Canyon Eye
Associates

WELCOME TO THE PRACTICE

Dear Patient,

Welcome to Canyon Eye Associates. Your time is very valuable to us, we understand that our visits are long, your visits with us may take up to 2+ hours. We make every effort to efficiently complete any testing that you may require for your condition and get 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 245 Taylor Station Rd. Columbus, OH 43213.

Your eyes will be fully dilated to ensure a complete eye exam, and may be dilated for 2-5 hours afterward. The effects tend to last longer in patients with light colored eyes. After your visit we will provide you with post dilation glasses unless you have your own sunglasses to wear.

Please bring the following with you to each visit:

- Your Drivers' License or Photo ID
- Your current health insurance cards
- Your prescription glasses (if applicable)
- A current list of your medications
- Your copay is required at the time of visit

Please review and fill out the attached forms, please do not hesitate to ask any questions. We will also need to know who your primary care physician is, who referred you (physician or patient) or any other doctors that may need reports.

Please notify our office at least 24 hours in advance if for any reason you cannot keep your appointment.
****Please reference our Late Cancellation and No-Show Policy*

We strive to make your visit to our office as enjoyable as possible. Please let us know if there is anything we can do to make your visit more pleasant.

Thank you so much, we look forward to taking care of you and your vision!

The Physicians and Staff of Canyon Eye Associates, Inc.

Canyon Eye Associates

PATIENT INFORMATION

NAME: ______________________________ **SEX**: **M** **F**

ADDRESS: ______________________________
STREET CITY STATE ZIP

DATE OF BIRTH: ____/____/______ **MARITAL STATUS**: Married Single Divorced Widow

Social Security #: ______________ **RACE**: __________ **LANGUAGE**: __________

HOME PHONE: ( ) - **CELL PHONE**: ( ) - **EMAIL**: __________

OCCUPATION: __________ **EMPLOYER**: __________ PHONE: ( ) -

PHARMACY: ______________________ **PHONE**: __________

PRIMARY PHYSICIAN: ______________________ **PHONE**: __________

REFERRING PHYSICIAN: ______________________ **PHONE**: __________

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

PATIENT CONTACTS:

EMERGENCY: ______________ RELATIONSHIP: __________ PHONE: __________

NAME: ______________ 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

Insurance Eligibility and Guarantee of Payment:

I understand that it is my responsibility to provide the practice with current and accurate information to include my insurance information, address, telephone number, and email. _______

We ask that your insurance card be present at every visit, as a courtesy, we will attempt to verify your insurance eligibility, but this does not guarantee coverage. If your card is not available, you must provide the policy/member ID number, group number, claim mailing address, provider services phone number and verify coverage is active otherwise you may be held responsible for all cost incurred for services provided until your current insurance is obtained and/or provided to us. I accept responsibility for knowing and understanding my insurance carrier(s) plan coverage______

I certify that I (or my dependent) have insurance coverage with ________________________. I assign directly to Canyon Eye Associates, Inc., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges incurred for services rendered if not covered in full by my insurance or due to invalid insurance information. I hereby authorize the practice to release all information necessary to secure payment of benefits. I authorize the use of the signature on all insurance submissions. ______

My signature indicates that I understand this authorization is valid until rescinded in writing or replaced by one at a later date.

Signature: ____ Date: _________________________

Self-Pay Patients:

If you are a patient with no vision or medical insurance, it is our office policy that payment is due at the time services are rendered unless a prior payment arrangement has been made in advance of your appointment.

I understand that I am financially responsible for payment of all charges incurred for services received from the physician practice.

Signature: ____ Date: _________________________

Notice of Refraction Fee:

Refraction is the test the doctor or technician will perform to determine if you need a new prescription for corrective lenses and is not considered part of your routine medical eye exam. This test is <u>NOT COVERED</u> by most health insurance plans. If you decide to get a refraction done at your visit, you will be responsible for the refraction fee of **$60.00**. This is in addition to the co-pay and will be collected at the time of service.

We do accept VSP and EyeMed vision plans. If you have one of these vision plans and want to use it, you must tell us when making the appointment. If you are seen and have not informed us of these plans until after the appointment, you will still be responsible for the refraction fee

Signature: ____ Date: _________________________

CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your healthcare information. Our Notice of Privacy Practices provides a detailed explanation of how we may disclose your protected health information for the purposes of treatment, payment, and health care operations.

I AUTHORIZE THE USE OF DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED BELOW:

Consent for Treatment

I hereby give consent to Canyon Eye Associates (a division of The Eye Physicians, LLC) to use and disclose my protected health information for the purpose of treatment. The medical care may include services and supplies related to my health care and may include, but not limited to, preventive, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment of physical or mental status, dispensing of drugs required and in accordance with prescription. This includes any verbal contact with other healthcare professionals. _____

Consent for release of information for payment and operations

I authorize Canyon Eye Associates (a division of The Eye Physicians, LLC) to provide information to the identified insurance carrier(s) to secure payment of services. I also consent to the use for any practice operational needs as identified in the privacy notices. I understand that Canyon Eye Associates may bill me if such information cannot be obtained and/or my insurance company denies my claim for services because protected health information could not be obtained ______

Consent related to Privacy Notice:

I have reviewed the privacy notice as part of this registration process. I understand that the terms of the privacy notice may change, and I may obtain these revised notices by contacting the practice by phone or writing. I understand my rights for disclosure of the protected health information (PHI). _________

OTHER INFORMATION COVERED BY THIS AUTHORIZATION:

1. How do you prefer to be contacted: ☐ Mail ☐ eMail ☐ Phone ☐ Text
2. Are we permitted to give medical information regarding your healthcare services and any billing issues to family or other parties? ☐ YES ☐ NO

   If YES, please list names here:

   Name: ___________________________________ Relationship: ____________________

   Name: ___________________________________ Relationship: ____________________

Expiration: This authorization is effective for one year through the date signed below unless terminated by the patient or their representative.

Revocation:

I understand that I must sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Canyon Eye Associates nor will it affect my eligibility for benefits. I understand that I have a right to inspect and copy my own protected health information to be used and disclosed in accordance with the requirements of the Federal Privacy Protection regulations found under 45CFD-164-524

My signature indicates that I acknowledge and agree that Canyon Eye Associates may use and disclose my personal health information for the purpose of carrying out treatment, payment, and healthcare operations for me, or on my behalf.

____
Printed Name

____ Date: _________________
Signature

Notice of Privacy Practices

Policy Effective January 1, 2025

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. PHI is information about you, including demographic information, which may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required by law to maintain the privacy of your PHI and to provide you with this Notice of Privacy Practices informing you of our legal duties and our privacy practices regarding your PHI. We are required to abide by the terms of our Notice of Privacy Practices. We will notify you if a breach occurs that may have compromised the privacy or security of your information.

Uses and Disclosures

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our offices who are involved in your care and treatment for the purpose of providing health care services to you.

The following are examples of the types of uses and disclosures of your protected health information that your physician's office is allowed to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment Your health information may be used by Canyon Eye Associates and the staff members, or your information may be disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment Canyon Eye Associates may use your health information to seek payment from your health Insurance plans, or for other sources of coverage, for example: workers' compensation, automobile insurers, and any third-party liability coverage. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated, which we are required to provide in order to obtain payment for services. 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.

NOTICE: If Canyon Eye Associates cannot obtain needed documentation from you, a treating physician, lab, or hospital to obtain payment from your insurance carrier we will request payment from you.

Healthcare Operations Canyon Eye Associates may use your health information as necessary to support the day-to-day operations, activities, and management of Canyon Eye Associates. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information; to the extent that the, use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility, and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Canyon Eye Associates

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise allowed or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Appointment reminders, billing, and collection notices: Your information will be used to send you appointment reminders, billing statements, and collection notices.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information. As allowed by state and federal law, we may charge you a reasonable copy fee for your records. Federal law restricts the inspection and copying of certain types of records. Please contact our Privacy Office for these restrictions.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Canyon Eye Associates - Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required by law to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices.

You may contact our Privacy Officer to submit a concern about our privacy practices by sending a letter to:

Privacy & Security
245 Taylor Station Rd.
Columbus, OH 43213

Acknowledgement of Receipt of Notice of Privacy Practices

Patient: ______________________________ DOB: ____________________

☐ I acknowledge that I have received a copy of Canyon Eye Associates Notice of Privacy Practices.
☐ I acknowledge I was offered a copy of Canyon Eye Associates Notice of Privacy Practices but declined it.

______________________________ ____________________
Representative Date

______________________________ ____________________
Patient or Representatives Signature Date

Canyon Eye Associates provided a copy of this Notice of Privacy Practices to this patient and to obtain his/her acknowledgement of the same. The Patient: ☐ Accepted ☐ Declined the Notice and refused to sign.

Reason: ____

______________________________ ____________________
Canyon Eye Associate Date

Please sign and return this page