CENTER FOR EYE HEALTH PATIENT INFORMATION SHEET

Date: ______________________

Name: ____ **DOB:** ___/___/___

Address (Apt#) ____

____

Age: ______ **Sex: M F Social Security #:** __________________ **Marital Status:** ____________

Billing Address (if different from above): ______________________________

____

Home #: ________________ **Cell#:** ________________ **Work:** ________________

Email Address: ____

Contact Preference: ______________________________ **Phone#:** ________________

Mother's (child) Name: ____________________ **Employer:** ______________ **Phone:** __________

Address: (if different from patient) ____

____

Father's (child) Name: ____________________ **Employer:** ______________ **Phone:** __________

Address: (if different from patient) ____

____

Emergency Contact: ____________________ **Phone:** ________ **Relation to Patient:** ____________

____

Family Physician/Pediatrician: (complete name, address and phone) ______________________________

Referring Physician Information/Optometrist: (complete name, address, phone) ______________________

Primary Insurance Name: ____

Address of Insurance: ____

Member ID#: ______________________________ **Group#:** ______________________________

Company Name: ________________________ **Company Address:** ________________________

Subscriber Name: ______________________________ **SSN#:** ____________ **DOB:** ____________

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ADDITIONAL INSURANCE:

Address of Insurance: ____

Member ID#: ______________________ Group#: ______________________

Company Name: ____________________ Company Address: ____________________

Subscriber Name: ______________________ SSN#: __________ DOB: __________

***If you are here for a routine eye exam only, and have a Vision Plan, please inform the front office staff to obtain authorization for your routine eye exam today.**

COPAYS: Effective August 1, 2009, if you do not have your copay on the day of your exam, a $10.00 charge will be added to your bill.

REFFERALS: If your insurance requires a referral, you must contact your primary care provider and request a referral prior to the date of your exam. If we do not have an active referral on file the day of your exam, you will be required to sign a waiver stating that you will be responsible for the bill if we do not receive a referral within 3 days following your appointment. You may also reschedule your appointment if you choose to do so.

MEDICARE: Medicare does not pay for routine eye examinations (refraction).

WORKMEN'S COMPENSATION OR MOTOR VEHICLE CLAIM:

Employer Name: ______________________________ Telephone #: __________

Employer Address: ____

Claim#: ______________________ Date of Injury: ______________________

Approved By: ______________________ Title: ______________________

Attorney (complete name, address and phone): ______________________________

Motor Vehicle Insurance:

Insurance Company Name: ____

Policy#: ____

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS. I AUTHORIZE THE PAYMENT OF MEDICAL BENEFITS TO THE CENTER FOR EYE HEALTH, INC.. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY DEDUCTIBLES, BALANCES AND/OR COPAYS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY SERVICES NOT COVERED BY MY INSURANCE.

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION AS NECESSARY TO POROVIDE MEDICAL CARE, AND FINDINGS TO REFERRING PRACTITIONERS AND CONSULTANTS.

SIGNATURE: ______________________________ DATE: __________

Truesdale Health, Inc.
1030 President Avenue
Fall River, MA 02720
508-676-3411

Center for Eye Health, Inc.
surgery and diseases of the eye

Pearl Street Medical Center
One Pearl Street
Brockton, MA 02301
508-584-2100

Patient Consent For Use And Disclosure Of Protective Health Information

I hereby give my consent for Center for Eye Health, Inc. to-use and disclose Protected Health Information (PHI) about me to carry out treatment; payment, and healthcare operations (TPO). Center for Eye Health's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

1. I have read the Notice of Privacy Practices prior to signing this consent. I have the right to review the Notice of Privacy Practices and can obtain a copy at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Mary Silvia, Privacy Officer, Center for Eye Health, Inc., 1030 President Avenue, Fall River, MA 02720.

2. With this consent, Center for Eye Health, Inc. may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice In carrying out Treatment, Payment, and Operations. These include appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

3. With this consent, Center for Eye Health, Inc. may mail to my home or other alternative location any items that assist in carrylng out Treatment, Payment, and Operations, such as appointment reminder cards, and patient statements,

4. I have the right to request that The Center for Eye Health Inc. restrict how it uses or discloses my Protected Health information to carry out Treatment, Payment, and Operations. However, the practice is not required to agree to my requested restrictions. But if It does, it is bound by this agreement.

5. The doctors from The Center for Eye Health Inc. may ask you to view a educational videos about your ophthalmologic conditions. We may ask you to view this video in a room with, other patients. If this is not acceptable to you and if there is space available, we may be able to show you the video in a private setting. The viewing of this video is voluntary.

6. I give The Center for Eye Health Inc. permission to obtain a list of my medications electronically, from our Electronic Prescription Service.

By signing this form, I am consenting to Center for Eye Health Inc's use and disclosure of my Protected Health Information to carry out Treatment, Payment, and Options. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior Consent. If I do not sign this consent, or later revoke It, Center for Eye Health Inc. may decline to provide treatment to me.

Signature of Patient or Legal Guardian: ____________________

Date: ____________________

Print Name of Patient or Legal Guardian: ____________________

PATIENT HEALTH INFORMATION (PHI) RELEASE

It is okay to contact me in the following manner:
(Please check all that apply)

- ☐ Home Telephone: ______________________
  - ☐ O.K. to leave detailed message.
  - ☐ Leave message with call back information.
- ☐ Work Telephone: ______________________
  - ☐ O.K. to leave detailed message.
  - ☐ Leave message with call back information
- ☐ Written Communication
  - ☐ O.K. to mail to my home address.
  - ☐ O.K. to mail to my work/office address
  - ☐ O.K. to fax to: ______________________
- ☐ PHI can be released to the following family/ friends:

____

____

____

If this information changes, it is your responsibility to inform our practice of those changes.

______________________	______________________
Patient Signature: (or Authorized Person)	Date:
______________________	______________________
Print Name: (of Patient)	Birth Date: (of Patient)

The PHI requires that physicians take reasonable steps to protect PHI and limit the use and release of this information. These rules do not apply to the requests made by the individuals regarding the disclosure of their Information. Healthcare records must reflect all PHI release.

New national healthcare standards require that we collect the following additional demographic Information from all patients. This data Is designed to help reduce healthcare disparities, improve care, and assist with research.

Please select one for each of the following categories.

RACE	ETHNICITY	PREFERRED LANGUAGE
☐ American Indian	☐ Hispanic or Latino	☐ English
☐ Asian	☐ Not Hispanic or Latino	☐ Spanish
☐ African American or Black	☐ Other	☐ Portuguese
☐ Caucasian or White	☐ Decline to Answer	☐ Other
☐ Multiracial		☐ Decline to Answer
☐ Hawaiian or Pacific Islander		
☐ Other		
☐ Decline to Answer		

You have the right to decline to provide this information. Declining to answer will have no effect on your care.