Eye Surgeons of Springfield, Inc.

Patient Information Form – Child

Please print and complete form in its entirety

Account # ____________

Patient's legal name ____________ ____________ ____________ Date ____________
First Middle Last

Prefers to be addressed by ____________ Birthdate ___ / ___ / ___ Age ___

Sex: ☐ M ☐ F Patient social security # ___-___-___ Phone (___) ____________

Address ____________ ____________ ____________ ____________
Include apartment # or box # City State Zip Code

Marital status of parents: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Child resides with ____________

Father's name ____________ DOB ___ / ___ / ___ Phone (___) ____________

Father's employer ____________ Phone (___) ____________

Mother's name ____________ DOB ___ / ___ / ___ Phone (___) ____________

Mother's employer ____________ Phone (___) ____________

How were you referred to our office? ____________

Nearest relative ____________ Phone (___) ____________
Not living at same address as patient

Address ____________

Responsible party information

Responsible party ____________ Relationship to patient ____________

Responsible party's employer ____________ Phone (___) ____________

Insurance information – please complete this section on the PATIENT

Medicaid # ____________

State ____________

Primary insurance information

Insurance carrier name ____________ ID# ____________ Group# ____________

Subscriber's name ____________ Subscriber's DOB ___ / ___ / ___

Secondary insurance information

Insurance carrier name ____________ ID# ____________ Group# ____________

Subscriber's name ____________ Subscriber's DOB ___ / ___ / ___

PLEASE COMPLETE ON REVERSE SIDE OF FORM

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is the responsibility of the patient and/or responsible party to pay any deductible amount, co-insurance, or any other balance not paid for by the insurance carrier. I understand I will be responsible for payment in full for services rendered if I do not furnish the required referral forms.

ALL CO-PAYMENTS, CO-INSURANCE, and NON-COVERED FEES ARE DUE THE DATE SERVICES ARE RENDERED.
In the event this account is assigned to a collection agency, **the patient and/or responsible party will incur all costs of collection and attorney fees in ADDITION TO THE ORIGINAL BALANCE.**

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including private insurance, and other health plans to:

Eye Surgeons of Springfield, Inc.
1330 E. Kingsley St.
Springfield, MO 65804

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, paid or unpaid by the above said insurance. I hereby authorize Eye Surgeons of Springfield, Inc. to release all information necessary to secure payment for services rendered.

Signed ______________________________ ☐ Parent ☐ Guardian ☐ Other

Printed name ______________________________ Date ____________________

HEALTH AND MEDICATIONS INFORMATION

Thank you for taking a few moments to complete this form

Patient Name:______________________________

Date ________________
Update ________________
Update ________________
Update ________________
Update ________________
Update ________________
Update ________________
Update ________________
Update ________________

Primary Physician name and address:
(name)__________________________
(city)__________________***(state)***____

Please list any other specialists you see.
Please list their name, specialty, and location (city & state).

______________________________ ______________________________ ______________________________
______________________________ ______________________________ ______________________________
______________________________ ______________________________ ______________________________

Please circle any disease or medical condition you currently have or have had in the past.

Eye Surgery___________ or Disease ___________
Diabetes Type I, Type II, Thyroid Disease
Kidney, Prostate, Bladder, Uterus, Ovary
Heart Disease, High Blood Pressure, Cholesterol
Pacemaker, Defibrillator, Oxygen Use: ___________
Asthma, Emphysema, Bronchitis, Lung
Difficulty Lying Flat
Sleep Disorder or Sleep Apnea: CPAP Use? Yes/No
Stomach, Ulcers, Acid Reflux, Colon
Liver Disease, Gall Bladder
Fever, Weight Gain or Loss: How Much: _________
Arthritis, Lupus, Bone, Muscle Disease
Skin, Breast Disease, Pregnant
Cancer: Type: ______________________________
Headaches, Stroke (date) ___ Seizures, Neurological
Psychiatric/Mental Disorder, Anxiety, Depression
Hearing aids: Yes or No. (right, left, or both sides)
Ear, Hard of hearing, Nose, or Throat Disease
Blood, Lymph Disease, Hepatitis, HIV, AIDS
Seasonal or Food Allergies, Immunologic Disease
Adverse reaction to general anesthesia in the past
Other: ______________________________________

Social History: Do You:
Smoke, Use Tobacco: How Much: _____________
Drink Alcohol: Frequency: __________________
Sexually Transmitted Disease, Drug Abuse: _______

Family History: Does anyone in your family have:
Lazy Eye, Crossed or Turning Eye, Glaucoma,
Macular Degeneration, Retinitis Pigmentosis

Please List Any Surgeries and the Date:
______________________________ Date: _________
______________________________ Date: _________
______________________________ Date: _________
______________________________ Date: _________
______________________________ Date: _________

Currently in Hospice Care or Care Facility? Y/N
Children (under 18) Current Height _______
Weight_______

List any Drug Allergies:
____
____
____

Please list ALL Medications and Supplements:

Name of Drug	Mg	Dosage	Route

____
Name of Your Pharmacy **City and State**

Pharmacy phone: ______________________________

____
Physician's Signature

Eye Surgeons of Springfield, Inc.

Springfield, Missouri

Authorization to Release Information, Assignment of Benefits, and Consent for Treatment

1. **Release of Information:** I authorize the disclosure of any or all of the information in my medical record to:

   a. Any person, corporation, or agency responsible for all or part of Eye Surgeons of Springfield, Inc. services who may be responsible for determining the necessity, appropriateness, payment, or other matters related to Eye Surgeons of Springfield, Inc. treatment of services;

   b. This includes but is not limited to, insurance companies, health maintenance organizations, referred provider organizations, workers compensation carriers, welfare funds, the Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carriers.

   c. I further authorize Eye Surgeons of Springfield, Inc. at its discretion, to disclose such information to its insurance carrier or carriers when so requested by such carrier.

2. **Assignment of Benefits:** I assign to Eye Surgeons of Springfield, Inc. the benefits due me covering Eye Surgeons of Springfield, Inc. services, under my policy(s), managed care plan, HMO, or the Centers for Medicare and Medicaid Services (CMS) or its intermediaries or carriers.

3. **Medicare Patients:** I authorize Eye Surgeons of Springfield, Inc. to obtain information from the Social Security Administration regarding my entitlement and health insurance claim numbers.

4. **Financial Obligation for Eye Surgeons of Springfield, Inc:** I agree that I am financially responsible for payment of all amounts for services provided by the office and/or physicians. I am responsible to pay for my services regardless of insurance coverage or other responsible parties. I will not be responsible to pay if my obligation is waived by contractual agreements between Eye Surgeons of Springfield, Inc. and my insurer, or if prohibited by state or federal laws or regulations. If my insurance plan is a Health Maintenance Organization (HMO), I understand that I am financially responsible for non-covered services or deductibles, co-pay, or co-insurance as defined in my policy or plan. I also agree that if the account is placed for collection, I will pay all collection agency costs, and reasonable attorney fees. I agree to waive venue and do agree that any action filed to collect any amounts due for services rendered shall be filed in Greene County, Missouri. This includes patient's account balances and the collection of other expenses related to the patient's account balance such as service fees, court costs, and attorney fees.

5. <u>**Guarantor's Responsibility:**</u> I have read and understand the financial obligation above and agree to the terms as stated.

CONSENT FOR TREATMENT: As a patient of Eye Surgeons of Springfield, Inc., I agree, request, and authorize my attending physician to administer such treatment as is necessary. This includes their associates and /or assistants. Treatment may include such services, care, diagnostic procedures, and/or medical treatments, as the physician(s) deems reasonable and necessary.

AUTHORIZATION FOR DISCLOSURE: I give express permission to discuss with the individual(s) I have listed:
<u>Please check appropriate box(es)</u>

☐ Any aspect of my health care ☐ Health information only ☐ Financial information only

I understand that I am responsible for notifying this office, in writing, of any changes to this authorization to disclose my personal health information.

Name ____________________ Relationship ____________________ Phone# ____________

Name ____________________ Relationship ____________________ Phone# ____________

Name ____________________ Relationship ____________________ Phone# ____________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM: The Notice of Privacy Practices of Eye Surgeons of Springfield, Inc. sets forth the ways in which my personal health information may be used or disclosed and outlines my rights with respect to such information. I acknowledge that on ____________ *(date)*,

☐ I received a copy of the Eye Surgeons of Springfield, Inc. Notice of Privacy Practices

☐ I declined a copy of the Eye Surgeons of Springfield, Inc. Notice of Privacy Practices

Patient Name (print) ____________________ Signature: ____________________
(Patient or legal representative) *Date*

Patient Date of Birth or SSN: ____________________ Relationship if signed by other: ____________________

Eye Surgeons of Springfield

HIPAA Notice of Privacy Practices

____ **[Name]**

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.

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 (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: 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. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**