PVC

PATIENT INFORMATION:

Name (first) _____ (middle)_____ (last)_____ ☐ male ☐ female

Address _____ Apt#_____

City _____ State _____ Zip _____

Birth Date _____ Age _____ Social Security # _____-_____-_____

Home Phone _____ Work Phone _____

Cell Phone _____ Which Number Would You Like us to Contact You On _____

Employed: ☐ yes ☐ no Employer Name _____

Employer Address _____ City _____ State _____

Marital Status: ☐ single ☐ married ☐ divorced ☐ widowed

If Married, Spouse's Name _____ Date of Birth _____

EMERGENCY CONTACT:

Name _____ Phone # _____

Relationship _____ Work Phone # _____

PHARMACIES:

Name (local) _____ Phone # _____

Address _____

Name (mail order) _____ Phone # _____

Address _____

INSURANCE INFORMATION:

Note: We require that your card be presented at every visit - OR – if card is not available you must verify eligibility, and provide ID#, group#, mailing address & provider services phone #. If not, you will be responsible for the cost of the visit.

Primary Insurance Company _____ Co-payment $ _____

Policy ID # _____ Policy Group # _____

Card Holder Name (if other than patient) _____

Date of Birth _____ Social Security # _____-_____-_____

Relationship to Cardholder: ☐ self ☐ spouse ☐ other Insurance Through Employer ☐ yes ☐ no

If yes, employer name _____

Secondary Insurance Company _____ Co-payment $ _____

Policy ID # _____ Policy Group # _____

Card Holder Name (if other than patient) _____

Date of Birth _____ Social Security # _____-_____-_____

Relationship to Cardholder: ☐ self ☐ spouse ☐ other Insurance Through Employer ☐ yes ☐ no

If yes, employer name _____

I understand that when I sign this document I am confirming that all information completed by me is correct. I am also authorizing The Pataskala Vision Center to bill my insurance(s) on my behalf & agree to pay any balances left after insurance pays.

Signature_____ **Today's Date**_____

PVC

ADDITIONAL DEMOGRAPHIC INFORMATION

We need your help collecting additional demographic information for quality of care improvement and to meet objectives outlined in the "meaningful use" of Electronic Health Records released by the Department of Health and Human Services (HHS).

Why are physicians being urged to collect a patient's race, ethnicity and preferred language? We are collecting this data to track quality of care, health outcomes and mortality rates by relevant groups to monitor for and address disparities as well as communicate effectively with patients.

Did you know that a person's race and/or ethnicity affects the reference values used for some diagnostic testing such as Spirometry which measures lung function? Documenting accurate race and ethnicity data improves the accuracy of the result(s).

Thanks for your help!

Date: _____ Doctor: _____

<table>
<tr><td colspan="2">Name:</td><td colspan="2">Date of Birth:</td></tr>
<tr><td rowspan="2">Race</td><td rowspan="2">☐ American Indian or Alaska Native
☐ Asian ☐ Black or African American
☐ Hispanic ☐ White (Caucasian)
☐ Other Race _____
☐ Native Hawaiian or Other Pacific Islander</td><td>Ethnicity</td><td>☐ Hispanic or Latino
☐ Not Hispanic or Latino</td></tr>
<tr><td>Preferred Language</td><td></td></tr>
</table>

PVC

Patient Financial Agreement

1. Payment in full is required at the time of service if you do not have insurance. We accept cash, checks, money orders, Visa, Discover, Mastercard, American Express and Care Credit. You will receive a 10% discount when you pay in full at the time of service if we do not need to submit the claim to anyone. We will also collect any prior balances due us at that time.

2. All co-pays are due at the time of service. Please also be aware that a co-pay is part of your contractual agreement between you and your insurance company. If you fail to pay your co-pay at your visit, your insurance company could consider this a breach of your contract which could lead to the termination of your coverage.

3. You are also financially responsible for any deductibles, coinsurance or any other amount not covered by your insurance. Payment is due in our office within 30 days of receipt of our statement unless you call and make payment arrangements.

4. Insurance is a contract between you and your insurance company. We will file your claims for you if you have supplied us with current insurance information. It is your responsibility to know your policy as to whether you have preventative coverage or need something pre-certified, pre-authorized, etc. Not all services are a covered benefit in all insurance contracts. Payment for these services will be your responsibility.

5. In the case of divorce or separation the parent authorizing treatment for a child will be the parent responsible for any charges or co-pays. In the state of Ohio a doctor cannot be held to collect from the parent who was deemed responsible to pay medical bills for his/her children in a divorce decree. It is the authorizing parent's responsibility to collect from the other parent if need be.

6. There is a $20.00 fee for any returned checks. Payment will need to be made by cash, credit card or money order within 14 days for the amount due and the returned check fee.

7. Accounts that are sent to collection are subject to the collection agency's fees that are charged to The Pataskala Vision Center. This fee is usually 40% of the balance sent to collection. We reserve the right to terminate patients who have an account that is delinquent, whether we send the account to our collection agency or not.

_____ _____

Print Name Date

_____ _____

Signature of Patient or Guardian Relationship to pt

The Pataskala Vision Center
180 E. Broad Street, Suite A
Pataskala, OH 43062
Phone: 740-927-3061
Fax: 740-927-7042

Dr. James Mason

Dr. Steve Walsh

Dr. Amber Slezak

Mail: _____.

Email: _____.

Text: _____.

Thank you very much!

The Pataskala Vision Center
180 E. Broad Street, Suite A
Pataskala, OH 43062

Patient's Name:_____ **DOB:**___/___/___ **Phone:**(___)_____-_____

Dear Patient,

As part of your eye examination, our doctors perform a diagnostic procedure called *Digital Retinal Imaging*. This procedure captures a detailed digital image of the back part of your eye, the Retina. It is not an X-ray or ultrasound procedure, and nothing will touch your eyes.

The procedure provides us with a permanent and accurate digital record of the retina and is very valuable in the evaluation of some of the most important structures of your eyes. Safeguarding these structures from diseases like glaucoma, macular degeneration, and from damage caused by diabetes and high blood pressure is vital to your vision. If this testing reveals abnormal findings in your eye(s), it could indicate that these issues are affecting other organ systems throughout your body. A detailed evaluation of your retina is essential as it can provide information related to the overall health of your entire body.

If you would like to have Digital Retinal Imaging performed during your exam today please indicate by marking below. There is an additional fee of $20 to perform this test to offset the cost of providing this technology in our office. The doctor will review the results of this test with you in detail. Depending upon what the tests reveal, the procedure may be covered by your medical insurance or Medicare. It is NOT a covered procedure for most vision plans (VSP, Eyemed, etc) and if it is not covered by your medical insurance then you will be responsible to pay for this test.

☐ **YES**, I would like to have *Digital Retinal Imaging* performed today.

☐ **NO**, I decline to undergo *Digital Retinal Imaging*

Insurance and Fees Agreement

By signing below you acknowledge that your insurance may only cover a portion or none of your fees. If your insurance company does not pay as expected, you agree to be responsible for all charges. The Pataskala Vision Center cannot be responsible if you are not eligible for benefits and any unpaid balances will be turned over to a collection agency after 90 days.

Signature: _____ Date: _____/_____/_____

Effective date of notice: 4-1-2015

The Pataskala Vision Center

180 E. Broad Street, Suite A Pataskala, OH 43062

Phone: 740-927-3061, Fax: 740-927-7042, Email:PataskalaVisionCenter@gmail.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESSTO 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.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record. You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).

Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting us at the number listed above. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting . We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to: 1) Share information with your family, close friends, or others involved in your care. 2) Share information in a disaster relief situation. 3) Include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission: 1) Marketing purposes. 2) Sale of your information. 3) Fundraising - We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways. 1) Treat you. We can use your health information and share it with other professionals who are treating you. 2) Run our organization. We can use and share your health information to run our practice, improve your care, and contact you when necessary. 3) Bill for your services. We can use and share your health information to bill and get payment from health plans or other entities.

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.
Help with public health and safety issues. We can share health information about you for certain situations such as: 1) Preventing disease. 2) Helping with product recalls. 3) Reporting adverse reactions to medications. 4) Reporting suspected abuse, neglect, or domestic violence. 5) Preventing or reducing a serious threat to anyone's health or safety.
Do research. We can use or share your information for health research.
Comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests. We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests. We can use or share health information about you: 1) For workers' compensation claims. 2) For law enforcement purposes or with a law enforcement official. 3) With health oversight agencies for activities authorized by law. 4) For special government functions such as military, national security, and presidential protective services.
Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

1) We are required by law to maintain the privacy and security of your protected health information. 2) We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 3) We must follow the duties and privacy practices described in this notice and give you a copy of it. 4) We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. 5) For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html. 6) Changes to the Terms of this Notice.

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office.

APPOINTMENT REMINDERS

We may call or write 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.

OUR NOTICE OF PRIVACY PRACTICES

By law, 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 one in our office and have copies available in our office.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax, or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of The Pataskala Vision Center's Notice of Privacy Practices.

Patient name_____

Signature_____ Date_____