Center FOR Sight

Making your world 20/happy

PATIENT REGISTRATION

Name	Nickname	Gender
Legal Guardian	Date of Birth	SSN
Home Address		
Marital Status	Preferred Pharmacy	
Home Phone	Mobile Phone	Work Phone
Email Address		Preferred Contact Method
How Did You Hear About Us?	Occupation	
Referring Provider Name	Referring Provider Phone	
Primary Care Physician Name	PCP Phone	
Emergency Contact Name	Phone	

Race	Language	Ethnicity
Primary Insurance	Group Name/Number	Policy Number
Insured Party's Name	Date of Birth	Relationship to Insured
Secondary Insurance	Group Name/Number	Policy Number
Insured Party's Name	Date of Birth	Relationship to Insured
Vision Insurance	Group Name/Number	Policy Number

I acknowledge that the information provided is complete and accurate.

_____ _____

Signature of Patient or Responsible Party **Date**

Please give those listed below access to my protected health information (PHI)

_____

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FINANCIAL AGREEMENT

Thank you for choosing Center For Sight for your eye care needs. We are pleased to welcome you to our practice. Our chief concern is that you and your family receive the finest care in maintaining healthy vision. Please be advised that you, the patient are responsible to understand the insurance plan you have selected and meet all requirements to fulfill contractual agreements between your plan and our practice. If you feel you are unaware of your plans co-pays, deductibles or co-insurance we ask that you kindly reschedule your appointment until you completely understand your financial responsibility. We will be glad to submit your claims to your insurance carrier for payment. However, the final responsibility of payment due for services rendered is the sole liability of you, the patient or the guarantor. Prior authorization does not guarantee payment of services and if a referral is required from your insurance carrier you will be responsible for obtaining one prior to your visit. **The patient is responsible for all charges not paid by the insurance company.** At the time of the visit, please present all necessary information to avoid non-payment by the insurance carrier, including insured party's information, current insurance card(s), any required insurance referral and accurate completion of registration paperwork. If we do not participate with your insurance carrier, payment is due at time of service. Further I authorize release of medical information to referring providers, consultants and insurance company. For any legitimate healthcare services, I authorize benefits and payment to Center For Sight or the provider.

Please note Medicare and other medical insurance carriers do not pay for your refraction. A fee of $45 is due at time of service.

We accept payment in the form of cash, check or credit card. Returned checks are subject to a $50 service charge and any cancellation of product will incur a 20% fee. We require a 24 Hour Notice of Cancellation of your appointment. **As of 10/1/2015, each appointment no show or late cancellation will result in a $45 fee to the patient. Each surgery appointment no show or late cancellation will result in a $200 fee to the patient.**

It is your responsibility to advise our office if you are being seen as part of a Vision Benefit package provided by your employer prior to your appointment. If we are a participating provider with your insurance company, we are contracted to adjust your account by a certain amount which is known as a "contractual write-off." This does not mean you will not have a balance. We will bill you for monies directed by your insurance company. If your account goes into "collections," in additional to your outstanding balance, you will be responsible to pay 25% fee charged by the collection agency as well as legal or court cost as specified by our collection agency.

Administrative Fees: Any medical necessary forms/letters required by your insurance company, or any communication outside the usual and customary forms required for billing or communication with other physicians or providers, will be subject to a $25 administrative fee (including MVA forms). We will be happy to complete your disability forms which are subject to a $25 administrative fee. As a courtesy to our patients relocating out of the area, we will be happy to supply your new eye care provider a copy of your medical records at no charge. Any other requests for copies of medical records will be subject to a 10 cents per page fee.

We understand that occasionally some of our patients will experience financial difficulties. It is our hope that you will bring these situations to the attention of our billing department or office manager to allow us to help manage your account in the most effective way.

_____ _____

Signature of Patient or Responsible Party **Date**

HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about your, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your health information in order to support the business activities of your physician's practice. These activities include, but are not limited to: quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food or drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization, at any time, in writing, except that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization. (Provided by HCSI)

Consent to Download Medications: Patients of Center For Sight have the option to enroll into an E-Prescribing program which allows our office to submit your prescription(s) electronically using our electronic health record system and RX clearing house Emdeon. By signing below, you authorize Center For Sight to enroll you in such program in efforts to expedite this process with your selected pharmacy and provide convenience to you the patient. This authorization also allows us to request your prescription medication history from other healthcare provider and third party pharmacy benefits for treatment purposes. This authorization affects your Personal Health Care Information which is protected by the Health

Insurance Portability and Accountability Act of 1996. If you have questions regarding this program please ask one of our representatives before signing below.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.
You have the right to inspect and copy your protected health information (fees may apply) – Under federal law however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we much comply when the protected health information pertains to a health care item or service for which the health care provider involved has been paid out of pocket in full. You may also request that any part of your protected health information may not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want to the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – if we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2006, or six years prior to the date of this request.

You have the right to receive a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by use. You may file a complaint with us by notifying our Compliance Officer of your complaint. We will not retaliate against your for filing a complaint. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by the phone at our main phone number. Please Sign the accompanying "Acknowledgement" form. Please note that by signing the Acknowledgement form you are only acknowledging that you have received or have been given the opportunity to receive a copy of our Notice of Privacy Practices.

_____ _____

Signature of Patient or Responsible Party **Date**