

Anderson Hills
Eye Care & Optical

DAVID G. HOWARD, M.D.
REGISTRATION FORM

PATIENT INFORMATION

Mr. Ms. Mrs. Sex: Male Female
Patient Name _____ Date of Birth ____/____/____
Social Security ____/____/____ Marital Status: Single Married Separated Divorced Widowed
Home Address _____
City _____ State _____ Zip _____ Phone (____) _____
E mail _____ (optional)
Cell phone (____) _____

Employer _____ Phone (____) _____
Address _____
City _____ State _____ Zip _____
Employment Status (Circle One): Full-Time, Part-time, Not Employed, Self, Retired, Active Duty

Student Status (Circle One): Full-Time, Part-time

Family Physician _____ Referring Physician _____
Other Referral Source: Phone Book Friend Advertisement explain _____

Complete this section for either Spouse or Parent (if patient is a minor)

Name _____ Date of Birth ____/____/____
Employer _____ Phone (____) _____
Address _____
City _____ State _____ Zip _____

IN CASE OF EMERGENCY CALL

Name _____ Relationship _____ Phone (____) _____

INSURANCE INFORMATION

Please complete the following for the subscriber of each insurance plan for which you have coverage.

Primary Insurance _____
Subscriber's Name _____ Relationship _____
Date of Birth ____/____/____ Social Security ____/____/____ Sex ____
Employer of Subscriber _____
Address of Employer _____
City _____ State _____ Zip _____ Phone (____) _____

Secondary Insurance _____
Subscriber's Name _____ Relationship _____
Date of Birth ____/____/____ Social Security ____/____/____ Sex ____
Employer of Subscriber _____
Address of Employer _____
City _____ State _____ Zip _____ Phone (____) _____

Third Insurance _____
Subscriber's Name _____ Relationship _____
Date of Birth ____/____/____ Social Security ____/____/____ Sex ____
Employer of Subscriber _____
Address of Employer _____
City _____ State _____ Zip _____ Phone (____) _____

Work Related Injury Yes No

Workers Comp Paperwork Completed Yes No

Anderson Hills Eye, Inc. (Dr. David Howard) and Tri-State Centers for Sight Inc. (Drs. Schott, Sheppard, Spaulding) are independent health care providers.

Dr. Howard (Anderson Hills Eye Inc.) and/or Drs. Schott, Sheppard, Spaulding (Tri-State Centers for Sight Inc.) have my permission to review any or all of my medical records.

Signature of patient or Guardian

**ANDERSON HILLS EYE, INC.
FINANCIAL POLICY**

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Always bring your current health and vision plan card to the office. We cannot bill the charges to your insurance company without your card and therefore you would be responsible for the entire fee.
2. Please notify us at the time of check-in of any change in insurance, address, phone number, etc.
3. Please make sure prior to your visit that you have all referrals and/or preauthorization required by your insurance company for the visit.
4. **Payment is required at the time of service for copay, deductible, refraction fee, and/or any non-covered services. We accept cash, check/debit card, Visa/MC/Discover/American Express. If you are unable to pay at the time of service, payment arrangements can be made but there will be an additional \$20.00 fee to cover the costs of billing.**
5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered" you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
6. Keep in mind that your insurance policy is basically a contract between you and your insurance company. **We will file all insurance claims for you: however, the ultimate responsibility for payment is yours.**
7. Please make sure to verify with your insurance company the participation status of the physician you are seeing. We will not deny care to any patient due to uncertainty as to participation of our physician with your insurance plan. If our physician is not part of your plan, your portion of the fees will most likely be higher. **Ultimate responsibility for payment of fees is yours.**
8. *We request that you kindly give 24 hours' notice if you are unable to keep your appointment.*
9. **I understand that I am responsible to pay for all services not covered by insurance, including collection fees, attorney fees up to and including court costs in the event of default.**
10. Return check fee \$20.00.

Printed Name of Patient

Signature of Patient (or legal guardian)

Date

Witness (staff member)

Date

Anderson Hills

Eye Care & Optical

NOTICE OF USE OF PRIVATE HEALTH INFORMATION

Effective Date: April 14, 2003

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 Pledge

Anderson Hills Eye is an association of caring medical professionals dedicated to providing superior, comprehensive and cost effective eye care of the highest quality at our Centers of Excellence.

Your Health Information

An important part of our commitment to you is keeping your protected health information ("PHI") private in accordance with Federal and State Laws. We are required to provide you with a paper copy of this Notice of Privacy Practices ("Notice") should you desire which contains our privacy practices, our legal duties, and your rights concerning your PHI. We are also required to document your receipt of this notice after April 14, 2003.

Who Sees and Shares my Health Information?

Treatment Physicians, Nurses, Technicians, Assistants, and others involved in your medical care.

Payment Front Office Personnel, Managers, Billing Entry Personnel, Business Office Personnel, Collections Staff, and others involved in collecting payment for services rendered to you.

Health Care Operations Quality Assurance Audits, Reviews, Training Programs, Accreditation, Certification, Licensing, or Credentialing Activities among others to insure the quality of your health care.

May I see My Health Information?

You may see your health information, unless it is the private notes taken by a mental health provider or it is part of a legal case. Most of the time you can receive a copy if you ask. You may be charged a small amount for the copying costs.

If you think some information is wrong, you may ask in writing that it be changed or new information be added. You may ask that the changes or new information be sent to others who have received your health information from us. You may ask for a list of any of the places where health information may have been sent, unless it was sent for the treatment, payment, health care operations, or to make sure laws are being followed.

What if my Health Information Needs to go Somewhere Else?

You may be asked to sign a separate form, called an authorization form, allowing your health care information to go somewhere else if:

1. Your health care provider needs to send it to other places;
2. You want us to send it to another health care provider; or,
3. You want it sent to another person for you.

The authorization form tells us what, where and to whom the information must be sent. Your authorization is good until the date you put on the form. You may cancel or limit the amount of information sent at any time by letting us know in writing.

Note: If you are less than 18 years old, your parents or guardians will receive your private health information, unless by law you are able to consent for your own health care treatment. If you are, then your private health information will not be shared with parents or guardians unless you sign an authorization form. You may also ask to have your health information sent to a different person that is helping you with your health care.

Could my Health Information be Released Without my Authorization?

When private health information is released without Authorization, It is normally used to support **Treatment** or **Payment** or **Health Care Operations**. The release of health information for these purposes are not tracked or accountable to you, the patient (HIPAA rule 164.506). Any other release made without your authorization is tracked and is accountable. We always report:

1. Contagious diseases (as required by law), cancer;
2. Reactions and problems with medicine;

3. To the police when they are investigating a crime, when child or elder abuse may be happening, or when the court orders us to do so;
4. To the government to review how Anderson Hills Eye is performing;
5. Work related injuries to Workers Compensation;
6. To the Federal Government to when they are investigating something important to protect our country, the President and/or other government workers.
7. To employers relating to the medical surveillance of the workplace and work-related illnesses and injuries.

How Can I find out if my Health Information has been Released Without my Authorization?

To find out if your health information has been released without your authorization for purposes other than Treatment, Payment or Operations, you may call 513-388-4000 and ask for a Request for Accounting for Disclosures Form. Simply fill out the form and send it to:

HIPPA Contact Person
Anderson Hills Eye
7815 Beechmont Avenue
Cincinnati, OH 45255

How else can my Health Information be Used?

The staff of Anderson Hills Eye may use your health information to contact you to provide appointment reminders, collection of payment, describing or recommending treatment alternatives, or providing information about health related benefits and services that may be of interest to you. With your permission, or in some emergencies, we may disclose your health information to your family, friends, or other people to aid in your treatment or the collection of payment. A disclosure of your health information may also be made if we determine it is reasonable necessary or in your best interests for such purposes as allowing a person acting on your behalf to receive prescriptions, prescription eyewear, medical supplies, test results etc.

Questions or Complaints?

If you have any questions about this notice, or you think that we have not protected your private health information and you wish to complain about it, please contact either of the following:

HIPPA Contact Person
Anderson Hills Eye
7815 Beechmont Avenue
Cincinnati, OH 45255

OR

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, DC 20201-0004

or by calling the Office for Civil Rights at (800) 368-1019

What will Happen to my Medical Records/Medical Care with if I do File a Complaint?

Absolutely nothing. It is against the law for us to take any retaliatory or other negative action against you if you file a complaint.

Can This Notice Change?

Anderson Hills Eye reserves the right to update or change this Notice as Laws of our practice changes. If the Notice changes you will be notified as to how you can receive an updated copy.

Anderson Hills Eye Care & Optical

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

1. By signing below, I acknowledge that I have been given the opportunity to read and receive a copy of Anderson Hills Eye's Notice of Privacy Practices ("Notice").

Date: _____

Signature (Patient or Authorized Representative) _____

Printed (Patient or Authorized Representative) _____

FOR OFFICE USE:

If you are unsuccessful in obtaining a signature from the patient or authorized representative explain circumstances below.

_____ Signature Staff Member

_____ Date