Name:_____ Birthdate:_____ Date:_____

Male / Female Marital Status _____ Occupation _____

What is the reason for your visit today?_____

_____

Social History: Patients 14 years of age or older:

Alcohol: NO YES,Amount_____ Drug Abuse History: NO YES,Substance:_____

Smoker: NO YES,Amount_____ X-Smoker: NO YES,Amount_____ Date you Quit:_____

Have you ever had any of the following transmitted diseases? AIDS: NO YES HIV+: NO YES

Hepatitis: NO YES Gonorrhea: NO YES Syphilis: NO YES Tuberculosis: NO YES

Do you have any medical/physical limitations? NO Yes, Hearing Impaired Vision Impaired Need Wheelchair Assistance Poor Mobility Wheelchair-Unable to transfer to Exam Chair Other_____

DO YOU HAVE ANY CURRENT OR PAST MEDICAL HISTORY? NO YES(list below)

ARE YOU CURRENTLY USING ANY PRESCRIPTION OR OVER THE COUNTER MEDICATION? NO YES(list)

ARE YOU ALLERGIC TO ANY MEDICATION? NO YES(LIST BELOW)

HAVE YOU HAD ANY SURGERY FOR YOUR HEALTH OR EYES? NO YES(list below; include dates)

EYE HISTORY BELOW

	Cataracts	Cornea Prob	Dry Eyes	Eye Injury	Floaters	Glaucoma	Lasik	Lazy Eye	Macula Prob	Retinal Prob	Other
NONE											
SELF											
FAMILY											

Health History

	Allergies	Arthritis	Asthma	Cancer	Depression Anxiety	Diabetes	Heart Attack	High Blood Pressure	High Cholest	Migraines	Thyroid	Stroke
NONE												
SELF												
FAMILY												

Today's Date: _____

Patient Name (Printed):_____

DOB:_____

Communication of Protected Health Information (PHI)

Please place a checkmark next to the way we may contact you. This refers to information other than the confirming of routine appointments or recalls.

Home Telephone

_____OK to leave a message on the machine/voicemail
_____OK to leave a message with the person who answers
_____OK to leave a call back number only

Work Telephone

_____OK to leave a message on the machine/voicemail
_____OK to leave a message with the person who answers
_____OK to leave a call back number only

Written Communication

_____OK to leave a message on the machine/voicemail
_____OK to leave a message with the person who answers
_____OK to leave a call back number only

Please note: For patients who only provide 1 number, it will be considered to be your home number.

I have been given a copy of the Branchburg Eye Physicians Privacy Policy with the new patient forms package. The Privacy Policy is included on our website, posted at our front desk bulletin board, or you may request an additional copy at our front desk.

Patient Signature: _____ 4/2016

FINANCIAL POLICY AND BILLING PROCESSES

- **Payment Due**: I understand payment is due when services are rendered.
- **Copay, Co-insurance and Deductibles**: I understand I am responsible to pay these and that copays are due at the time of service.
- **Insurance Coverage**: I understand that it is my responsibility to know my benefits with my insurance carrier since benefits and coverage vary by employer.
- **Insurance cards/accurate information**: I understand it is my responsibility to provide my current insurance cards and accurate information. If my claim is denied as a result of providing inaccurate insurance information, there will be a reprocessing fee $30.
- **Referrals:** I understand that I am responsible for knowing if my insurance plan requires a referral. Patients will not be see without a insurance referral.
- **Participating insurance plans**: I understand that only my insurance company representative can guarantee if the doctor is in network.
- **The reason for the patient visit**: I understand that it is the patient's responsibility to communicate the reason for the visit. The doctor's findings must support the eye complaint in order to be billed as a medical visit.
- **Medical plans and eye visits**: Eye exams can be done for medical eye reasons such as an eye infection, eye injury, existing eye diagnosis that needs continued management such as glaucoma, macular degeneration, or cataracts. Vision complaints such as blurred vision may or may not be due to a medical reason.
- **Medical plans and vision benefits**: Some medical plans have routine vision benefits; however, sometimes the vision benefits are administered through a third party separate of the medical plan. We may participate with your medical plan but not the vision plan. Patients are advised to contact their medical plan to determine who provides the vision benefit, if any.
- **Vision Plans**: We participate with several vision plans but not all vision plans. I understand I am responsible to know if my vision benefit is through my medical plan or a vision plan. I understand I will be charged a reprocessing fee of $30 if I do not provide accurate information at the time of check in.
- **Refraction:** Refraction is a necessary test used to determine the patient's best corrected or potential visual acuity. It is part of a routine exam but may be necessary during a medical exam to understand if the patient is capable of 20/20 vision. Medicare and some medical plans do NOT cover a refraction. I understand I am responsible for the refraction fee if it is deemed a non-covered service.
- **Non-Covered Services:** Since benefits vary per plan and per patient, it is not possible for Branchburg Eye to know the individualized benefits for each and every patient. I understand that some services may be considered non-covered services by my insurance plan. I understand I am financially responsible for paying all non-covered services.
- **Cancellation/No Show Fee**: There is a fee of $35 for no show appointments.

I read, understand, and agree to abide by Branchburg Eye Physicians' financial policy.

Patient Name (Print):_____DOB:_____

Patient (or guardian) Signature:_____Date:_____4/2016

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.

A federal regulation, known as the "HIPAA Privacy Rule" requires that we provide detailed notice in writing of our privacy practices. We know that this Notice is long. The HIPAA Privacy Rule requires us to address many specific things in the Notice.

OUR COMMITMENT TO PROTECT HEALTH INFORMATION ABOUT YOU.

In this Notice, we describe the ways that we may use and disclose health information about our patients. The HIPAA Privacy Rule requires that we protect the privacy of health information that identifies a patient. This information is called "protected health information" or "PHI". This Notice describes your rights as our patient and our obligatins regarding the use and disclosure of PHI. The law requires us to:

- Maintain the privacy of PHI about you.
- Give you this Notice of our legal duties and privacy practices with respect to PHI.
- Comply with the terms of our Notice of Privacy Practices that is currently in effect.

We reserve the right to make changes to this Notice and to make such changes effective for all PHI we may already have about you. If and when this Notice is changed, we will post a copy in our office in a prominent location. We will also provide you with a copy of the revised Notice upon your request.

USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The following categories describe the different ways we may use and disclose PHI for treatment, payment or health care operations. This examples iincluded with each category do not list every type of use or disclosure that may fall within that category.

TREATMENT: We may use and disclose PHI about you to provide, coordinate or manage you health care. We may consult with health care provideres regarding your treatment and coordinate and manage your health care with otheres. E.g. We may use and disclose PHI when you need a prescription. E.g. If you are referred to another physician we may disclose PHI to your new physician regarding whether you are allergic to any medications.

PAYMENT: We may use and disclose PHI so that we can bill and collect payment for the treatment and services provided to you. E.g. Before providing treatment we may ask for payment approval from your health plan. E.g. We may use and disclose PHI for billing, claims management and collection activities. E.g. We may disclose PHI to second insurance companies providing you with coverage.

HEALTH CARE OPERATIONS: We may use and disclose PHI in performing business activities, which are called health care operations. E.g. Reviewing and evaluating qualifications and performance of the health care provider taking care of you. E.g. Provide training programs for students, heath care providers

or non health care professional (billing personnel.) E.g. Cooperating with organizations that evaluate, certify or license health care providers or staff. E.g. Use and disclose PHI in the event that we sell our practice to someone else or combine with another practice.

COMMUNICATION FROM OUR OFFICE: We may contact you to remind you of appointments and provide you with information about treatment alternatives or other health related services that may be of interest to you.

OTHER USES AND DISCLOSURES WE CAN MAKE WITHOUR YOUR WRITTEN AUTHORIZATION FOR WHICH YOU HAVE THE OPPORTUNITY TO AGREE OR OBJECT.

- Individuals involved in your care or payment for your care: We may disclose PHI about you to your family member, friend or other person identified by you if that information is directly relevant to the person's involvement in you care or payment for your care. You have the opportunity to inform us of your wishes in advance. If you are not present or you are unable to consent or object we may exercise professional judgement in determining whether the use or disclosure of PHI is in your best interest. E.g. If you are brought to this office and are unable to communicate with your physician for some reason, we may find it is in your best interest to give your prescription and or instructions to a friend or relative who brought you in for treatment.

OTHER USES AND DISCLOSURE WE CAN MAKE WITHOUT YOUR WRITTEN AUTHORIZATION OR OPPORTUNITY TO AGREE OR OBJECT.

We may use and disclose PHI about you in the following circumstances without your authorization or opportunity to agree or object, provided that we comply with certain conditionsi that may apply.

REQUIRED BY LAW: We may use and disclose PHI as required by federal, state or local law. Any disclosures that comply with the law and are limited to the requirements of the law.

PUBLIC HEALTH ACTIVITIES: We may use or disclose PHI to public health authorities or other authorized persons to carry out certain activities relate to public health, including the following;

- To prevent or control diseases.
- To report child or elder abuse or neglect.
- To report reactions to medications or problems with products to the FDA.
- To locate and notify persons of recalls of products they may be using.
- To notify a person who may have been exposed to a communicatble disease.

ABUSE, NEGLECT, OR DOMESTIC VIOLENCE: We may disclose PHI in certain cases to proper governmment authorities if we reasonable believe that a patient has been a victim of domestic violence, abuse, or neglect.

HEALTH OVERSIGHT ACTIVITIES: We may disclose PHI to a health oversight agency for oversight activities including audits, investigations, inspections, licensure and other activities conducted by health oversight agencies to monitor the healthcare system,

LAWSUITS AND OTHER LEGAL PROCEEDINGS: We may use or disclose PHI when required by a court order, subpoenas, discovery request or othre legal process when efforts have been made to advise you of the request or to obtain an order protecting the information requested.

LAW ENFORCEMENT: Under certain conditions, we may disclose PHI to law enforcement officials for the following purposes where the disclosure is:

- Required by law.
- About a crime or supected crime comminted at our office.
- To alert law enforcement of any wound that we suspect was a result of criminal conduct.

CORONERS, MEDICAL EXAMINERS, and FUNERAL DIRECTORS: We may disclose PHI to identify a deceased person and determine the cause of death to coroners, medical examiners, and funeral directors as authorized by law so that they may carry out their jobs.

ORGAN AND TISSUE DONATION: If you are an organ donor, we may use or disclose PHI to organizations that help procure, locate and transplant organs in order to facilitate an organ, eye or tissue donation and transplantation.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY: We may use or disclose PHI about you in limited circumstances when necessary to prevent a threat to the health or safety of a person or to the public.

SPECIALIZED GOVERNMENT FUNCTIONS: Under certain circumstances we may disclose PHI for certain military and veteran activities, including determination of eligibliity for veterans benefits and where deemed necessary by military command authorities.

- For national security and intelligence activities.
- To help provide protective services for the president and others.
- For the health or safety of inmates at correctional institutions and law enforcement custodial situations.

DISCLOSURES REQUIRED BY HIPAA PRIVACY RULE: We are required to disclose PHI to the Secretary of the United States Department of Health and Human Services when requested to review our compliance with the HIPAA Privacy Rule.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION THAT REQUIRE YOUR AUTHORIZATION

WORKERS COMPENSATION: We may disclose PHI as authorized by workers' compensation laws or other similar programs that provide benefits for work-related injuries or illness.

ALL OTHER USES AND DISCLOSURES OF PHI NOT DESCRIBED: If you have authorized us to use or disclose PHI about, you may revoke your authorization at any time, except to the extent we have taken action based on the authorization. E.g. You would like records transferred to another doctor. E.g. You have applied for life insurance and your rercords are needed to secure coverage.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU. Under federal law,. You have the following rights regarding PHI about you.

- Right to request Restrictions: You have the right to request additional restrictions on our disclosure of PHI to certain individuals involved in you care that otherwise are permitted by the Privacy Rule. We are not required to agreee to your request. If we do agree to your request, we are required to comply with our agreement except in certain cases, including where the information is needed to treat you in the case of an emergency. To request a restriction, you must make your request in writing. In you request, please include the information that you want to restrict and how you want to restrict the information. E.g. Restricting use to this office only. Restricting disclosure to persons outside this office.
- Right to receive confidential communications: You have the right to request that you receive communication regarding PHI in a certain manner or a certain location. You must make your request

in writing; we have provided a communication grid for you to fill out. We are required to accommodate reasonable requests.

- Right to inspect and copy: You have the right to request and the opportunity to inspect and receive a copy of PHI about you that we maintain. This includes your medical and billing records but does not include psychotherapy notes or information gathered for a civil, criminal, or administrative proceeding. We may deny your request to inspect and copy PHI only in limited circumstances. To inspect and copy PHI pleasse make your request in writing. If you request a copy of PHI about you, we may charge you a reasonable fee for the copying, postage, labor and supplies used in meeting your request.
- Right to amend: You have the right to request that we amend PHI about you that we maintain in your records. You must make this request in writing. You must also give us a reason for your request. We may deny your request in certain cases.
- Right to receive an accounting of disclosures: You have the right to request an accounting of certain disclosures that we have made of PHI about you. This is a list of disclosures made by us during a specified period of up to six years other than disclosures made for treatment, payment and health care operations, to someone involved in your care or to your directly.
- Right to a paper copy of this notice at any time.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a written complaint with our privacy officials or the Secretary of the United States Department of Health and Human Services. We will not retaliate or take action against your for filing a complaint.

If you have questions about this notice, please contact our Privacy Officials at: Branchburg Eye Physicians, PA, 3461 Route 22, Branchburg, NJ 08876 or call 908-526-5424.