Canyon Eye Associates

Dear Patient,

Welcome to Canyon Eye Associates. We look forward to seeing you for your upcoming appointment.

We understand that your time is valuable. Please be aware that visits in our office can be lengthy and may take up to two or more hours, depending on the testing and care needed for your condition. We make every effort to complete any necessary testing efficiently and have you seen by the provider as quickly as possible.

You have been scheduled for an appointment with Dr. _____ on _____ at _____**.**

Our office is located at:

Canyon Eye Associates
245 Taylor Station Road
Columbus, OH 43213

During your visit, your eyes may be fully dilated to allow for a complete eye examination. Dilation may last approximately 2–5 hours after your appointment, and the effects may last longer in patients with light-colored eyes. After your visit, we will provide post-dilation glasses unless you have your own sunglasses to wear.

Please bring the following items with you to each visit:

- Your driver's license or photo ID
- Your current health insurance card/cards
- Your prescription glasses, if applicable
- A current list of your medications
- Your copay, which is due at the time of service

Please review and complete the attached forms prior to your appointment. We will also need the name of your primary care physician, the name of the person or physician who referred you, and the names of any other doctors who may need to receive reports from your visit.

If you are unable to keep your appointment, please notify our office at least 24 hours in advance.

Please reference our Late Cancellation and No-Show Policy.

We strive to make your visit to our office as pleasant and comfortable as possible. Please let us know if there is anything we can do to better assist you during your visit.

Thank you so much. We look forward to taking care of you and your vision.

The Physicians and Staff of Canyon Eye Associates

Canyon Eye Associates

PATIENT DEMOGRAPHICS

NAME: _____ **SEX**: **M** **F** **DATE OF BIRTH**: ____/____/____

ADDRESS: _____
STREET *CITY* *STATE* *ZIP*

Social Security #: _____ **RACE:** _____ **LANGUAGE:** _____

HOME PHONE: (___) ___-____ **CELL PHONE:** (___) ___-____ **EMAIL**: _____

PREFERRED CONTACT METHOD: ☐MAIL ☐PHONE ☐EMAIL ☐TEXT

MARITAL STATUS: ☐Married ☐Single ☐Divorced ☐Widow

LAST EYE EXAM: _____ **DO YOU WEAR GLASSES OR CONTACTS?** ☐**YES** ☐**NO** ☐**BOTH**

ARE YOU CURRENTLY IN A SKILLED NURSING FACILITY? _____ IF SO, WHERE: _____

ARE YOU CURRENTLY RECEIVING HOSPICE CARE? ☐**YES** ☐**NO**

How did you hear about us? ☐ Family/Friend ☐ Referral ☐ Insurance Directory ☐ Google ☐ Social Media ☐ Website ☐ Other: _____

PHARMACY: _____ **PHONE**: _____

PRIMARY PHYSICIAN: _____ **PHONE**: _____

REFERRING PHYSICIAN: _____ **PHONE:** _____

EMERGENCY / HIPAA CONTACT:

NAME: _____ RELATIONSHIP: _____ PHONE: _____

MAY WE DISCUSS YOUR MEDICAL OR BILLING INFORMATION WITH ANOTHER INDIVIDUAL? ☐**YES** ☐**NO**

AUTHORIZED PERSON: _____ RELATIONSHIP _____ PHONE: _____

INSURANCE INFORMATION: ***Please present your insurance card to the receptionist at each visit.***

PRIMARY INSURANCE: _____ POLICY/ID: _____

GROUP #: _____ EFFECTIVE DATE: _____

POLICY HOLDER: _____ DOB: ____/____/____ SS# _____

RELATIONSHIP TO PATIENT: ☐SELF ☐SPOUSE ☐OTHER: _____

SECONDARY INSURANCE: _____ POLICY/ID: _____

GROUP #: _____ EFFECTIVE DATE: _____

POLICY HOLDER: _____ DOB: ____/____/____ SS# _____

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ OTHER: _____

VISION INSURANCE: _____ POLICY/ID: _____

GROUP #: _____ EFFECTIVE DATE: _____

POLICY HOLDER: _____ DOB: ____/____/____ SS# _____

RELATIONSHIP TO PATIENT: ☐ SELF ☐ SPOUSE ☐ OTHER: _____

Canyon Eye Associates

Patient Acknowledgments & Consents

Assignment of Benefits
I authorize payment of medical and/or vision insurance benefits directly to Canyon Eye Associates for services rendered. ____

Financial Responsibility
I understand that I am financially responsible for any charges not covered or paid by my insurance company, including copays, deductibles, coinsurance, non-covered services, and services determined not medically necessary by my insurance carrier. ____

I understand it is my responsibility to provide current insurance information and notify the office of any demographic or insurance changes. ____

No-Show, Late Cancellation, and Late Arrival Acknowledgment
I acknowledge that Canyon Eye Associates requires at least 24 hours' notice when cancelling or rescheduling an appointment. Patients who arrive 10 minutes or more after their scheduled appointment time may need to be rescheduled. I understand that repeated no-shows or late cancellations may result in a $35 fee and possible dismissal from the practice at the physician's discretion.____

Communication Consent
I consent to receive appointment reminders, statements, and communications from the office by phone, voicemail, text message, and/or email. Standard messaging and data rates may apply.

I understand that certain methods of communication, including email and text message, may not be fully secure. I authorize Canyon Eye Associates to contact me using the method selected above unless I notify the practice otherwise in writing.____

Consent to Treat
I voluntarily consent to examination, testing, and treatment by the physicians and clinical staff of Canyon Eye Associates as deemed necessary for my care. ____

HIPAA Notice of Privacy Practices Acknowledgment
I acknowledge that I have been offered and/or provided access to Canyon Eye Associates' Notice of Privacy Practices, which explains how my health information may be used and disclosed and how I may access this information. ____

I certify that the information provided above is accurate and complete to the best of my knowledge.

Patient/Guardian Signature: _____ **Date:** _____

Canyon Eye Associates

Medical & Social History

Patient Name: _____ **DOB:** _____

Medical History

Medical Conditions *Please check any conditions you currently have or have had*

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Thyroid Disease
- ☐ Asthma/COPD
- ☐ Kidney Disease
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Arthritis
- ☐ Cancer
- ☐ Other: _____

Ocular/Eye History

- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Dry Eye
- ☐ Eye Injury
- ☐ Other: _____
- ☐ Glaucoma
- ☐ Diabetic Eye Disease
- ☐ Retinal Tear/Detachment
- ☐ Eye Infection

Family History *Please check any family history of the following and the relationship of family member*

- ☐ Glaucoma _____
- ☐ Diabetes _____
- ☐ Macular Degeneration _____
- ☐ Blindness _____
- ☐ Other: _____

Surgical History *Please list any surgeries, including eye surgeries*

_____ _____
_____ _____
_____ _____
_____ _____

Current Medications *Please list medication name, dosage, and how often taken*

_____ _____
_____ _____
_____ _____
_____ _____

Canyon Eye Associates

Patient Name: _____ **DOB:** _____

Social History *Do you currently or have you previously used any of the following:*

Tobacco Use:

☐ Never Smoked ☐ Former Smoker
☐ Current Every Day Smoker ☐ Smokeless Tabacco User

If former or current smoker, how many packs per day? _____

How many years? _____

If former smoker, when did you quit? _____

Alcohol Use:

☐ None ☐ Occasional ☐ Social ☐ Daily How many drinks per Day / Month / Year _____

Recreational Drug use:

☐ Never ☐ Former ☐ Current If former/current, Type/Frequency _____

Living Situation:

☐ Alone ☐ Spouse/Partner ☐ Assisted Living ☐ Nursing Home

Fall Risk:

Do you have difficulty walking or climbing stairs? ☐Yes ☐No

Have you fallen in the past month? ☐Yes ☐No Number of falls _____

Have you fallen in the past year? ☐Yes ☐No Number of falls _____

Canyon Eye Associates

Patient Financial Policy

Thank you for choosing Canyon Eye Associates for your eye care needs. This policy explains our financial expectations, insurance billing procedures, and patient responsibilities.

Insurance Information & Eligibility

Patients are responsible for providing current and accurate demographic and insurance information at every visit, including insurance cards, identification, address, telephone number, and email address.

As a courtesy, Canyon Eye Associates will attempt to verify insurance eligibility and benefits prior to your appointment; however, verification of benefits is not a guarantee of coverage or payment by your insurance carrier. Patients are responsible for understanding their insurance plan benefits, referral requirements, prior authorization requirements, deductibles, copayments, coinsurance amounts, and coverage limitations.

If current insurance information is not provided at the time of service, patients may be required to pay in full until valid insurance information is received and claims can be processed. Failure to obtain required referrals or authorizations may also result in patient responsibility for services rendered.

Assignment of Benefits & Authorization to Bill Insurance

I authorize Canyon Eye Associates to release medical and billing information necessary to process insurance claims and secure payment for services rendered. I assign all insurance benefits otherwise payable to me directly to Canyon Eye Associates.

I authorize the use of my signature on all insurance submissions and understand this authorization remains valid until rescinded in writing.

Patient Financial Responsibility

I understand that I am financially responsible for all charges related to services provided by Canyon Eye Associates, including copayments, deductibles, coinsurance, non-covered services, self-pay balances, outstanding balances, and services denied by insurance carriers.

Payment is due at the time of service unless prior payment arrangements have been approved. Patients without active insurance coverage are considered self-pay and are responsible for payment in full at the time services are rendered unless prior arrangements have been made. Balances remaining after insurance processing become the patient's responsibility.

Refraction & Vision Services

Refraction services are generally considered non-covered by most medical insurance plans and are the patient's responsibility. A separate Refraction Consent form outlining refraction fees, coverage information, and patient responsibility is provided and maintained on file.

Canyon Eye Associates accepts VSP and EyeMed vision plans. Patients wishing to utilize vision insurance benefits for routine vision services must notify the office prior to the appointment so scheduling can be coordinated appropriately. Contact lens fitting fees are separate from routine eye examinations and refractions.

Surgery & Procedure Financial Policies

Patients undergoing surgical, elective, or non-covered procedures may have financial responsibility including deductibles, coinsurance, premium lens upgrades, elective services, and other non-covered charges.

Insurance coverage and benefits are determined by the patient's insurance carrier and are not guaranteed by Canyon Eye Associates. Patients are financially responsible for any balance determined by their insurance plan.

Payment Plans

Payment plans may be available for eligible balances. Payment arrangements generally require a minimum down payment of 30% and scheduled monthly payments until the balance is paid in full.

Failure to maintain agreed-upon payment arrangements may result in account default and referral to collections. Balances exceeding office thresholds may require payment arrangements prior to scheduling future non-emergent appointments.

Canyon Eye Associates

Collections Policy

Patients are expected to maintain current accounts. Statements are issued for outstanding balances. Failure to respond to billing statements or maintain payment arrangements may result in additional collection efforts, including referral to a third-party collection agency.

Patients may be responsible for collection fees or costs permitted by applicable law.

Returned Check Policy

A $35 returned check fee will be applied to any check returned by the bank for insufficient funds or other reasons.

Credit Card Surcharge Policy

A credit card surcharge, not to exceed 2.99%, is applied to applicable credit card transactions for both Canyon Eye Associates and Canyon Eye Optical. This surcharge is disclosed through posted signage within our office and does not exceed our cost of acceptance. Debit card transactions are not subject to this surcharge.

Missed Appointment & Cancellation Policy

We respectfully request adequate notice for appointment cancellations. A second no-show or late cancellation may result in a **$30** fee.

A third consecutive no-show or late cancellation may result in dismissal from the practice. Patients dismissed from the practice will receive written notice and emergency care for thirty (30) days from the date of notification in accordance with applicable standards.

Optical Policies

All optical sales are final due to the custom nature of eyewear products. Exceptions may be made for prescription errors or manufacturing defects.

Remakes may be offered when appropriate and in accordance with Canyon Eye Optical policies. Frame and lens warranties may vary by manufacturer and product.

Contact Lens Policies

Contact lens fitting fees are separate from routine examinations and include evaluation, fitting, and follow-up care related to contact lens wear.

Contact lenses are not returnable. A valid contact lens prescription is required for all contact lens orders.

Medical Records & Forms

Certain administrative forms and requests may be subject to processing fees, including disability forms, FMLA paperwork, attorney requests, and special medical forms.

Medical record requests are processed in accordance with applicable state and federal laws.

Acknowledgment of Financial Policy

By signing below, I acknowledge that I have read, understand, and agree to the Financial Policy of Canyon Eye Associates. I understand that I am financially responsible for all charges not paid by my insurance carrier.

If the patient is a minor or unable to enter into a financial agreement, the undersigned responsible party accepts financial responsibility for all charges incurred.

Patient Name	Date of Birth	
Patient / Responsible Party Signature	Relationship to Patient	Date

Canyon Eye Associates

NOTICE OF PRIVACY PRACTICES

Effective Date: January 1, 2025 | This notice describes how medical information about you may be used and disclosed.

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.

We are required by law to maintain the privacy of your protected health information (PHI), to provide you with notice of our legal duties and privacy practices, and to abide by the terms of this notice. We will notify you of any breach that may have compromised the privacy or security of your information.

What Is Protected Health Information (PHI)?

Protected Health Information (PHI) is information about you — including demographic data — that may identify you and that relates to your past, present, or future physical or mental health, the provision of health care to you, or payment for that health care.

How We May Use and Disclose Your PHI

Treatment

We may use and disclose your PHI to provide, coordinate, or manage your health care and related services. For example, your health information may be shared with other health care professionals who are involved in your care, such as specialists, laboratories, or hospitals.

Payment

We may use and disclose your PHI to obtain payment for services we provide to you. For example, we may share your health information with your health insurance plan so that it can pay for your care. If you pay for a service or health care item out-of-pocket in full, you may request that we not share that information with your insurer for payment or operations purposes.

Health Care Operations

We may use and disclose your PHI for our internal health care operations, including quality assessment and improvement activities, employee training, licensing, and business management. We may share your PHI with third-party 'business associates' (such as billing companies or transcription services) under written agreements that require them to protect the privacy of your information.

Other Permitted Uses and Disclosures Without Your Authorization

We may use or disclose your PHI without your written authorization in the following circumstances, as required or permitted by law:

- Required by Law: To comply with applicable federal, state, or local law.
- Public Health Activities: To public health authorities to prevent or control disease, injury, or disability.
- Communicable Diseases: To persons who may have been exposed to a communicable disease, if authorized by law.
- Health Oversight Activities: To government agencies for audits, investigations, and inspections.
- Abuse or Neglect: To authorities authorized to receive reports of child or adult abuse, neglect, or domestic violence.
- Food and Drug Administration (FDA): For reporting adverse events, product defects, recalls, or other FDA-regulated activities.
- Legal Proceedings: In the course of judicial or administrative proceedings, in response to a court order, subpoena, or other lawful process.

- Law Enforcement: To law enforcement officials for lawful purposes, including identifying or locating suspects or victims of a crime.
- Coroners, Medical Examiners & Funeral Directors: As necessary to carry out their lawful duties.
- Organ Donation: For cadaveric organ, eye, or tissue donation purposes.
- Serious Threats to Health or Safety: To prevent or lessen a serious and imminent threat to a person or the public.
- Military & National Security: For activities deemed necessary by authorized military command or federal intelligence authorities.
- Workers' Compensation: To comply with workers' compensation laws and similar programs.
- Inmates: If you are an inmate of a correctional facility, to the facility as needed for your care and safety.

Uses and Disclosures Requiring Your Written Authorization

All other uses and disclosures of your PHI not covered by this notice — or not otherwise permitted or required by law — will be made only with your written authorization. You may revoke your authorization at any time in writing. Revocation does not apply to disclosures already made in reliance on your prior authorization.

The following require your written authorization:

- Uses and disclosures of PHI for marketing purposes
- Sale of your PHI
- Most uses and disclosures of psychotherapy notes

Your Rights Regarding Your PHI

You have the following rights with respect to your protected health information:

Right to Request Restrictions

You may request restrictions on how we use or disclose your PHI for treatment, payment, or health care operations. We are not required to agree to most restrictions, but if we agree, we are bound by that agreement. However, we must agree to restrict disclosure to a health plan for services you paid for entirely out of pocket.

Right to Confidential Communications

You may request that we communicate with you about your PHI in a specific way or at a specific location (for example, by phone only, or at a different address). We will accommodate reasonable requests.

Right to Access and Copy Your PHI

You have the right to inspect and obtain a copy of your PHI that we maintain. We may charge a reasonable, cost-based fee. Some types of records may be restricted under state or federal law. Please contact our Privacy Officer for details.

Right to Amend Your PHI

If you believe your PHI is incorrect or incomplete, you may request that we amend it. We may deny your request under certain circumstances.

Right to an Accounting of Disclosures

You may request a list of instances in which we have disclosed your PHI for purposes other than treatment, payment, health care operations, or disclosures you authorized.

Right to a Paper Copy of This Notice

You may request a paper copy of this notice at any time, even if you have agreed to receive it electronically.

Our Duties

We are required by law to maintain the privacy of your PHI, to provide you with this notice of our privacy practices, and to abide by the terms of this notice currently in effect.

Right to Revise This Notice

We reserve the right to change this notice and to make the revised notice effective for PHI we already have as well as any information we receive in the future. We will post the current notice in our office and on our website. You may request a copy of the current notice at any time.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you for filing a complaint.

To file a complaint with us, contact our Privacy Officer:

Privacy Officer Contact

Canyon Eye Associates, Inc.
Attn: Privacy Officer
245 Taylor Station Road
Columbus, OH 43213
Phone: (614)866-9134

Canyon Eye Associates

ACKNOWLEDGEMENT OF RECEIPT — PLEASE SIGN AND RETURN THIS PAGE

Patient Name:

Patient Name (Print) *Date Of Birth*

Date

Please select one of the following:

☐ I acknowledge that I have received a copy of [Practice Name]'s Notice of Privacy Practices.

☐ I acknowledge that I was offered a copy of [Practice Name]'s Notice of Privacy Practices but declined to receive it.

Patient or Authorized Representative Signature *Date*

Relationship to Patient (if Representative) *Date*

For Office Use Only

The patient: ☐ Accepted ☐ Declined the Notice and refused to sign.

Reason (if declined): _____

Practice Representative Signature / Name *Date*