Patient Information

Today's Date:_____

Patient Name _____
First Middle Last

Address _____ Apt #_____

City _____ State _____ Zip _____

DOB _____ Social Security #_____ Sex: ○ M ○ F

Home Phone _____ Cell Phone _____ E-Mail_____

NOTE: By providing WV Eye Consultants with your email and/or cell phone number you can take advantage of receiving email or text message appointment reminders through our appointment reminder service (Demandforce). Please check below if you would like to receive reminders in this manner. ○ **Opt In to Email** ○ **Opt In to Text Messages**

Patient's Employer _____ Check if ☐ Retired / Not Employed

Employer's Address _____

City _____ State_____ Zip_____ Work Phone _____

Martial Status - ○ Single /○ Married /○ Divorced /○ Other (Describe):_____

Spouse's Name _____

Spouse's DOB _____ Spouse's Social Security #_____

Spouse's Employer _____ Employer Phone #_____

Person to Contact in case of emergency _____ Phone_____

Preferred Language - Select one -○ English /○ Spanish /○ Other (Describe):_____

Ethnicity/Race – Select one -○ Asian /○ Black or African American /○ Hispanic or Latino /○ White /○ Other:_____

RESPONSIBLE PARTY – if patient is under the age of 18

Name of person responsible for this account_____

Relation to patient _____ Phone _____

Address _____ City _____ State _____ Zip _____

Social Security #_____ DOB_____

INSURANCE INFORMATION

Name of Primary Insurance _____ Policy # _____

Name of Insured/Employee _____ Relation to patient _____

ID # _____ Group # _____

Name of Secondary Insurance _____ Policy # _____

Name of Insured _____ Relation to patient _____

ID # _____ Group #_____

X _____ _____ _____

Signature of Patient (or parent if minor) Relationship to Patient Date

Name: _____ **Date:**_____ **DOB:**_____

What Medical diseases or illnesses have you had?

☐Diabetes ☐High Blood Pressure

Other (list): _____

_____

_____

_____

What medicines do you take?

_____

_____

_____

_____

_____

_____

Have you ever taken: ☐Plaquenil ☐Interferon ☐Amiodarone ☐Steroids ☐Flomax

Any Drug Allergies? (Please List)

_____

_____

_____

_____

Please list any eye injuries or surgeries:

_____

_____

_____

_____

Other Surgeries: _____

_____

_____

_____

_____

_____

Do you use any of the following?

☐Tobacco ☐Alcohol ☐None

Do you currently or in the past have any of the following conditions?

☐Glaucoma ☐Diabetes ☐Stroke

☐Heart Attack ☐Cancer ☐Cataract

Macular Degeneration

Other (list): _____

Do any of these conditions run in your family?

☐Glaucoma ☐Diabetes ☐Stroke

☐Heart Attack ☐Cancer ☐Cataract

☐Macular Degeneration

Other (list): _____

Current Occupation: _____

Hobbies: _____

_____ ___

Special Vision Needs (music, sewing, computer)

_____

_____

Please circle any of the following that apply to you

General Health ☐Healthy ☐Recent Illness ☐Hospitalization ☐Weight Loss/Gain ☐Falls ☐Seasonal Allergies ☐Fever

Ear/Nose/Throat ☐Healthy ☐Sore Throat ☐Ear Pain ☐Ring in ears ☐Dizziness ☐Deaf/HOH ☐Sinus Pain

Other:_____

Digestive System: ☐Healthy ☐Constipation ☐Diarrhea ☐Bowel Habit Change ☐Heart Burn/Reflux ☐Hernia ☐Difficulty Swallowing ☐Ulcers

Other:_____

Muscle & Bones: ☐Healthy ☐Back Pain ☐Neck Pain ☐Arthritis ☐Osteoporosis ☐Pain Chewing ☐Weakness Other:_____

Neurological: ☐Healthy ☐Mini-Stroke or TIA ☐Stroke ☐Headache ☐Multiple Sclerosis ☐Seizure ☐Paralysis ☐Parkinson Disease Other:_____

Endocrine System: ☐Healthy ☐Diabetes ☐Goiter ☐Borderline Diabetes ☐ Thyroid Problems ☐Nervousness Other:_____

Thoughts & Feelings: ☐Healthy ☐Anxiety ☐Depression ☐Panic Attacks ☐Suicidal Thoughts

Other:_____

Blood & Immune System: ☐Healthy ☐Anemia ☐Bruises Easily ☐Leukemia ☐Blood Disease ☐Hepatitis ☐HIV or AIDS ☐Bleeding

Other:_____

Lungs & Breathing: ☐Healthy ☐Cough ☐Asthma ☐Shortness of Breath ☐Emphysema ☐COPD ☐Pneumonia ☐Coughing Up Blood ☐Tuberculosis

Other: _____

Heart & Blood Vessels ☐Healthy ☐Heart Attack ☐Chest Pain ☐Heart Surgery ☐Blood Clots ☐High Blood Pressure ☐High Cholesterol ☐Stress Test ☐Heart Murmur Other:_____

Urinary/Gyn/OB: ☐Healthy ☐Incontinence ☐Urgency to Void ☐Painful Urination ☐Pregnancy

Other:_____

Skin: ☐Healthy ☐Rash ☐Itching ☐Changing Moles ☐ Psoriasis Other:_____

PATIENT NAME: _____ DOB: _____

STATEMENTS OF ACCEPTANCE

Unless refused and marked as such within this document, I the undersigned accept the provisions outlined herein. The signature below designates acceptance of all the following provisions:

(1) ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES;
(2) CONSENT TO USE AND DISCLOSE HEALTH INFORMATION
FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS; (Restrictions as requested)
(3) CONSENT FOR DIAGNOSIS AND TREATMENT;
(4) ASSIGNMENT OF BENEFITS;
(5) RESPONSIBILITY FOR PAYMENT FOR SERVICES.
(6) FINANCIAL POLICY

Signature of Acceptance: X _____ DATE:_____

Signature of Witness: x _____ DATE:_____

☐ **REFUSED ACCEPTANCE OF ALL PROVISIONS**

DATE: _____

(1) ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A copy of this office's Notice of Privacy Practices has been made available to me.

Accepted Per Signature Above Unless Checked: ☐ (REFUSED)

FOR OFFICE USE ONLY BELOW THIS LINE

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign.

☐ Communication barriers prohibited obtaining the acknowledgement.

☐ An emergency situation prevented us from obtaining the acknowledgement.

☐ Other (please specify):

EMPLOYEE INITIALS: _____

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HIPAA 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

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.

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 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: Worker's 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 **Feb. 01, 2011**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 304-343-3937.

(2) CONSENT TO USE AND DISCLOSE HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competency of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry
- out treatment, payment or healthcare operations and that the organization is not required
- To agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already
- Taken action in reliance thereon.

☐ **I request the following restrictions to the use or disclosure of my health information:**

(Check one)	**Relationship**	**Name**
○ **Include – Exclude** ○	_____	_____
○ **Include – Exclude** ○	_____	_____
○ **Include – Exclude** ○	_____	_____

Accepted Per Signature Above Unless Checked: ☐ **(REFUSED)**

3) CONSENT FOR DIAGNOSIS AND TREATMENT

I, the undersigned, hereby consent to and authorize the administration and performance of all treatment as may be deemed necessary or advisable in the treatment of this patient, all of which to the judgment of the attending physician or their assigned designees, may be considered medically necessary or advisable.
I fully understand that this consent is given in advance of any specific diagnosis or treatment and I understand this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. This consent shall remain in full force and effective until revoked in writing.

Accepted Per Signature Above Unless Checked: ☐ **(REFUSED)**

(4) ASSIGNMENT OF BENEFITS

This is to certify that the above information is true and correct to the best of my knowledge. I authorize West Virginia Eye Consultants to release any medical information necessary to submit my or my child's insurance claims or to notify others as required for advice or treatment. I understand that I am financially responsible to West Virginia Eye Consultants for all services received and that finance charges may be assessed for any charges not paid according to policy. I understand that I am responsible to pay all expenses incurred in collecting any unpaid fees, including all reasonable attorney or collection fees. I hereby assign to West Virginia Eye Consultants for any services rendered, insurance benefits and/or benefits due because of liability of a third party for the above patient unless I pay the patient's account in full upon completion of service. I understand that every effort will be made to collect benefits on my behalf, but it is my responsibility to collect benefits from my insurance company. I take full responsibility for assuring that my insurance companies are properly notified in the event that referrals, second opinions or pre-certifications are required prior to services rendered.

Accepted Per Signature Above Unless Checked: ☐ **(REFUSED)**

(5) RESPONSIBILITY FOR PAYMENT FOR SERVICES

I understand that the ultimate responsibility for all charges incurred on my account is mine and agree to pay all deductibles, co-insurance amounts, and charges for non-covered or denied services.

Accepted Per Signature Above Unless Checked: **(REFUSED)**

(6) FINANCIAL POLICY
(Effective 07/01/2017)

We are so excited you have chosen West Virginia Eye Consultants as your eye care provider. We are fully committed to enhancing the lives of every patient, by providing the best quality eye care, with an excellent team of providers and support staff; all sharing a united focus on your needs and well-being every day. We must emphasize that as Medical Care providers, our relationship is with you, our patient, not with your insurance company. However, as a courtesy to you, we will bill most insurance companies. Please let us know if you have any questions about our fees, our policies and procedures, or your payment responsibilities during your visits with us.

Patient Co-Payments:

Patients at WVEC will be asked to present an insurance card for each visit. All co-payments and any past due balances are due at the time of check-out, unless previous arrangements have been made with our billing team. We accept cash, check, credit card or Care Credit at time of payment. No post-dated checks will be accepted.

Refractive Services:

I understand that the $30.00 refraction fee is **NOT** covered by most **medical** insurances even though it is considered part of the comprehensive eye exam at WVEC. I understand that I am responsible for payment of the fee unless I request not to have a refraction performed **prior** to the examination. The refraction test is an eye examination that measures a person's ability to see an object at a specific distance. WVEC physicians can determine if you have nearsightedness, farsightedness, astigmatism (asymmetrical cornea), or presbyopia (inability to focus on objects that are close to you). This test helps confirm the extent of vision difficulty. The information obtained from a refraction test allows the prescription for eyeglasses or contact lenses to be correct for each person. This test can be done as part of a routine eye test to determine if a person has normal vision. When a person complains of blurred vision, this test can help determine the extent of poor vision. It can also be performed to help follow the progress of treatments for diseases of the eye such as cataracts. The test is also used to prescribe glasses if needed.

Surgical Procedure and Specialty Contact Lens Products:

Patients receiving any type of surgical procedure or specialty contact lens fitting are required to pay any co-payment deductible 48 hours prior to the surgical procedure, or dispensing of products. The Billing office will counsel you on all your financial options when you have your surgical evaluation and/or specialty contact lens fitting.

Optical:

If a patient needs glasses ordered at WVEC, we will take half of the total payment at the time of order. When glasses are dispensed to the patient, the final payment is due at this time.

Insurance Claims:

Your personal insurance is a contract between you and your insurance company. WVEC will bill your primary insurance company after the completion of your visit. In order to bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, along with any changes that have occurred with your insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Your insurance company will make the final determination of your eligibility and benefits. If your insurance provider is not contracted with WVEC, the patient agrees to pay any charges not covered by the insurance provider. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to take care of the outstanding balance with WVEC immediately. If your insurance plan is one that WVEC is not a participating provider, you are responsible for payment in full at the time of check-out. Secondary insurance claims will be submitted one time as a courtesy to the patient. However, the patient will remain responsible for the balance except in the instances where WVEC are in contractual arrangement with the secondary insurance. If payment is not received from the secondary insurance, the balance will become the responsibility of the patient. IF WVEC IS FORCED TO SUBMIT A DELINQUENT ACCOUNT TO A COLLECTION AGENCY, THERE WILL BE A 30% LATE FEE ADDED TO THAT ACCOUNT.

Referrals and Pre-authorizations:

There are health insurance companies that require the patient to obtain a referral or prior authorization form from your Primary Care Provider before visiting a specialist. If your insurance company requires a referral or pre-authorization, the patient is responsible for obtaining it. Failure to obtain the referral along with the pre-authorization may result in a lower or no payment from the insurance company, and the outstanding balance will be the patient's responsibility. This may require the patient's appointment to be rescheduled if not obtained before seeing the doctor.