Ophthalmic Association

❑ Pittsburgh ❑ Greensburg ❑ Cranberry ❑ McMurray ❑ Monroeville ❑ Rostraver ❑ Weirton ❑ Butler

Tel 412.288.0885 • info@everett-hurite.com • Toll Free 1.800.423.6800

PATIENT INFORMATION

Account #______________ Appointment Date__________

Dr.______________________________

Patient's Name____ ❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.
Last First Middle Initial

Address____
Street Apt. #

____
City State Zip Code

Phone: Home_(_____)______-________ Work_(_____)______-________ Email______________________

Social Security #__________________________ Birthdate__________

Your Primary Care Physician____________________________________ Fax_(_____)______-________

Referrer's Name____

Referrer's Address____

Were you referred by:

MD ❑ Yes ❑ No
Optometrist ❑ Yes ❑ No
Family or Friend ❑ Yes ❑ No

Would you like a report to be sent to your referring Physician?
❑ Yes ❑ No

Marital Status:
❑ Single ❑ Divorced
❑ Married ❑ Widow(er)

Sex:
❑ Male
❑ Female

Person responsible for payment______________________________________ Relationship__________________

Address______________________________________ Phone_(_____)______-________ ❑ Work ❑ Home ❑ Cell

Emergency Contact______________________________ Phone_(_____)______-________ ❑ Work ❑ Home ❑ Cell

**** CO-PAY MUST BE PAID IN FULL AT TIME OF CHECK-IN ****

INSURANCE INFORMATION - PLEASE COMPLETE - In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

PRIMARY INSURANCE

Ins. Co. Name__________________________
AS IT APPEARS ON YOUR CARD

Employer__________________________

Identification No.__________________________

Group No.__________________________

Insured / Subscriber:

Name__________________________

Date of Birth___/___/___ SSN_____-_____-_____

Relationship to Patient__________________________

SECONDARY INSURANCE

Ins. Co. Name__________________________
AS IT APPEARS ON YOUR CARD

Identification No.__________________________

Group No.__________________________

Insured / Subscriber:

Name__________________________

Date of Birth___/___/___ SSN_____-_____-_____

Relationship to Patient__________________________

VISION INSURANCE DAVIS/VBA

Ins. Co. Name__________________________
AS IT APPEARS ON YOUR CARD

Identification No.__________________________

Group No.__________________________

Insured / Subscriber:

Name__________________________

Date of Birth___/___/___ SSN_____-_____-_____

Relationship to Patient__________________________

WORKERS COMPENSATION - AUTO ACCIDENT

Company (Employer)______________________________________ Claim No.__________________

Address____

Was report of injury filed with employer? ❑ Yes ❑ No Date of Injury______________ Insurance Carrier__________________

Person Authorized for Verification______________________________________ Phone_(_____)______-________

I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Everett & Hurite Ophthalmic Association** for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service.

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, private insurance and any other health plans to: **Everett & Hurite Ophthalmic Association.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Revised 4/12/11

______________________________ Signature

______________________________ Date

**** IMPORTANT ****
Is it OK to leave a message on your answering machine when confirming an appointment? ❑ Yes ❑ No

Everett&Hurite
Ophthalmic Association

PATIENT HISTORY FORM

(Please complete **both** sides of this form)

Date__________ Referred By__________ Birth Date__________

Patient's Name__________ (Last / First / Mid. Initial) Soc. Sec #__________ Sex______ Age______

Please list medications you are taking, including eye drops, vitamins and aspirin.

1. __________
2. __________
3. __________
4. __________
5. __________
6. __________
7. __________
8. __________

Allergies to any medications? ☐ Yes ☐ No If yes, please explain__________

Family/Social History: Are there any medical or eye diseases in your family. If YES, please note relationship to patient.

Glaucoma	☐ Yes	☐ No	Relationship__________
Diabetes	☐ Yes	☐ No	Relationship__________
High Blood Pressure	☐ Yes	☐ No	Relationship__________
Macular Degeneration	☐ Yes	☐ No	Relationship__________
Other	☐ Yes	☐ No	Relationship__________
Smoking	☐ Yes	☐ No	Relationship__________
Drinking Alcohol	☐ Yes	☐ No	Relationship__________

Past Surgery__________

Comments:

Please also complete the other side of this form OVER ➡

REVIEW OF SYSTEMS			
Do you currently have any of the following problems?	**Yes**	**No**	**If yes, please explain**
1. **Do you smoke**			How Much?
2. **Do you drink alcohol**			
3. **Do you have any allergies to any medication**			What Type?
4. **Constitutional** (fever, weight loss, other)			
5. **Eyes** (glaucoma, cataract, lazy eye, retina problems, Other - please specify)			
6. **Ear / Nose / Mouth / Throat** (hearing loss, sinus problems, sore thorat)			
7. **Cardiovascular** (heart problems, chest pain, irregular heart beat)			
8. **Respiratory** (asthma, shortness of breath, wheezing, coughing)			
9. **Gastrointestinal** (heartburn, abd, pain, diarrhea, vomiting)			
10. **Genitourinary** (urinary problems, blood in urine)			
11. **Integumentary** (skin rashes, excessive dryness)			
12. **Musculoskeletal** (muscle aches, joint pain, swollen joints)			
13. **Neurological** (numbness, weakness, headaches, paralysis)			
14. **Hematologic / Lymphatic** (blood disorders, leukemia, anemia)			
15. **Allergic / Immunologic** (hay fever, allergies)			
16. **Endocrine** (thyroid problems, pituitary problems)			
17. **Pyschiatric** (depression, anxiety)			
18. **Cancer**			What Kind?
19. **Born Prematurely**			

Patient Signature (Consent to Treatment)________________________________ Date____________

REGISTRATION INFORMATION

As part of your registration, please complete the information requested below:

Preferred Language:	English	
	Spanish	
	Other ______________(please write in)	
Race:	White	Black/African American
	Asian	American Indian/Alaskan Native
	Native Hawaiian or Pacific Islander	Patient Declined
Ethnicity:	Hispanic Origin	Not of Hispanic Origin
	Patient Declined	

PATIENT CONTACT

What is your preferred method of communication with our clinic?

First Method of Communication

Please tell us your preferred method of communication by checking the appropriate box and providing your contact information below.

Home Phone	Pager	Durable Power of Attorney
Work Phone	Fax	
Cell Phone	Letter	
E-mail	Other Method	

Please Print Clearly:

____

Second Method of Communication

Please tell us an alternative method of communication by checking the appropriate box and providing your contact information below. We will use the alternative method of communication if we cannot reach you using your preferred method of communication.

Home Phone	Pager	Durable Power of Attorney
Work Phone	Fax	
Cell Phone	Letter	
E-mail	Other Method	

Please Print Clearly:

____

Everett&Hurite
Ophthalmic Association

SECTION 1: ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,____________________________________(PRINT NAME) hereby acknowledge that on the date set forth below, I have received Everett & Hurite Ophthalmic Association's Notice of Privacy Practices.

Signature____________________________________ **Date**__________ **Time**________ **AM/PM**
(Patient or Legal Representative)

If signed by someone other than the patient, please state your legal relationship to the patient:____________________

SECTION 2: AUTHORIZATION TO RELEASE INFORMATION

In the event that we are unable to reach <u>YOU</u> to relay results from <u>YOUR</u> test results and you want to give us permission to release this information to another individual (other than your referring physician who will automatically be given your results); please fill out the following:

- ❑ My Spouse____________________________________ Phone________________
- ❑ My Parent (Mother)______________________________ Phone________________
  (Father)______________________________ Phone________________
- ❑ Other (please specify name and relationship)
  ____ Phone________________

<u>OR</u>

- ❑ **ONLY GIVE MY TEST RESULTS TO ME IN PERSON OR VIA TELEPHONE.**
- ❑ **YOU MAY LEAVE A MESSAGE FOR ME ON THE ANSWERING MACHINE ALTHOUGH ANYONE MAY HEAR.**

Signature____________________________________ **Date**__________ **Time**________ **AM/PM**
(Patient or Legal Representative)

SECTION 3: AUTHORIZATION TO RELEASE FAX TRANSMISSIONS OF PATIENT INFORMATION

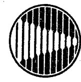
I authorize this office to use facsimile (fax) as a means of quick communication with other physician's offices, medical facilities and/or insurance companies for information that pertains to my care. I have read and understand the above statements.

Signature____________________________________ **Date**__________ **Time**________ **AM/PM**
(Patient or Legal Representative)

Signature & Name______________________________ Date__________ Time________ AM/PM
(Witness, If Applicable)

For more information about your privacy rights, please see our "Notice of Privacy Practices" available on our website at www.everett-hurite.com or call our Privacy Officer, Marc Hoffman, D.O. at 412.288.0885, or send a written request to: Marc Hoffman, D.O., Everett & Hurite Ophthalmic Association, 1835 Forbes Avenue, Pittsburgh, PA 15219. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

7/18/2007



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INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the physician to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make sunlight and other bright lights bothersome. It is not possible for your physician to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, **it's best if you make arrangements not to drive yourself. It is also recommended that you bring sunglasses with you.**

Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize the doctors of Everett & Hurite Ophthalmic Association and/or such designated assistants to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

______________________________	______________
Patient (or person authorized to sign for patient)	**Date**
______________________________	______________
Witness	**Date**

Everett&Hurite
Ophthalmic Association

Financial Policy

Welcome and thank you for choosing Everett & Hurite Ophthalmic Association (E&H) for your eye care. We are committed to providing you with the highest quality eye care in a cost effective manner. Our professional fees have been determined through careful consideration in addition to being reasonable and customary within our geographical area. Your clear understanding of this policy is important to our professional relationship. Payment, in full, is due at the time services are rendered.

Appointments:

- Please bring with you to each appointment: *Health Insurance Card(s), Driver's License and Method of Payment*
- If you are more than 15 minutes late for your appointment, you may be asked to reschedule your appointment.
- To our established patients, please inform the Front Desk Staff of any demographic changes. Particularly if you are now residing in a nursing home or rehab facility. Failure to notify us of changes may result in you being financially responsible for services not covered by your insurance carrier.
- All copays are due the time of service. Any copay not received at the time of service will result in a $5.00 surcharge.
- No child under the age of 18 will be seen by the physician without a parent or legal guardian.

Insurance Plans:

- Medicare/Medicaid:
  > Please make sure you have a full understanding of your benefits and what might be your responsibility if not covered by your insurance plan. We are contracted with multiple insurances to accept assignment of benefits.
- "In Network" vs "Out of Network":
  >Your insurance coverage and benefits are a contract between you and your insurance company and therefore all disputes must be handled between you and your insurance company.
  >It is your responsibility to verify that our specialist is currently under contract with your insurance plan and that you have obtained all necessary referrals and/or authorizations ***before*** your scheduled appointment.
  >If you have insurance coverage under a plan in which we do not have a contract with, you will be treated as a *self-pay* patient.
- Self-Pay Patients:
  >Full payment is expected for services rendered, if the patient is unable to comply, financial arrangements can be made with our billing department.

Auto Accidents/Workers' Compensation:

- Motor Vehicle Accidents (MVAs) will be filed to your auto insurance as a courtesy to you, providing that the patient provides all pertinent information.
- Our office will send appropriate workers compensation claims for services rendered on your behalf as a courtesy, providing that the patient provides all pertinent information.
- If claims are denied or benefits are exhausted, full payment is expected from the patient within 30 days unless health insurance is provided.
- E&H will not be a participant with any third party disputes. Payment is expected in a timely manner.

Please complete other side of this form

Payment of services rendered:

- Co-pays and coinsurance amounts, deductibles and all non-covered items and charges are the insured/patients financial responsibility. Failure to produce copayment at check-in may result in your appointment being rescheduled.
- If you receive more than one type of service on the same day, you may be responsible for more than one copay. (Example: diagnostic testing, medications, etc.)
- Requests to complete reports such as for FMLA, disability, schools, etc. will incur a processing fee expected to be paid upon completion.
- Please note any checks returned by the bank will incur an additional fee.
- As a courtesy to our patients, we accept cash, personal check, and money order, Visa, MasterCard, Discover and American Express.

Payment Plans:

- Our Billing Department will be happy to assist you in order to pay any previous balanced owed to our practice.
- A formal payment plan will be signed by both parties and kept in accordance with your medical record.
- Any default with predetermined arrangements will accelerate the balance owed causing the payment plan to be terminated.

Collections and Outstanding Balances:

- Unpaid balances over 90 days may be turned over to a collection agency unless other arrangements have been made. The provider reserves the right to add a processing fee to any unpaid balance.
- Patients with unpaid delinquent accounts or accounts which have been turned over to our collection agency may be discharged from the practice.

Refunds:

- Refunds are issued to the appropriate party.
- Patient refunds will not be processed until all active or past due charges are paid in full.
- Refunds less than $10.01 will not be issued unless requested by the patient. A credit will be kept on your account.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s):____

Responsible Party Member's Name: ___________________________________**Relationship:**________________________

Responsible Party Member's Signature: ____**Date:**_____________

At your request, we will provide you with a copy for your records.

NOTICE OF PRIVACY PRACTICES

Effective as of February 17, 2015

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.

Our Responsibilities: This notice describes your rights and certain obligations we have regarding the use and disclosure of health information. This notice applies to all medical records created or received at our offices, and covers those physicians and health care providers that provide health care services at our offices. Everett & Hurite Ophthalmic Association and such individuals will share patient health information for the purpose of providing treatment to you and for billing and health care operations as described in this notice. We are required by state and federal law to maintain the privacy of your health information. We must also give you this notice of our legal duties and privacy practices, and we must follow the terms of the notice that is currently in effect. We reserve the right to change this notice and to make the new provisions effective for all health information we maintain as well as any information we receive in the future. We will post a copy of the current notice in our offices, and on our website at www.everett-hurite.com. A copy of our current notice will be available at the registration area of each of our offices.

Permitted Uses and Disclosures: The following categories describe different ways that we may use and/or disclose your health information. We have not listed every use or disclosure within the categories, but describe some of the types of uses and disclosures we may make.

Treatment: We may use and disclose your health information to provide you with medical treatment. For example, we may disclose health information about you to doctors, nurse, technicians, or other personnel who are involved in your care.

Payment: We may use and disclose your health information so that the treatment and services you receive may be billed to and payment collected from you, an insurance company, or a third party. For example, we may send a bill to your insurance company for the procedures you received. When you come to our offices for services we will obtain your consent for these types of payment disclosures. If you have paid for services “out of pocket”, in full, and you request that we do not disclose health information related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

Health Care Operations: We may use your health information for our health care operations. For example, we may use your health information to assess the care and outcomes in your case and others like it.

Business Associates: We provide some services through contacts with business associates. For example, we may disclose your health information to our business associates to perform services on our behalf, such as diagnostic services and certain laboratory tests. To protect your health information we require our business associates to appropriately safeguard your information.

Appointment Reminders and Alternative Treatments: We may contact you for appointment reminders or information about treatment alternatives or other health-related benefits and services that may interest you.

Individuals Involved in Your Care or Payment for Your Care: We may disclose relevant portions of your health information to your friends, family members, or any person you identify unless you tell us in advance not to do so. We may also use or disclose your health information to notify (or assist in notifying) your family members, personal representatives, an entity assisting in a disaster relief effort, or another person involved in your care of your condition, status, or location.

Specifically Approved Research: We may disclose your health information to researchers when an Institutional Review Board or Privacy Board has reviewed the research proposal, has established certain procedures to ensure the privacy of your health information, and has approved the research.

Other Permitted Uses and Disclosures: We may also use or disclose your health information for the following purposes in accordance with applicable law: the creation and distribution of de-identified health information by removing all reference to individually identifiable information; for public health activities or legal authorities charged with preventing or controlling disease, injury, or disability, including to report abuse, neglect, or domestic violence; to health oversight agencies; for judicial and administrative proceedings (in response to a subpoena or court order); for law enforcement purposes, for ex ample to identify a suspect, to provide information about the victim of a crime, or to report criminal conduct; to provide information regarding decedents, for example, to coroners, medical examiners, and funeral homes; for cadaveric organ, eye or tissue donation; to avert a serious threat to health or safety; for specialized government functions, for example, national security and intelligence activities, or to the military if you are a member of the armed forces; to comply with worker's compensation laws; or as required or permitted by law.

Authorizations: Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your authorization under federal law or your consent under state law. For example, we will disclose confidential HIV-related information about you only in accordance with state law. Generally, state law requires that confidential HIV-related information may only be released to whom you specify in a written consent or to those persons specified by state law who may receive the information without your consent. You may always refuse to sign an authorization or consent for these types of uses and disclosures. You may always revoke your authorization or consent at any time. If you revoke your authorization or consent, we will no longer use or disclose your health information except to the extent that we or others have previously relied on your authorization or consent. To revoke your authorization or consent, please contact our Privacy Officer.

Your Rights: You have the following rights with regards to your health information. If you have any questions regarding how you may exercise your health information rights, please contact our Privacy Officer.

You have the right to request restrictions on certain uses and disclosures of your health information. We are not required to agree with your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing.

You have the right to obtain a paper copy of this notice upon request, even if you have agreed to accept this notice electronically.

You have the right to inspect and copy or receive a summary of certain portions of your health record. We have the right to charge you a reasonable fee for a copy or a summary. Under limited circumstances, we can deny you the right to your medical records.

You have the right to amend your health record. You must make your request in writing and provide the reason(s) to support your request. Under certain limited circumstances, we may deny your request for an amendment. If we deny your request for an amendment, you may file a statement of disagreement with us, which we have the right to rebut.

You have the right to obtain an accounting of disclosures of your health information, except for those disclosures exempted by law; for example, among others, those to carry out treatment, payment, and healthcare operations or those for a time period which is longer than six (6) years. You must request this accounting in writing.

You have the right to request communications of your health information by alternative means or at alternative locations. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. To request restrictions, please contact our Privacy Officer.

For More Information: If you have questions or would like additional information, you may contact our Privacy Officer, Marc Hoffman, D.O. by calling 412-288-0885 or by writing: Marc Hoffman, D.O., Everett & Hurite Ophthalmic Association, 1835 Forbes Ave, Pittsburgh, PA 15219.

To Report a Problem: If you believe your privacy rights have been violated, you can file a complaint with our Privacy Officer by writing: Marc Hoffman, D.O., Everett & Hurite Ophthalmic Association, 1835 Forbes Ave, Pittsburgh, PA 15219. You may also file a complaint with the United States Department of Health & Human Services. There will be no retaliation against you for filing a complaint.