

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.

What is this Notice and Why Is It Important?

By law, Riverside Eye Center, P.C. must protect the privacy of your identifiable medical and other health information ("health information").

We are also required by law to give you this notice to tell you how we may use and give out ("disclose") your health information. This notice is effective as of July 1, 2013.

How Riverside Eye Center, P.C. May Use Your Health Information

As a general rule, you must give written permission before your health information can be used or released. There are certain situations where we are not required to obtain your permission. This section explains those situations where your health information may be used or disclosed without permission. Records may also be disclosed electronically as necessary.

Except with respect to Highly Confidential Information (described below), "Riverside" is permitted to use your health information for the following purposes:

• **Treatment:** We use and disclose your health information to provide you with medical treatment or services. This includes uses and disclosures to:

- treat your illness or injury, including disclosures to other doctors, practitioners, nurses, technicians or medical personnel involved in your treatment, or
- contact you to provide appointment reminders, or
- give you information about treatment options or other health related benefits and services that may interest you.

• **Payment:** We may use and disclose your health information to obtain payment for health care services that we or others provide to you. This includes uses and disclosures to:

- *submit health information and receive payment from your health insurer, HMO, or other company that pays the cost of some or all of your health care (payer), or*
- *verify that your payer will pay for your health care.*

• **Health Care Operations:** We may use and disclose your health information for our health care operations, such as internal administration and planning that improve the quality and cost effectiveness of the care we provide you. This also includes uses and disclosures to:

- evaluate the quality and competence of our health care providers, nurses and other health care workers,
- to other health care providers to help them conduct their own quality reviews, compliance activities or other health care operations,
- train students, residents and fellows, or
- identify health-related services and products that may be beneficial to your health and then contact you about the services and products.

We may also disclose your health information to third parties to assist us in these activities (but only if they agree in writing to maintain the confidentiality of your health information). In addition, we may use and disclose your health information under the following circumstances: .

• **Relatives, Caregivers and Personal Representatives:** Under appropriate circumstances, including emergencies, we may disclose your health information to family members, caregivers or personal representatives who are with you or appear on your behalf (for example, to pick up a prescription). We may also need to notify such persons of your location in our facility and general condition. If you object to such disclosures, please notify your health care provider. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practically be provided because of your incapacity or an emergency circumstance, we may exercise professional judgment to determine whether a disclosure is in your best interests. If information is disclosed to a family member, other relative or a close personal friend, we would disclose only information believed to be directly relevant to the person's involvement with your health care or payment related to your health care.

• **Public Health Activities:** We may disclose your health information for the following public health activities:

- To report to public health authorities for the purpose of preventing or controlling disease, injury or disability;
- To report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports;
- To alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease; or
- To report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

• **Victims of Abuse, Neglect or Domestic Violence:** If we reasonably believe that you are a victim of abuse, neglect or domestic violence, we may disclose your health information as required by law to a social services or other governmental agency authorized by law to receive such reports.

• **As Required by Law:** We may disclose health information when required to do so by any other law not already referred to in the preceding categories.

Your Written Authorization

FOR ANY PURPOSE OTHER THAN THE ONES DESCRIBED ABOVE WE MAY ONLY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION WHEN YOU GIVE US YOUR WRITTEN AUTHORIZATION.

Highly Confidential Information

Federal and state law require special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including your health information that is maintained in psychotherapy notes or is about: (1) mental health and developmental disabilities services; (2) alcohol and drug abuse prevention, treatment and referral; (3) HIV/AIDS testing, diagnosis or treatment; (4) communicable disease(s); (5) genetic testing; (6) child abuse and neglect; (7) domestic or elder abuse; or (8) sexual assault. In order for

your Highly Confidential Information to be disclosed for a purpose other than those permitted by law, your written authorization is required.

Your Rights Regarding Your Health Information:

Right to Request Access to Your Health Information: You have the right to inspect and maintain a copy of the patient records we maintain to make decisions about your treatment and care, including billing records. All requests for access must be made in writing. Under limited circumstances, we may deny you access to your records. If you would like access to your records, please ask your healthcare provider for the appropriate form to complete. If you request copies, we will charge you a reasonable fee for copies. We also will charge you for our postage costs, if you request that we mail the copies to you. If you are a parent or legal guardian of a minor, certain portions of the minor's medical record may not be accessible to you under state law.

Right to Request Amendments to Your Health Information: You have the right to request that we amend your health information maintained in your medical record file or billing records. If you wish to amend your records, please obtain an amendment request form from your healthcare provider. All requests for amendments must be in writing. We will comply with your request unless we believe that the information that would be amended is already accurate and complete or other special circumstances apply.

Right to Revoke Your Authorization: You may revoke (take back) any written authorization obtained by us for use and disclosure of your protected health information, except to the extent that we have taken action in reliance upon it. Your revocation must be in writing.

Right to Request how Information is Provided to You: You may request, and we will try to accommodate, any reasonable written request for you to receive health information by alternative means of communication or at a different address or location.

Right to Request Restrictions on the use of your Health Information: YOU MAY REQUEST THAT WE RESTRICT THE USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION. ALL REQUESTS FOR SUCH RESTRICTIONS MUST BE MADE IN WRITING.

While we will consider a request for additional restrictions carefully, we are not required to agree to a requested restriction, except for requests to restrict disclosure of information to a health plan in cases where you have paid for the service out of pocket and in full.

Right to be Notified of Breach: You have the right to be notified by us if we discover a breach of your unsecured protected health information.

Right to a Paper Copy of this Notice: Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such information electronically.



RIVERSIDE EYE CENTER, P.C.

Patient Registration

Today's Date

First, Middle, Last Name

Date of Birth

Address

City

State

Zip Code

Email Address

Social Security Number

Home Phone

Work Phone

Cell Phone

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Gender at Birth: ☐ Male ☐ Female Gender Identity in your own terms _____

Preferred Language: ☐ English ☐ Other _____

Race: ☐ White ☐ Native American ☐ Asian ☐ African American ☐ Pacific Islander

☐ Hispanic or Latino ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown _____

Primary Insurance Information

Name of Insurance Company

Subscriber's Name

Date of Birth

Subscriber's Employer

Secondary Insurance Information

Name of Insurance Company

Subscriber's Name

Date of Birth

Subscriber's Employer

Referring Physician

Name

Address

City State Zip Code

Phone

Primary Care Physician

Name

Address

City State Zip Code

Phone

Patient Employment

Name

Position

Emergency Contact

Name

Phone

☐ Have you seen another provider for this condition? If so, what is the provider's name?

How did you hear about our clinic?

☐ Referring Provider ☐ Family or Friend

☐ Insurance Company ☐ Internet Search

☐ Other _____

Provider Agreement

☐ Patient received a copy of patient provider agreement



Patient Health Information

| | | |
|---------------------------|-----------|--------------|
| Name: (Last, First, M.I.) | Birthdate | Today's Date |
|---------------------------|-----------|--------------|

Thank you for taking your time to carefully complete the patient health information form. This information will be reviewed by the doctor during your examination. All information provided will be held in strict confidence.

PERSONAL MEDICAL/EYE HISTORY

Please note if you have any of the following conditions.

- | | | | |
|-------------------------------|--|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Macular Degeneration |
| | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cataracts |
| | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Dry Eye | <input type="checkbox"/> Lazy Eye |
| | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Eye Injury |
| | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Other _____ | |
- ◆ List major injuries and surgeries you have had. _____
 - ◆ List all medications you are currently taking (prescription and over-the-counter). _____
 - ◆ Do you have any allergies to medications/Latex/Dyes? ☐ Yes ☐ No If yes, please list and describe reaction. _____
 - ◆ Date of your last physical exam _____ Are you pregnant / nursing? ☐ Yes ☐ No
 - ◆ Have you had your eyes dilated? ☐ Yes ☐ No If yes, were there any problems? _____
 - ◆ Do you wear glasses? ☐ Yes ☐ No If yes, how old are your glasses? _____
 - ◆ Date of last complete eye exam _____

FAMILY MEDICAL/EYE HISTORY

Please note any family members with the following conditions. Please also note on the line next to the condition how that person is related to you.

- | | | | |
|-------------------------------|--|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> High Cholesterol _____ | <input type="checkbox"/> Macular Degeneration _____ |
| | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Retinal disease _____ |
| | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Glaucoma _____ | <input type="checkbox"/> Lazy Eye _____ |
| | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Cataracts _____ | <input type="checkbox"/> Other _____ |

PERSONAL SOCIAL HISTORY

- ◆ Please list your hobbies/recreational activities. _____
- ◆ Do you use an electronic device at work/home? ☐ Yes ☐ No If yes, how many hours/day? _____
- ◆ Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No
- ◆ Do you use tobacco products? ☐ Yes ☐ No ☐ Previously: If yes, amount/how long? _____
- ◆ Do you drink alcohol? ☐ Yes ☐ No If yes, how often? _____
- ◆ Do you use illegal drugs? ☐ Yes ☐ No If yes, how often? _____
- ◆ Have you had a blood transfusion? ☐ Yes ☐ No If yes, how often? _____
- ◆ Have you ever been infected with the following: HIV? ☐ Yes ☐ No TB? ☐ Yes ☐ No Hepatitis? ☐ Yes ☐ No
- ◆ Influenza vaccine received? ☐ Yes ☐ No Pneumococcal vaccine received? ☐ Yes ☐ No
- ◆ Have you fallen in the past 12 months? ☐ Yes ☐ No

REVIEW OF SYSTEMS

Please indicate below if you currently have or have in the last month, had any of the following health signs and symptoms:

Eyes

- | | | | | |
|-------------------------------|---|--|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Burning | <input type="checkbox"/> Eye injury | <input type="checkbox"/> Light sensitivity/glare |
| | <input type="checkbox"/> Loss of vision | <input type="checkbox"/> Dryness | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Eye turn |
| | <input type="checkbox"/> Redness | <input type="checkbox"/> Excessive tears | <input type="checkbox"/> Flashes/floaters | <input type="checkbox"/> Double vision |
| | <input type="checkbox"/> Itching | <input type="checkbox"/> Tired/sore eyes | <input type="checkbox"/> Vision disturbance | <input type="checkbox"/> Other_____ |

Constitution

- | | | | | |
|-------------------------------|--------------------------------|--------------------------------------|---------------------------------|-------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Fever | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Chills | <input type="checkbox"/> Other_____ |
|-------------------------------|--------------------------------|--------------------------------------|---------------------------------|-------------------------------------|

Cardiovascular

- | | | | | |
|-------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Lightheaded | <input type="checkbox"/> Other_____ |
|-------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|-------------------------------------|

Ear, Nose, Mouth, Throat

- | | | | | |
|-------------------------------|---------------------------------------|---|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Other_____ |
|-------------------------------|---------------------------------------|---|--------------------------------------|-------------------------------------|

Respiratory

- | | | | | |
|-------------------------------|--|--|--|-------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Pain when breathing | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Other_____ |
|-------------------------------|--|--|--|-------------------------------------|

Gastrointestinal

- | | | | | |
|-------------------------------|---------------------------------|---------------------------------------|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Nausea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Other_____ |
|-------------------------------|---------------------------------|---------------------------------------|-----------------------------------|-------------------------------------|

Genitourinary

- | | | | | |
|-------------------------------|--|--|--|-------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Increased frequency | <input type="checkbox"/> Increased urgency | <input type="checkbox"/> Burning/itching | <input type="checkbox"/> Other_____ |
|-------------------------------|--|--|--|-------------------------------------|

Muscles/Bones/Joints

- | | | | | |
|-------------------------------|-------------------------------------|---|--|-------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Joint swelling | <input type="checkbox"/> Restricted motion | <input type="checkbox"/> Other_____ |
|-------------------------------|-------------------------------------|---|--|-------------------------------------|

Skin

- | | | | | |
|-------------------------------|---------------------------------|----------------------------------|--------------------------------|-------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Rashes | <input type="checkbox"/> Rosacea | <input type="checkbox"/> Sores | <input type="checkbox"/> Other_____ |
|-------------------------------|---------------------------------|----------------------------------|--------------------------------|-------------------------------------|

Neurological

- | | | | | |
|-------------------------------|------------------------------------|--|------------------------------------|-------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Headaches | <input type="checkbox"/> Seizures or Convulsions | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Other_____ |
|-------------------------------|------------------------------------|--|------------------------------------|-------------------------------------|

Psychiatric

- | | | | | |
|-------------------------------|----------------------------------|-------------------------------------|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Other_____ |
|-------------------------------|----------------------------------|-------------------------------------|--------------------------------------|-------------------------------------|

Endocrine

- | | | | | |
|-------------------------------|---|---|---|-------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Elevated blood sugar | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Other_____ |
|-------------------------------|---|---|---|-------------------------------------|

Blood / Lymph

- | | | | | |
|-------------------------------|--|--|--|-------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Swollen lymph nodes | <input type="checkbox"/> Low blood count | <input type="checkbox"/> Other_____ |
|-------------------------------|--|--|--|-------------------------------------|

Allergic / Immunologic

- | | | | | |
|-------------------------------|---|---|--|-------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Seasonal allergies | <input type="checkbox"/> Suppressed immune system | <input type="checkbox"/> Allergic rhinitis | <input type="checkbox"/> Other_____ |
|-------------------------------|---|---|--|-------------------------------------|

Please explain any of the signs and symptoms that you checked above:



Riverside Eye Center, P.C.

Advanced Beneficiary Notice (ABN)

4050 River. Rd.
East China, MI 48054
Ph. 810-329-9045
Fx. 810-329-8732

4656 24th Ave
Fort Gratiot, MI 48059
Ph. 810-385-3600
Fx. 810-385-0603

Patient Name _____ Date _____

Privacy Policy Statement

I have received a copy of the office's privacy policy. I have had an opportunity to review it and have had any questions answered. I also understand that by signing below, I gave Riverside Eye Center, P.C., and its staff permission to call regarding health care, insurance, or billing information, normal test results, and appointment dates. A message may be left with/on my answering machine, voice mail, sent by fax or left with a family member.

One Time Authorization Agreement

Statement to permit payment of insurance benefits to providers, physicians, and patients.

I request that payment of authorized insurance benefits be made to Riverside Eye Center, P.C. for any services furnished to me by this provider. I authorize any holder of medical or other information about me to be released to my insurer and their agents. This includes any information needed to determine these benefits for related services. I permit a copy of the authorization to be used in place of the original. If my insurance fails to pay for a service, even if you or your doctor feel it is beneficial I understand that I may be responsible for those charges.

Patient Provider Agreement

☐

Refraction Agreement

A refraction is the part of the eye exam that determines your eyeglass prescription. Although this test is a very important part of your exam and is required for certain surgical procedures (such as cataracts), it is not considered a "medical procedure". Therefore most medical insurances, including Medicare will not cover the cost of the refraction.

If you have "optical insurance" it may cover the refraction fee. Ask the receptionist for more information.

The charge for this service is \$45.00. Indicate below if you would like this service.

☐ **I want to receive this service.** I understand that payment is due when service is rendered or I may be charged a \$2.00 collection fee.

☐ **I have decided not to receive the service.**

Patient Signature _____ Date _____