Vision Specialists of Annapolis

Today's Date:_____

Patient Information

Legal Name:_____
Last Name First Name M.I.

Birth Date:_____ Social Security Number:_____

Sex: ○M ○F ☐Minor ○Married ○Widowed ○Single ○Divorced ○Partnered

Address:_____

City/State/Zip:_____

E-mail:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____

Guardian's Name (if applicable):_____ Relationship:_____

Primary Medical Insurance

Policy Holder:_____

Relationship to Patient:_____

Policy Holder DOB:_____

Insurance Company:_____

ID Number:_____

Secondary Medical Insurance

Policy Holder:_____

Relationship to Patient:_____

Policy Holder DOB:_____

Insurance Company:_____

ID Number:_____

Vision Insurance

☐Same as above

Policy Holder:_____ Relationship to Patient:_____

Policy Holder DOB:_____ Insurance Company:_____

ID Number:_____

Health History

Do you take any medications: ○Yes ○No If yes, please list below or attach a separate list:

_____

_____

_____

Do you have any of the following: Please check all that apply.

☐Dry Eye ☐Diabetes ☐Glaucoma ☐Arthritis ☐Cataracts ☐Sinus Trouble ☐Asthma

☐Thyroid Disease ☐Heart Disease ☐Cholesterol ☐High Blood Pressure ☐Allergies

Do you have headaches: ☐Never ☐Occasionally ☐Quite Often ☐Migraines ☐Sinus

☐When doing close work

Family History: ☐Cataracts ☐Glaucoma ☐Diabetes ☐Eye Disease ☐Lazy Eye ☐Heart Disease

☐High Blood Pressure ☐Macular Degeneration

Please list allergies to medications:

_____

_____

Financial Agreement:

Release of Information: I hereby authorize and direct Vision Specialists of Annapolis to release to government agencies, insurance carriers, or other who are financially liable for such professional and medical care, all information needed to substantiate claim and payment. Assignment of Insurance Benefits: I hereby authorize direct payment of my insurance benefits to Vision Specialists of Annapolis for services rendered to me by the physician or provider under his/her supervision. I understand that it is my responsibility to know my insurance benefits, and whether or not the services I am to receive are a covered benefit. I understand that I will be responsible for any balance due that Vision Specialists of Annapolis is unable to collect from my insurance carrier for whatever reason. I further agree and understand that this office can only code and file a claim for my visit with a diagnosis that was encountered and documented in my medical record.

Payment Requirement: Payment is expected at the time of your visit for any outstanding balances which could include: co-pay, coinsurance, unmet deductible or non-covered services. If you do not carry insurance, payment in full is expected at the time of your visit. Please note that outstanding balances may be subject to a $5.00 late fee every 30 days.

Insurance: Please be sure to check with your insurance company to verify we participate with your plan. It is your responsibility to provide us with your most current insurance information, along with a copy of your card and a photo ID. If you have a change in insurance coverage, please inform us immediately. As a courtesy Vision Specialists of Annapolis will file a claim to your insurance company. Please remember that insurance is a contract between you and your insurance company, and ultimately, you are responsible for payment in full. If your insurance company requires you to obtain a referral for your visit, it is your responsibility to obtain one. If your claim is rejected because you did not provide a referral, you will be responsible for payment in full.

Cancelled or Missed Appointments: If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a $35.00 missed appointment fee. These fees are not covered by insurance.

Collection Fee: In the event your account is placed in a collection status, fees incurred will be added to your outstanding account balance. This includes, but is not limited to, collection agency fees, court costs and interest.

By signing below, I verify that I have read and understand this financial agreement.

Signature:_____ Date:_____

VISION SPECIALISTS OF ANNAPOLIS

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information.
Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY:
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. In the event we make a material change in our privacy practices, we will change this Notice and provide it to you.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION:

We use and disclose health information about you for treatment, payment and healthcare operations. For example:
TREATMENT: We may use or disclose your health information to an optician, optometrist, ophthalmologist or other healthcare provider providing treatment to you for a} the provision, coordination, or management of health care and related services by health care providers; b} consultation between health care providers relating to a patient c} the referral of a patient for health care from one health care provider to another or d} recall information.

PAYMENT: We may use and disclose your health care information to obtain payment for services we provided to you. This may include: a} billing and collection activities and related data processing; b} actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; c} medical necessity and appropriateness of care reviews, utilization review activities and; d} disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursements.

HEALTHCARE OPERATIONS:
We may use and disclose your health information in connection with our health care operations. Health care operations could include quality assurance assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditations, certification, licensing or credentialing activities.

YOUR AUTHORIZATION:
In addition to our health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we can not disclose or use your health information for any reason except those described in this Notice.

MARKETING HEALTH PRODUCTS OR SERVICES:
We will not use your health information for marketing communications without your prior written consent or authorization. We may provide you with information regarding products and services that we offer related to your health care needs. We will never sell your health information without your prior authorization.

TO YOU, YOUR FAMILY AND FRIENDS:
We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help you with your health care or payment for your health care, if you agree that we may do so or, if you are not able to agree, if it is necessary in our professional judgment.

PERSONS INVOLVED IN CARE:
We may use or disclose health information to notify, or assist in notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with any opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

REQUIRED BY LAW:
We may use or disclose your health information when we are required to do so by law, including judicial and administrative proceedings.

ABUSE OR NEGLECT:
We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or thehealth or safety of others.

NATIONAL SECURITY:
We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal authorities/officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or a patient under certain circumstances.

APPOINTMENT REMINDERS AND TREATMENT ALTERNATIVES:
We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters) or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

PATIENT RIGHTS:

ACCESS: You have the right to review or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you requested unless we can not practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

DISCLOSURE ACCOUNTING:
You have a right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health care operations, where you have provided an authorization and certain other activities, for the last six years, but not for disclosure made prior to April 14, 2003. If you request this accounting more than once in a twelve-month period, we may charge you a reasonable, cost-based fee for responding to this additional request.

RESTRICTION:
You have the right to request that we place additional restrictions on our use and disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (Except in an emergency).

ALTERNATIVE COMMUNICATION:
You have the right to request in writing that we communicate with you about your health information by alternate means or to alternate locations. Your request must specify the alternate means or location, and provide satisfactory explanation how payments will be handled under the alternate means or location you request.

AMENDMENT:
You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

ELECTRONIC NOTICE:
If you receive this Notice on our Website or by email, you have the right to receive this Notice in written form.

QUESTIONS AND COMPLAINTS:
If you want more information about our privacy practices, have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternate means or alternate locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the UD Department of Health and Human Services upon request.
We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the US Department of Health and Human Services.

CONTACT PERSON: DR. SHARON L. MAGILL, OD
TELEPHONE: 410-224-8908 FAX: 410-224-0871
ADDRESS: 116 Defense Highway, Suite 502
EMAIL: DRMAGILL@ANNAPOLIS.VISION

HIPAA PRIVACY

Acknowledgment of Receipt of Privacy Notice

By signing this acknowledgment of Receipt of Notice of Privacy Practices (the "Notice"); I acknowledge and agree that I have received a copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below.

I understand that the Location may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/or type of products provided) to another party to permit the Location to perform its administrative duties, provide me with eye care services and products, process my vision benefit claims and communicate with me regarding vision care services provided by the Location (for example, mailings of exam reminders or information about services / products provided by the Location).

I can be assured that this Location does not sell my personal health information of any kind to a third party for such party's own use. I authorize the Location to submit my vision benefit claims to my plan sponsor or health plan to receive reimbursement directly for the vision services and products that I have received from the Location.

_____ _____

Patient Signature or Patient's Legal Representative Date