process and ask you to sign an authorization form, you do not have to sign it. 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 to the office manager or doctor at the practice at which you receive care or the practice that requested your authorization.

While we will make every attempt to secure your protected health information, we are required to notify you of any breach in your unsecured protected health information.

APPOINTMENT REMINDERS

We may call, write, text or email to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write 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, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. To exercise any of the rights below, send a written request to the office manager or doctor at the address, fax, or e-mail of the practice at which you receive care. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this (except as otherwise stated in this Notice), but if we agree, we must honor the restrictions that you want.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using e-mail to your personal e-mail address. We will accommodate these requests if they are reasonable and if you pay us for any reasonable additional costs we may incur.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us. If we cannot provide a copy of your health information within 30 days, we will send you a written statement explaining our delay and give you a date on which your request will be completed, which will not be later than 60 days from the date of your request. You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available.
- 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 received 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. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already.

We will comply with your request to restrict disclosure of your health information if the disclosure is for the purpose of carrying out payment or health care operations and you have paid for services out-of-pocket, in full. Your request must be in writing and that request should identify: 1) the information to be restricted; 2) the type of restriction being request (i.e. on the use of information, the disclosure of information, or both); and 3) to whom the limits should apply. If such a request to restrict the disclosure of your health information for purposes of carrying out payment or health care operation where you have paid for services out-of-pocket, in full, is made, we will honor your request, except where we are required by law to make a disclosure.

OUR NOTICE OF PRIVACY PRACTICES

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. We must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our website.

FOR MORE INFORMATION OR COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us and/or the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. You may complain in writing, in person, or by phone by contacting the manager of this office or the Privacy Officer at 910-692-3937 or via email at kab@pinehursteyes.com. We can provide you with a complaint form, or if you prefer, you may also submit the specifics of your complaint in your own format. If you want more information about our privacy practices or specific information on how to file a complaint, call, visit or contact the person listed below.

Carol McBryde
160 Fox Hollow Road
Pinehurst, NC 27874
Phone (910) 692-3937 Fax (910) 338-3296

ACKNOWLEDGEMENT OF RECEIPT You will be asked to provide a separate acknowledgement of receipt. You may request a copy of this notice for your records.