All-Care Eye Clinic, PA

Patient Information

Patient Name: _____
Gender Male ☐ Female ☐
Birthdate: _____/_____/_____
Race/Ethnicity: _____
Social Security #: _____-_____-_____
Street Address: _____
City, State, Zip: _____
Home Phone: (_____)_____-_____
Cell Phone: (_____)_____-_____ OK to text? ☐
Email Address: _____
How would you like us to contact you? _____
Emergency Contact: _____ Ph: (_____)_____-_____
Employer/School: _____ Ph: (_____)_____-_____ OK to call? YES NO
Address: _____

Spouse Information

Name: _____
Birthdate: _____/_____/_____
Social Security # _____-_____-_____
Spouse's Employer: _____
Work Phone: (_____)_____-_____

Guarantor Information (Person responsible for Payment of Personal Balance)

☐ Check if Same as above.

Guarantor's Name: _____
Street Address: _____
City, State, Zip: _____
Home Phone: (_____)_____-_____
Relationship to Patient: _____

SS#_____-_____-_____
Birthdate: _____/_____/_____
Guarantor's Employer: _____
Work Phone: (_____)_____-_____

Insurance Information

Name of Medical Insurance:_____ ID#:_____
Name of Vision Insurance:_____ ID#:_____

Signature: _____ Date: _____/_____/_____

All Care Eye Clinic, PA — Adult Patient Information

Visual & Eye Health Information

Patient Name:_____

What is the main purpose of today's visit? Please check appropriate box.
Date:_____/_____/_____
□ regular vision/eye health examination
□ experiencing visual difficulties.
Please describe _____

_____

Do you presently wear glasses? Yes or No
If no, did you ever have glasses prescribed? Yes or No
Are you currently a contact lenses wearer? Yes or No □ contact lenses
If no, have you worn contacts previously? Yes or No □ laser vision correction
List any previous eye problems, injury or surgery _____

Do you use prescription or non-prescription eye drops / medication? Yes or No If yes, please list:
Do you have a history of "lazy eye"? Yes or No
Are you bothered by bright lights (sun, headlights, etc.)? Yes or No
When was your last eye exam? _____ By Whom? _____

Medical History

Specify Condition

Do you currently have any problems in the following areas? If yes, please list specific condition.

- Cardiovascular (High blood pressure, heart disease, high cholesterol) Yes or No
- Pulmonary (asthma, bronchitis, emphysema) Yes or No
- Endocrine (diabetes, thyroid) Yes or No
- Ear, nose, mouth, throat (allergies, sinus problems) Yes or No
- Muscle, bones, and joints (arthritis, lupus, osteoporosis) Yes or No
- Skin (psoriasis, skin cancer) Yes or No
- Neurologic (migraine headaches, seizure, stroke) Yes or No
- Gastrointestinal (ulcer, colitis) Yes or No
- Genitourinary (kidney, prostate) Yes or No
- Hematology (anemia, bleeding tendency) Yes or No
- Psychiatric (anxiety, depression) Yes or No

List prescription and non-prescription medications you take and dosages: _____

_____

Are you allergic to any medications? Yes or No If yes, please list: _____
Name of family physician: _____ Pharmacy: _____
Are you/could you be pregnant at this time? Yes or No

Family History

Has anyone in your family had any eye diseases? Yes or No
(Glaucoma, retinal degeneration, night blindness, retinal detachment, crossed eyes, etc.)
If yes, name the problem and the family relationship to you: _____
List any medical conditions that tend to run in your family: _____

Social History

Do you use a computer? Yes or No How many hours per day? _____
List your recreational activities: _____ What is your occupation? _____
Do you drink alcohol? Yes or No Do you use tobacco? Yes or No Do you drive? Yes or No
Do you use recreational or illegal drugs? Yes or No

I. AGREEMENT OF FINANCIAL RESPONSIBILITY

ACEC will file claims with your primary insurance provider for services provided to patients with managed care organizations in which we participate. Co-payments, co-insurance, non-covered services and deductibles are the responsibility of the patient and payable at the time of services. Managed care patients are billed for any remaining patient responsibility after claims have been processed by the insurance company. Proof of insurance is not a guarantee of payment. Patients without insurance or covered under any insurance plan of which we are not contracted, are financially responsible for all charges incurred at the time of services. In the event that payment for a service performed is denied by the insurance carrier, the patient is responsible for payment for all services. It is the patient's responsibility to pursue action with the insurance carrier as the policy is a legal contract between the patient and the insurance carrier. It is also the responsibility of the patient to be aware of plan benefits and their right to appeal claims. Insurance contracts are subject to change. Provider directories produced by Managed care plans may not provide the most current information regarding plan participation and therefore are not a guarantee of our participation. Patients must verify plan participation with our office.

The maximum fee allowed by law will be charged for returned checks. A fee will be accessed for all after hour phone calls requiring medical advice, placed after regular office hours. Accounts are considered past due 60 days from the date a service is billed.

I, _____, **(Patient's Name/Parent)** request release of payment information to ACEC by third party payers when required by coordination of benefits. Furthermore, I irrevocably assign any benefits available to me to ACEC and I authorize payment of those benefits directly to that provider.

Signature of Parent/Patient:

_____ **Date:** _____

II. ACCEPTANCE OF FINANCIAL TERMS

By signing this agreement, I accept the financial terms noted above and certify that the information contained on this form is true and correct. Furthermore, I understand it is my responsibility to present ACEC with valid insurance information at the time of each visit and inform ACEC should any information on this form change at any time in the future. I also assume financial responsibility for any and all healthcare services provided to the patient(s).

Signature of Parent/Patient:

_____ **Date**: _____

All Care Eye Clinic
NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY. Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained, or transmitted by us while providing health care items or services to you (referred to as "health information" in this Notice).

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. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information 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 health information from another professional that you may have seen before us. Examples of how we use or disclose your health information 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 health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

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 disclose your health information without your consent or authorization. Not all these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information 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 devices;
- 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; for audits by Medicare or
- 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;

- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected
- to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened
- somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral
- directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high
- ranking government officials; for lawful national intelligence activities; for military purposes; or for the
- evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- 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 or disclosures;
- disclosures to "business associates" and their subcontractors who perform health care operations for us and who
- commit to respect the privacy of your health information in accordance with HIPAA;
- [specify other uses and disclosures affected by state law].

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for health care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION

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

Marketing activities. We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals 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 health information 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 we generally must obtain your authorization prior to using or disclosing any such notes.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

- Other uses and disclosures of your health information 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 health information or to disclose it to anyone for any purpose.
- We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.
- We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right:

- **To request restrictions on the health information we may use and disclose for treatment, payment, and health care operations.** We are not required to agree to these requests. To request restrictions, please send a written request to us at the address below.
- **To receive confidential communications of health information about you in any manner other than described in our authorization request form.** You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.
- **To inspect or copy your health information**. You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.
- **To amend health information.** If you feel that health information, we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:
    - was not created by us, unless the person that created the information is no longer available to make the amendment,
    - is not part of the health information kept by or for us,
    - is not part of the information you would be permitted to inspect or copy, or
    - is accurate and complete.
- **To receive an accounting of disclosures of your health information**. You must make such requests in writing to the address below. Not all health information is subject to this

request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).

- **To designate another party to receive your health information**. If your request for access of your health information directs us to transmit a copy of the health information directly to another person, the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

Contact Persons:

Our contact people for all questions, requests or for further information related to the privacy of your health information are:

Rocio Rosales: rocio@allcareeye.com (214)239-2176

Cristian Aguilar: cristian@allcareeye.com (214)353-3398

Complaints:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to 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 E mail shown above. If you prefer, you can discuss your complaint in person or by phone.

Secretary of Human and Health Services
1-800-709-9858 or hfc.complaints@hhs.texas.gov

Changes to This Notice:

We reserve the right to change our privacy practices and to apply the revised practices to health information 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. Copies of this Notice are also available upon request at our reception area.

Notice Revised and Effective: November 3, 2021

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY

I acknowledge that I received a copy of All Care Eye Clinic's, Notice of Privacy Practices.

Date _____ Patient name_____

Signature _____

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for All Care Eye Clinic to share my protected health information with anyone listed below.

Name_____**Relationship**_____

Name_____**Repationship**_____

Name_____**Relationship**_____