Pacific EyeCare of Poulsbo
Patient Registration Form

Referred By: _____

Patient Information:

Name: _____ Today's Date: _____
SS#: _____ Birthdate: _____ Age: _____ Male / Female
Telephone (home): _____ (work): _____ (cell): _____
Mailing address: _____
City: _____ State: _____ Zip: _____
E-Mail Address: _____
Marital status: _____ Student status:(□ Full Time / □ Part Time)
Spouse's name:_____ Birthdate:_____
Spouse's SS#: _____ Spouse contact phone #:_____

Personal Contact: **(Other than spouse if possible)**

Name: _____ Relationship: _____
Address: _____ City: _____
State: ____ Zip: _____ Phone: _____

Employment Information:

Name of employer: _____ Occupation: _____
Employer's address: _____
Spouse's employer: _____ Occupation: _____

Responsible Party: (If different from patient or patient is minor)

Guarantor: _____ Relation to patient: _____
Birthdate: _____ Home #: _____ Daytime #: _____
Mailing Address: _____
SS#: _____ Employer: _____
Person who brought in child: _____ Relationship: _____

Insurance Information:

Primary Insurance: _____ Subscriber: _____
Secondary Insurance: _____ Subscriber: _____
Vision Insurance: _____ Subscriber: _____

If injury, date of injury: _____ **Job related injury? Yes or No**

PACIFIC EYECARE OF POULSBO
INSURANCE AND PAYMENT POLICY

GOOD COMMUNICATION IS ESSENTIAL FOR A HEALTHY DOCTOR-PATIENT RELATIONSHIP, NOT ONLY HEALTH-WISE, BUT ALSO CONCERNING POLICIES TOWARD INSURANCE AND FEES. IF YOU EVER HAVE ANY QUESTIONS REGARDING YOUR ACCOUNT, PLEASE DO NOT HESITATE TO ASK.

WE ARE A PREFERRED PROVIDER FOR MANY INSURANCE COMPANIES, SO PLEASE CHECK WITH OUR OFFICE TO MAKE SURE YOUR PLAN IS ONE OF THESE SO THAT WE CAN BILL CORRECTLY.

WE CAN BILL MOST INSURANCES AS A COURTESY IF WE ARE GIVEN THE PROPER INFORMATION AT THE TIME OF YOUR VISIT. THE PATIENT IS STILL RESPONSIBLE FOR THE BALANCE AT THE TIME OF SERVICE AS MOST INSURANCE COMPANIES WILL SEND PAYMENT TO THE PATIENT DIRECTLY. PLEASE REMEMBER YOUR INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER AND THE INSURANCE COMPANY. WITH MANY OF THE NEW COMPLIANCE REGULATIONS, WE MAY NOT BE ABLE TO OBTAIN INFORMATION FOR YOU AND THIS WILL BE SOMETHING THAT YOU WILL NEED TO CALL AND RECEIVE.

COPAYS ARE ALWAYS DUE AT THE TIME OF SERVICE.

ANY CHARGES NOT COVERED BY YOUR INSURANCE WILL BE DUE AT THE TIME OF YOUR VISIT UNLESS OTHER PAYMENT ARRANGEMENTS HAVE BEEN APPROVED IN ADVANCE.

CONTACT LENS FITTING CHARGES ARE DUE AT THE TIME OF SERVICE UNLESS COVERED BY YOUR INSURANCE WHICH MANY INSURANCES DO NOT COVER.

REGARDING REFERRALS: IF YOUR INSURANCE COMPANY REQUIRES A REFERRAL, THIS WILL BE YOUR OBLIGATION. IF YOU NEED ANY INFORMAION FROM OUR OFFICE WE WILL BE HAPPY TO GIVE THAT TO YOU SO YOU CAN REQUEST YOUR REFERRAL.

PATIENT SIGNATURE _____ DATE _____

NOTICE OF PRIVACY PRACTICES — ACKNOWLEDGEMENT
PACIFIC EYECARE OF POULSBO

Pacific EyeCare of Poulsbo has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns, or complaints.

We may change the Notice of Privacy Practices at any time, and you may contact the office manager at 360-779-2020 to obtain a current copy of the Notice of Privacy Practices or to ask questions.

PLEASE LIST THE INDIVIDUALS YOU WISH TO PARTICIPATE IN YOUR CARE: This will be someone we can leave messages with regarding appointment times, ask questions regarding insurance and account information, and patient care.

_____

CONTACT NAME **RELATIONSHIP/ PHONE#**

_____

CONTACT NAME **RELATIONSHIP / PHONE#**

_____

CONTACT NAME **RELATIONSHIP / PHONE#**

_____ I wish to opt out of receiving any future marketing emails or mailings.

_____ I wish to receive future marketing emails or mailings.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____Patient or legally authorized individual signature DATE

_____

Printed name if signed on behalf of the patient
Relationship (parent, legal guardian, personal representative)

This form will be retained in your medical record. Last Update: 06-25-2013

PACIFIC EYECARE OF POULSBO (PECP)

20669 Bond Rd NE, Ste 100, Poulsbo, WA 98370 PHONE: (360) 779-2020 FAX: (360) 779-3093

AUTHORIZATION TO USE OR DISCLOSE MY HEALTH CARE INFORMATION

Patient Name: _____ Previous Name:_____

DOB: (MM/DD/YYYY)_____SSN: _____-_____-_____

You may use or disclose health care information regarding (check all that apply):

☐ All health care information in my medical record

☐ Health care information in my medical record relating to the following treatment or condition:

_____

☐ Health care information in my medical record for the date(s): _____

☐ Other (e.g., x-rays, bills), specific dates: _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

☐ Psychiatric disorders/Mental Health ☐ HIV (AIDS Virus)

☐ Drug and/or alcohol use ☐ STD's (Sexually transmitted diseases)

Please choose one of the following:

☐ Pacific EyeCare of Poulsbo is obtaining records from another provider as listed below:

☐ Pacific EyeCare of Poulsbo is being asked to provide records to the provider listed below:

Name (or title) and organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ & Fax Number: _____

Information is to be: ☐ Picked up at PECP office

☐ Mailed to the above address ☐ Faxed to the above (no more than 20 pgs)

Reason(s) for this authorization (check all that apply):

☐ At my request ☐ Transferring care ☐ Legal ☐ Insurance

☐ Other (explain): _____

This authorization ends: *(This document does not permit disclosure of health information created more than 90 days after the date it is signed.)* ☐ 90 days from the date signed ☐ On (date): _____

☐ When the following event occurs: _____
(no longer than 90 days from date signed)

My Rights:

I understand I do not have to sign this authorization in order to get health care benefit (treatment, payment, or enrollment). However, I do have to sign an authorization form in order:

- To receive health care when the purpose is to create health care information for a third party or
- To take part in a research study.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Pacific EyeCare based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Two ways to revoke this authorization are:

- Fill out a revocation form. (A form is available at PECP) or
- Write a letter to PECP at 20669 Bond Rd NE, Ste 100, Poulsbo, WA 98370

Once health care information is disclosed, the person or organization that receives it **may** re-disclose it. **Privacy laws no longer protect it.**

_____ _____

Patient or Legally authorized individual signature Date Time

_____ _____

Printed name if signed on behalf of the patient Relationship

Revision 04/27/2012

Notice of Privacy Practices

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.

Pacific EyeCare of Poulsbo respects your privacy. We understand that your personal health information is very sensitive. The law protects the privacy of the health information we create and obtain in providing care and services to you. Your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services.

We will not use or disclose your health information to others without your authorization, except as described in this Notice, or as required by law.

1. Your health information rights.

The health and billing records we create and store are the property of Pacific EyeCare of Poulsbo. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request unless the request is to restrict disclosure of your protected health information to a health plan for payment or health care operations and the protected health information is about an item or service for which you paid in full directly.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices ("Notice").
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information—except in certain circumstances.
- Ask us to change your health information that is inaccurate or incomplete. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of certain disclosures of your health information. The list will not include disclosures for treatment, payment, or health care operations. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another confidential means of communication or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we receive the revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights during normal business hours, please contact:
Linda Welling, Office Manager
360-779-2020 ext 220 or 1-800-562-2020 ext 220

2. Our responsibilities.

We are required to:

- Keep your protected health information private.
- Give you this Notice.
- Follow the terms of this Notice for as long as it is in effect.
- Notify you if we become aware of a breach of your unsecured protected health information.

We reserve the right to change our privacy practices and the terms of this Notice, and to make the new privacy practices and notice provisions effective for all of the protected health information we maintain. If we make material changes, we will update and make available to you the revised Notice upon request. You may receive the most recent copy of this Notice by calling and asking for it, by visiting our office to pick one up, or by visiting our Web site, if we maintain one.

3. To ask for help or complain.

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact:

Linda Welling, Office Manager
360-779-2020 ext 220 or 1-800-562-2020 ext 220

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to **Office Manager** at **Pacific EyeCare**. You may also file a complaint with the Department of Health and Human Services Office for Civil Rights (OCR).

We respect your right to file a complaint with us or with the OCR. If you complain, we will not retaliate against you.

4. How we may use and disclose your protected health information.

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways we may use and disclose your protected health information without your permission. For each category, we will explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose health information will fall within one of the categories.

Below are examples of uses and disclosures of protected health information for treatment, payment, and health care operations.

For treatment:

- We may contact you to remind you about appointments.
- We may use and disclose your health information to give you information about treatment alternatives or other health-related benefits and services.
- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used by members of our health care team to help decide what care may be right for you.
- We may also provide information to health care providers outside our practice who are providing you care or for a referral. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.
- We bill you or the person you tell us is responsible for paying for your care if it is not covered by your health insurance plan.

For health care operations:

- We may use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may use and disclose your information to conduct or arrange for services, including:
  - Medical quality review by your health plan,

○Accounting, legal, risk management, and insurance services; and
○Audit functions, including fraud and abuse detection and compliance programs

For fund-raising communications:

- We may use certain demographic information and other health care service and health insurance status information about you to contact you to raise funds. If we contact you for fund-raising, we will also provide you with a way to opt out of receiving fund-raising requests in the future.

Some of the other ways that we may use or disclose your protected health information without your authorization are as follows.

- **Required by law:** We must make any disclosure required by state, federal, or local law.
- **Business Associates:** We contract with individuals and entities to perform jobs for us or to provide certain types of services that may require them to create, maintain, use, and/or disclose your health information. We may disclose your health information to a business associate, but only after they agree in writing to safeguard your health information. Examples include billing services, accountants, and others who perform health care operations for us.
- **Notification of family and others**: Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital.
- **Public health and safety purposes:** As permitted or required by law, we may disclose protected health information:
  - To prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
  - To public health or legal authorities:
    - To protect public health and safety.
    - To prevent or control disease, injury, or disability.
    - To report vital statistics such as births or deaths.
    - To report suspected abuse or neglect to public authorities.
- **Research:** We may disclose protected health information to researchers if the research has been approved by an institutional review board or a privacy board and there are policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **Coroners, medical examiners, and funeral directors:** We may disclose protected health information to funeral directors and coroners consistent with applicable law to allow them to carry out their duties.
- **Organ-procurement organizations:** Consistent with applicable law, we may disclose protected health information to organ-procurement organizations (tissue donation and transplant) or persons who obtain, store, or transplant organs.
- **Food and Drug Administration (FDA)**: For problems with food, supplements, and products, we may disclose protected health information to the FDA or entities subject to the jurisdiction of the FDA.
- **Workplace injury or illness:** Washington State law requires the disclosure of protected health information to the Department of Labor and Industries, the employer, and the payer (including a self-insured payer) for workers' compensation and for crime victims' claims. We also may disclose protected health information for work-related conditions that could affect employee health; for example, an employer may ask us to assess health risks on a job site.
- **Correctional institutions:** If you are in jail or prison, we may disclose your protected health information as necessary for your health and the health and safety of others.
- **Law enforcement:** We may disclose protected health information to law enforcement officials as required by law, such as reports of certain types of injuries or victims of a crime, or when we receive a warrant, subpoena, court order, or other legal process.

- **Government health and safety oversight activities:** We may disclose protected health information to an oversight agency that may be conducting an investigation. For example, we may share health information with the Department of Health.
- **Disaster relief:** We may share protected health information with disaster relief agencies to assist in notification of your condition to family or others.
- **Military, Veteran, and Department of State:** We may disclose protected health information to the military authorities of U.S. and foreign military personnel; for example, the law may require us to provide information necessary to a military mission.
- **Lawsuits and disputes:** We are permitted to disclose protected health information in the course of judicial/administrative proceedings at your request, or as directed by a subpoena or court order.
- **National Security:** We are permitted to release protected health information to federal officials for national security purposes authorized by law**.**
- **De-identifying information:** We may use your protected health information by removing any information that could be used to identify you.

5. Uses and disclosures that require your authorization.

Certain uses and disclosures of your health information require your written authorization. The following list contains the types of uses and disclosures that require your written authorization:

- **Psychotherapy Notes:** if we record or maintain psychotherapy notes, we must obtain your authorization for most uses and disclosures of psychotherapy notes.
- **Marketing Communications**: we must obtain your authorization to use or disclose your health information for marketing purposes other than for face to face communications with you, promotional gifts of nominal value, and communications with you related to currently prescribed drugs, such as refill reminders.
- **Sale of Health Information:** disclosures that constitute a sale of your health information require your authorization.

In addition, other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization. You have the right to cancel prior authorizations for these uses and disclosures of your health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we receive the revocation. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

6. Web site

We have a Web site that provides information about us. For your benefit, this Notice is on the Web site at the following address: **www.pacificeyecare.com**.

7. Effective date

This Notice is effective as of 06-17-2013

Pacific EyeCare of Poulsbo
Health History Form

Name: _____ Today's Date: _____

Family Physician: _____ Birthdate: _____

How were you referred?: _____

CURRENT MEDICAL HISTORY

Do you have any of the following medical illnesses? (circle all that apply):		List all current eye problems or eye injuries: (**List which eye**)
High blood pressure	High Cholesterol	
Diabetes	Heart disease	
Asthma	Depression	
Stroke	Clotting disorder	
AIDS	Cancer	

MEDICATIONS

List all medications on the Medication Flow Sheet

Drug Allergies:

PAST MEDICAL HISTORY
(when appropriate, list dates and eye involved)

High blood pressure	High Cholesterol	List all medical illnesses and surgeries:
Diabetes	Heart disease	
Asthma	Depression	
Stroke	Clotting disorder	
AIDS	Cancer	List previous eye problems or eye injuries:

PERSONAL / SOCIAL / FAMILY HISTORY

Smoking History: Y / N # of packs/ day? _____ # of years? _____

Social History: Marital Status: _____ Occupation: _____

Family History (please circle all that apply):

Retinal detachment	Loss of vision at a young age	Cataract
Macular degeneration	Congenital defects	Diabetes
Corneal transplant	Blood clotting problems	
Glaucoma	Heart disease	

Please complete other side.

_____
Physician signature / Date

Phys Sig/Date_____ Phys Sig/ Date _____ Phys Sig/Date _____ Phys Sig/Date _____

Revision 09/21/2012

Pacific EyeCare of Poulsbo

Health History Form

Please circle what pertains to your health:
(Circle NONE if none applies)

Patient Name: _____ Today's Date: _____

- **Constitutional**: **NONE**, headaches, fatigue, fever, insomnia, weight loss, weight gain, or other: _____
- **HEENT** (Head, Ears, Nose, Throat)**: NONE**, hearing loss, hoarseness, nasal congestion, pain, sore throat, ringing in ears, dizziness, or other: _____
- **Respiratory**: **NONE**, asthma, shortness of breath, cough, coughing up blood, TB exposure, or other: _____
- **Cardiovascular (Heart)**: **NONE**, palpitations, chest pain, history of heart attack, or other:

  _____
- **Vascular**: **NONE**, ankle swelling, circulation problems, leg ulcer, or other: _____

  _____
- **Gastrointestinal: NONE**, abdominal pain, constipation, diarrhea, vomiting, nausea, acid reflux, or other: _____
- **Genitourinary: NONE**, incontinence, kidney stones, blood in urine, pain with urination, bladder infections, or other: _____
- **Reproductive:** For Female patients only: Are you pregnant? _____
- **Metabolic/Endocrine: NONE**, weight gain/loss, increased thirst, increased urination, generalized weakness, hair loss, blood sugar abnormalities (explain), or other: _____

  _____
- **Neurological/Psychiatric: NONE,** anxiety, dementia, depression, dizziness, headaches, migraines, memory loss, stroke, numbness of extremities, tremors, seizures, dizziness, Alzheimer's, or other: _____
- **Dermatological (Skin): NONE**, acne, contact allergy, eczema, hair loss, pigment changes, rashes, skin lesions, or other: _____
- **Musculoskeletal: NONE**, back pain, bone/joint symptoms, muscle pain, rheumatism, or other: _____
- **Hematological (Blood): NONE**, bruises easily, HIV virus, prior transfusion, or other:

  _____
- **Immunological: NONE**, asthma, bee sting allergies, environmental allergies, food allergies, hay fever, or other: _____
- Have you ever taken steroid medication of any kind? **Y / N** If so, why? _____

  _____
- Are you taking aspirin, aspirin related products or blood thinners? _____
- Any other conditions we should be aware of? _____

  _____

  _____

_____ _____

Patient signature/Date Physician signature / Date

Patient Name: **DOB:** **Date:**

Date Started	NAME OF MEDICATION / DOSAGE / STRENGTH	Date Stopped	Office Use Only

E-EPRESCRIBE F-FAX HW-HANDWRITTEN P-PRINT **PACIFIC EYECARE OF POULSBO**