Anderson & Chhabra EyeCare Center

WELCOME!

Please print and complete both sides of this form.

Today's Date:_____/_____/_____ (MM/DD/YYYY)

Patient's Last Name _____

First Name: _____MI:_____

Preferred Name: _____

Address: _____

Apt #: _____ City: _____

State: _____Zip Code: _____

Home Phone:_____

Daytime Phone:_____

Cell Phone: _____Text OK: Yes / No

Fax #: _____

E-mail:_____

Referred by: _____

Sex: M / F / Other

Patient's Date of Birth:____/____/_____ (MM/DD/YYYY)

Social Security #: _____

Status: Married / Single / Widowed / Divorced
Domestic Partnership / Other

Employment Status: Full Time / Part Time / Unemployed
Retired / Full-Time Student

Employer: _____

Occupation:_____

Driver's License #: _____

Preferred Language: ☐ English ☐ Spanish

Race: ☐ Native American Indian or Alaska Native ☐ Asian
☐ Black or African American ☐ Native Hawaiian/Other
☐ Pacific Islander ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Hawaiian / Other Pacific Islander

Communication Pref.: ☐ Email ☐ Postal ☐ Telephone

VISION Insurance: _____ ID #:_____

Policy Holder's First & Last Name: _____

Policy Holder's Date of Birth: _____ Relationship to Patient: _____

MEDICAL Insurance: _____ ID #:_____Group #: _____

Policy Holder's First & Last Name: _____ Circle one: HMO Plan / Not an HMO Plan

Policy Holder's Date of Birth: _____ Relationship to Patient: _____

Second/Supplemental Insurance: _____ ID #:_____Group #: _____

I CONFIRM THAT ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT

_____

Signature of Patient or Legal Representative Print Name of Patient or Legal Representative Date

PLEASE TURN PAGE OVER

FINANCIAL AGREEMENT

- I authorize Anderson & Chhabra EyeCare Center to release any information necessary to expedite insurance claims. I authorize use of signatures on this form for insurance claims submissions. I authorize payment directly to my doctor.
- As a courtesy, Anderson & Chhabra EyeCare Center will submit claims on my behalf to my Primary Insurance (provided the doctor has a contract with my insurance company).
- I understand that it is my responsibility as a patient to know and understand my insurance coverage. Anderson & Chhabra EyeCare Center will try to assist me in receiving maximum benefits from my insurance.
- In the event that my account becomes overdue, I agree to reimburse the fees of any collection agency, which may be based on a percentage of 32% of the debt, and all costs, expenses, including attorney's fees we incur in such collection efforts.
- I understand the fact that having insurance does not release me of my personal responsibility for payment. If I do not provide complete and correct insurance information at the time of service, it may not be possible to bill insurance at a later date and I will be responsible for payment. I understand I must pay for non-covered services, services deemed non-reimbursable by my insurance company, coinsurance and deductibles due for medical services.

Signature of Patient or Legal Representative Print Name of Patient or Legal Representative Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been provided a copy of the Notice of Privacy Practices for Anderson & Chhabra EyeCare Center. I hereby authorize as indicated by my signature below, this office to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose.

I authorize Anderson & Chhabra EyeCare Center to speak to the following family/persons about my Protected Health Information (PHI), exam results, billing and/or tests results:

1. _____
   Name Relationship

2. _____
   Name Relationship

3. _____
   Name Relationship

Signature of Patient or Legal Representative Print Name of Patient or Legal Representative Date

PATIENT HISTORY

Patient Name:_____ DOB:_____ Today's Date:_____

Family and Personal Eye History
Have you or a family member been diagnosed with any of the following? (Check all that apply.)

	Self	Which family members?
Blindness		
Cataracts		
Glaucoma		
Macular Degeneration		
Retinal Problems		
Corneal Problems		
Eye turns		
Keratoconus		
Double Vision		

Other Eye Problems:_____

Past Eye Surgeries (Dates/Doctor):_____

Family Medical History (Blood Relatives)
Have you or a family member been diagnosed with any of the following? (Check all that apply.)

	Y	Which Family Member
Lupus		
High Blood Pressure		
Diabetes		
Cancer		
Heart Disease		
Thyroid Disease		
Other		

Do you use: □ Tobacco □ Alcohol □ Other Substances □ None
Height: _____ Weight: _____

Primary Healthcare Provider
Name: _____
Phone: _____
Address: _____

Personal Medical History (Please check all that apply or circle none)

Allergies None To Drugs: Environmental:	**Cardiovascular** None ___ Elevated Cholesterol ___ High Blood Pressure ___ Heart Disease ___ Stroke ___ Other_____	**Constitutional** None ___ Blackouts/Fainting ___ Dizziness ___ Other _____	**Musculoskeletal** None ___ Rheumatoid Arthritis ___ Marfans Syndrome ___ Ankylosing Spondylitis ___ Other
Endocrine None ___ Diabetes ___ Hormonal Dysfunction ___ Hypoglycemia ___ Thyroid problem ___ Other_____	**GastroIntestinal** None ___ Hepatitis ___ Liver Disease ___ Other _____	**Genitourinary** None ___ Sexually Transmitted Disease ___ Other Are you pregnant or nursing? Y N	**Neurological** None ___ Bell's Palsy ___ Horner's Syndrome ___ Multiple Sclerosis ___ Other
Head None ___ Injury ___ Other	**Hematologic/Lymphatic** None ___ Anemia ___ Blood Clotting Disorder ___ Temporal Arteritis ___ Other_____	**Immunologic** None ___ Herpes Simplex ___ Herpes Zoster ___ Sarcoid ___ Other_____	**Psychiatric** None ___ Depression ___ ADHD ___ Other

Current Systemic Medications (Please include Dosage/Start Date)_____

Current Eye Medications (Please include Dosage/Start Date)_____

Doctor's Initial:_____

Anderson & ChhabraEyecare Center

719 W. Fletcher Avenue, Tampa, FL 33612

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION ("PHI") AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY.

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice.

USES AND DISCLOUSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your PHI are for treatment, payment or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your PHI from another professional that you have seen before us. Examples of how we use or disclose your PHI for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we must carry out in order to run our office. Examples of how we use or disclose your PHI for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans, defense of legal matters; and business planning.

OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT

In some limited situations, the law allows or requires us to use or disclosure your PHI without your consent or authorization. Some such uses or disclosures are:

- When state or federal law mandates that certain PHI be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the Federal Food and Drug Administration regarding drugs or medical devides;
- Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- Uses and disclosures for health oversight activities, such as for the licensing of doctors audits by Medicare of Medicaid; or for investigation of possible violations of health care laws;
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- Uses and disclosures to prevent a serious threat to health or safety;
- Disclosures relating to worker's compensation programs;
- Disclosures of a "limited data set" for research, public health; or health care operations;
- Disclosures to "business associates" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your PHI in accordance with HIPAA.

SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION

The following are some specific uses and disclosures we may not make of your PHI without your authorization:

Marketing Activities. We must obtain your authorization prior to using or disclosing any of your PHI for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party, your authorization must also include consent to such payment.

Sale of Health Information. We do not currently sell or plan to sell your PHI and we must seek your authorization prior to doing so.

Psychotherapy Notes. Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that individuals are not automatically entitled to have access to psychotherapy notes.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

- Other uses and disclosures of your PHI that are not described in this Notice will be made only with your written authorization.
- You may give us written authorization permitting us to use your PHI or to disclosure it to anyone for any purpose.
- We will obtain your written authorization for uses and disclosures of your PHI that are not identified in this Notice or are not otherwise permitted by applicable law.

PATIENT'S RIGHTS UNDER HIPAA

Updated information on the HIPAA Privacy Rule as of June 1, 2016

- Right to Access – The Privacy Rule requires our office to provide you with access to your PHI in the form and format requested, if readily producible in that form or format. You have a right to have PHI e-mailed to you. You have a right to direct PHI to 3rd party, the request must be in writing, signed by you and clearly identify the designated person. A flat fee of $6.50 is set for copying PHI, this fee may also include postage, labor and supplies.
- Requested Amendments to Protected Health Information – The Privacy Rule grants individuals the right o request amendments to their PHI.
- Right to Request Confidential Communications – HIPAA states that we must accommodate reasonable requests for alternative communications such as mailing to a P.O. Box or only calling the patient on their cell phone.
- Accounting Disclosures – Patients have the right to receive an Accounting Disclosures for the past 6 years
- Restrictions to PHI – Restrictions requests should be honored when possible, but are not required under HIPAA. Such requests must be in writing and documented.
- Right to Restrict Information to their Health Plan – When a patient has a service or procedure performed and pays out-of-pocket and in full, the patient can require that your office not disclose this information to their insurance carrier.
- Right to Receive Notice of Privacy Practices (NPP) Right to File a Privacy Complaint with Our office or the Office for Civil Rights.

Complaints:

If you think that we have not properly respected the privacy of your PHI, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for the Civil Rights. All complaints must be in writing. You will not be penalized for filing a complaint.

Changes To This Notice:

We reserve the right to change our privacy practices and to apply the revised practices to PHI about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copy of this Notice are also available upon request.

Notice Revised and Effective: June 1, 2016