SOUTHERN EYE CARE OF FOREST

PHONE: 601-469-2020 FAX: 601-469-3449

PLEASE COMPLETE ALL AREAS BELOW IN PRINT

PATIENT INFORMATION

FIRST MI LAST

NAME: _____ **GENDER** M F

ETHNICITY (CHOOSE ONE) AFRICAN AMERICAN ___ HISPANIC ___ WHITE ___ OTHER _____

STREET CITY STATE ZIP

ADDRESS: _____ _____ _____ _____

SOCIAL SECURITY #: _____ **BIRTH DATE:** _____ **AGE:** _____

EMAIL ADDRESS: _____

HOME PHONE: _____ **CELL PHONE:** _____ **WORK PHONE:** _____

EMPLOYER: _____ **OCCUPATION:** _____

EMERGENCY CONTACT: _____ **PHONE:** _____ **RELATIONSHIP:** _____

RESPONSIBLE PARTY IF DIFFERENT FORM ABOVE

FIRST MI LAST

NAME: _____ **RELATIONSHIP TO PATIENT:** _____

ADDRESS: _____

SOCIAL SECURITY #: _____ **BIRTH DATE:** _____

HOME PHONE: _____ **CELL PHONE:** _____

WORK PHONE: _____ **EMPLOYER:** _____

ACKNOWLEDGEMENT: I understand payment is expected at the time service is rendered. If other arrangements are needed, I will discuss this with a member of the staff. I authorize any insurance company to pay benefits to the Doctor. I also authorize the release of medical information necessary in handling my claims. I further authorize this office to release or obtain any required medical information to or from any medical facility.

*****Delinquent accounts are subject to interest of 1.5% per month plus collection fees.*****

SIGNATURE: _____ **DATE:** _____

MEDICAL DOCTOR: _____ LAST EXAM: _____

PREGNANT OR NURSING: YES NO

PLEASE LIST ALL MEDICATIONS:

_____

_____

_____

_____

ANY ALLERGIES? _____

LIST ALL MAJOR SURGERIES: _____

_____

HAVE YOU HAD AN EYE SURGERY? YES NO

WHAT TYPE? _____ WHEN? _____

DO YOU HAVE EITHER OF THE FOLLOWING: GLAUCOMA MACULAR DEGENERATION

ARE YOU A DIABETIC? YES NO BLOOD SUGAR: _____ A1C: _____

PLEASE CIRCLE:

DO YOU USE ALCOHOL?	NONE	RARELY	MODERATELY	DAILY
DO YOU SMOKE?	NONE	RARELY	MODERATELY	DAILY
ILLEGAL DRUGS?	YES	NO	IF YES, HOW LONG? _____	

HAVE YOU EVER BEEN EXPOSED OR INFECTED WITH: HEPATITIS HIV SYPHILLIS GONORRHEA

DO YOU CURRENTLY HAVE OR EVER HAD PROBLEMS IN THE FOLLOWING AREAS?

LOSS OF VISION	Y	N	MIGRAINES	Y	N
BLURRED VISION	Y	N	CHOLESTEROL	Y	N
DRYNESS	Y	N	HEART TROUBLE	Y	N
REDNESS	Y	N	HYPERTENSION	Y	N
ITCHING	Y	N	ARTHRITIS	Y	N
BURNING	Y	N	ANEMIA	Y	N
GRITTY/SANDY	Y	N	THYROID	Y	N
EXCESS TEARING	Y	N	CANCER	Y	N
EYE PAIN/SORENESS	Y	N	LIGHT SENSITIVITY	Y	N
FLOATERS OR FLASHES	Y	N	CATARACTS	Y	N

DO YOU HAVE A FAMILY HISTORY OF: CATARACTS GLAUCOMA MACULAR DEGENERATION

SOUTHERN EYE CARE OF FOREST

521 DEERFIELD DRIVE, FOREST, MS 39074

INSURANCE STATEMENT

Our office is pleased accept your insurance assignment. We offer this service as a courtesy to our patients. However, it must be clearly understood that the "contract" is between you, the patient and your insurance company. You are hereby responsible for your account and any amount not paid by your insurance company.

The following is a statement of our policies governing insurance claims:

1. Although our office will bill your insurance company, it is necessary for the patient to fill out the insurance information form completely. If the form is not completed, we will not be able to appropriately bill the insurance company and the responsibility for payment then becomes that of patient. We are sorry, but there no exceptions to this policy.

2. We require our patients to sign an "Authorization to Pay the Doctor" form (or any other necessary assignment documents required by your insurance company). By doing so, the insurance company will make payment directly to our office.

3. The patient will pay the co-payment (the amount not covered by the insurance company) as agreed upon during the financial consultation.

4. Insurance payments ordinarily are received within 30 to 60 days from the time of billing. If a patient's insurance company has not made payments to our office within 90 days, we may request the patient to pay the balance due, and then reimburse the patient when and if the insurance company pays.

5. Our office does NOT guarantee that the patient's insurance company will pay. We will perform our routine insurance billing procedures upon verification of coverage. However, if for some reason, the patient's insurance claim is denied, the patient is then considered to be responsible for the full amount of the bill.

6. Our office will not enter into a "dispute" with an insurance company over any claim, although we will work with the insurance company to sort out any confusions or questions that might arise. We cooperate fully the regulations and requests of the insurance companies. It will be, however, the responsibility of the patient to handle with the insurance company any type of dispute over payment by the company.

OUR COMMITMENT TO YOU

We appreciate having you as a patient in our practice. We will do everything possible to deliver the highest quality care in a safe and comfortable environment. Please do not hesitate to ask any questions you have about our services and office policies. If you are satisfied with our office and the service you receive, please feel free to tell a friend. We welcome new patients and appreciate it when our patients refer their friends and family.

PATIENT SIGNATURE: _____ Date _____

Notice of Privacy Practices

Southern Eye Care of Forest
521 Deerfield Dr
Forest, MS 39074
601-479-2020; www.secforest.com
Wendi Marler, Privacy Official

IN COMPLIANCE WITH THE FEDERAL REGULATIONS OF HIPAA'S PRIVACY RULE, THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THAT INFORMATION. PLEASE REVIEW IT CAREFULLY

We respect our legal obligation to keep health information that might identify you private. We are obligated by law to provide you with 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 reasons we would use or disclose your health information is for treatment, payment, or business operations. We routinely use and disclose your medical information within the office on a daily basis. We do not need specific permission to use or disclose your medical information in the following matters, although you have the right to request that we do not.

Examples of how we might use or disclose health information for treatment purposes might include:

Setting up or changing appointments including sending postcards or letters, leaving messages with those at your home or office who may answer the phone or leaving messages on answering machines, voice mails, email and text; calling your name out in a reception room environment; prescribing glasses, contact lenses, or medications as well as relaying this information to suppliers by phone, fax or other electronic means including initial prescriptions and requests from suppliers for refills; notifying you that your ophthalmic goods are ready, including sending postcards or letters, leaving messages with those at your home or office who may answer the phone, or leaving messages on answering machines, voice mails or emails and text; referring you to another doctor for care not provided by this office; mailing glasses or contacts to your home or place of work; obtaining copies of health information from doctors you have seen before us; discussing your care with you directly or with family or friends you have inferred or agreed may listen to information about your health; sending you postcards or letters or leaving messages with those at your home who may answer the phone or on answering machines, voice mails or emails and also text reminding you it is time for continued care; at your request, we can provide you with a copy of your medical records via email transmission. We also use outside companies such as Demand Force and 4patient care to contact our patients through mail, text, email, mail and telephone to remind them of appts and when goods are ready.

Examples of how we might use or disclose health information for payment purposes might include:

Asking you about your vision or medical insurance plans or other sources of payment; preparing and sending bills to your insurance provider or to you; contacting HR department to discuss your insurance benefits; providing any information required by third party payors in order to insure payment for services rendered to you; sending notices of payment due on your account to the person designated as responsible party or head of household on your account with fee explanations that could include procedures performed and for what diagnosis: collecting unpaid balances either ourselves or through a collection agency, attorney, or district attorney's office.

Examples of how we might use or disclose health information for business operations might include:

Financial or billing audits; internal quality assurance programs; participation in managed care plans; defense of legal matters; business planning; certain research functions; informing you of products or services offered by our office; compliance with local, state, or federal government agencies request for information; oversight activities such as licensing of our doctors; Medicare or Medicaid audits; providing information regarding your vision status to the Department of Public Safety, a school nurse, or agency qualifying for disability status.

USES AND DISCLOSURES FOR OTHER REASONS NOT NEEDING PERMISSION

In some other limited situations, the law allows us to use or disclose your medical information without your specific permission. Most of these situations will never apply to you but they could.

- When a state or federal law mandates that certain health information be reported for a specific purpose
- For public health reasons, such as reporting of a contagious disease, investigations or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices
- Disclosures to government or law authorities about victims of suspected abuse, neglect, domestic violence, or when someone is or suspected to be a victim of a crime
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative hearings
- Disclosures to a medical examiner to identify a deceased person or determine cause of death or to funeral directors to aid in burial
- Disclosures to organizations that handle organ or tissue donations
- Uses or disclosures for health related research
- Uses or disclosures to prevent a serious threat to health or safety of an individual or individuals
- Uses or disclosures to aid military purposes or lawful national intelligence activities
- Disclosures of de-identified information
- Disclosures related to a workman's compensation claim
- 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 and disclosures

- Disclosure of information needed in completing form from a school related vision screening, information to the Department of Public Safety, information related to certification for occupational or recreational licenses such as pilots license.
- Disclosures to business associates who perform health care operations for Southern Eye Care of Forest and who commit to respect the privacy of your information
- Unless you object, disclosure of relevant information to family members or friends who are helping you with your care or by their allowed presence cause us to assume you approve their exposure to relevant information about your health

USES OR DISCLOSURES TO PATIENT REPRESENTATIVES

It is the policy of Southern Eye Care of Forest for our staff to take phone calls from individuals on a patients behalf requesting information about making or changing an appointment; the status of eyeglasses, contact lenses, or other optical goods ordered by or for the patient. Southern Eye Care of Forest staff will also assist individuals on a patient's behalf in the delivery of eyeglasses, contact lenses, or other optical goods. During a telephone or in person contact, every effort will be made to limit the encounter to only the specifics needed to complete the transaction required. No information about the patient's vision or health status may be disclosed without proper patient consent. Southern Eye Care of Forest staff and doctors will also infer that if you allow another person in an examination room, treatment room, dispensary, or any business area within the office with you while testing is performed or discussions held about your vision or health care or your account that you consent to the presence of that individual.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written *Authorization for Release of Identifying Health Information*. The content of this authorization is determined by federal law. The request for signing an authorization may be initiated by Southern Eye Care of Forest or by you as the patient. We will comply with your request if it is applicable to the federal policies regarding authorizations. If we ask you to sign an authorization, you may decline to do so. If you do not sign the authorization, we may not use or disclose the information we intended to use. If you do elect to sign the authorization, you may revoke it at any time. Revocation requests must be made in writing to the Privacy Officer named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your personal health information.

You may ask us to restrict our uses and disclosures for purposes of treatment (except in emergency care), payment, or business operations. This request must be made in writing to Privacy Officer named at the beginning of this Notice. We do not have to agree to your request, but if we agree, must honor the restrictions you ask for.

You may ask us to communicate with you in a confidential manner. Examples might be only contacting you by telephone at your home or using some special email address. We will accommodate these requests if they are reasonable and if you agree to pay any additional cost, if any, incurred in accommodating your request. Requests for special communication requests must be made to the Privacy Officer named at the beginning of this Notice.

You may ask to review or get copies of your health information. There are a very few limited situations in which we may refuse your access to your health information. For the most part we are happy to provide you with the opportunity to either review or obtain a copy of your medical information. All requests for review or copy of medical information must be made in writing to the Privacy Officer named at the beginning of this Notice. While we usually respond to these requests in just a day or so, by law we have thirty (30) days to respond to your request. We may request an additional thirty (30) day extension in certain situations.

You may ask us to amend or change your health care information if you think it is incorrect or incomplete. If we agree, we will make the amendment to your medical record within thirty (30) days of your written request for change sent to the Privacy Officer named at the beginning of this Notice. We will then send the corrected information to you or any other individual you feel needs a copy of the corrected information. If we do not agree, you will be notified in writing of our decision. You may then write a statement of your position and we will include it in your medical record along with any rebuttal statement we may wish to include.

You may request a list of any non-routine disclosures of your health information that we might have made within the past six (6) years (or a shorter period if you wish). Routine disclosures would include those used your treatment, payment, and business operations of Carthage Eye Clinic. These routine disclosures will not be included in your list of disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you must pay for them in advance at a fee of $30.00 per list. We will usually respond to your written request (made to the Privacy Officer named at the beginning of this Notice) within thirty (30) days but we are allowed one thirty (30) day extension if we need the time to complete your request.

You may obtain additional copies of this Notice of Privacy Practices from our business office or online at our website address shown at the beginning of this Notice.

CHANGING OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to substantially change the Notice. We reserve the right to change this Notice at any time. If we change this Notice, the new privacy practices will apply to your existing health information as well as any additional information generated in the future. If we change this Notice, we will post a new Notice in our office and on our website.

COMPLAINTS

If you think that anyone at Southern Eye Care of Forest has not respected the privacy of your health information, you are free to complain to the Privacy Officer named at the beginning of this Notice. We are more than happy to try to resolve any concern you may have in writing. If we cannot resolve your concern at that level, you may also file a complaint with the U.S. Department of Health and Human Services, Office of Civil Rights or the Mississippi Attorney General's Office. We will not retaliate against you if you make such a complaint.

ACKNOWLEDGEMENT

OF

NOTICE OF PRIVACY PRACTICES

The law requires that Southern Eye Care make every effort to inform you of your rights related to your personal health information. By signing below, I acknowledge that:

_____ I have read or had explained to me Southern Eye Care's Notice of Privacy Practice and agree to continue my care with Southern Eye Care under said terms.

_____ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as:

_____

I HAVE READ AND UNDERSTANDTHIS FORM. I AM SIGNING IT VOLUNTARILY.

PATIENT: _____ DATE: _____

If you are signing as a personal representative of the patient, please indicate your relationship:

REPRESENTATIVE: _____ RELATIONSHIP: _____

PERSONS WHO WE MAY DISCUSS YOUR INFORMATION WITH:

NAME: _____ DOB: _____

NAME: _____ DOB: _____