HIPPA NOTICE

THE EYE CLINIC, PA
1900 23rd Avenue
Gulfport, MS 39501

228-864-2633
228-865-0339 (fax)

KEEP FOR YOUR INFORMATION

Your Information.
Your Rights.
Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

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ACCT. # ______

PATIENT INFORMATION: (Please Print)

FIRST NAME ______ MI ______ LAST NAME ______ FEMALE or MALE ______ AGE ______

ADDRESS (Apt., Rm., Lot, Suite #) ______ CITY ______ STATE ______ ZIP CODE ______

HOME PHONE ______ CELL PHONE ______ WORK PHONE ______ EMPLOYER ______

BIRTH DATE ______ SOCIAL SECURITY NUMBER ______ MARITAL STAUS (CIRCLE ONE) M D W S

SPOUSE'S NAME ______ SPOUSE SOCIAL SECURITY NUMBER ______ SPOUSE DOB ______ SPOUSE CELL# ______ SPOUSE WORK # ______

★ ★ ★ PLEASE HAVE INSURANCE CARDS AND PICTURE I.D. READY FOR COPYING ★ ★ ★

FINANCIAL RESPONSIBILITY: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Supplemental
☐ Self Pay ______ Responsible Party ______ Phone / Cell Phone

EMERGENCY CONTACT #'S

Name	Relationship	Home #	Cell #	Work #

FOR MEDICARE AND MEDICAID PATIENTS

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE OR MEDICAID BENEFITS BE MADE ON MY BEHALF TO THE EYE CLINIC P.A. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE DIVISION OF MEDICAID OR MEDICARE OR THE FISCAL AGENT ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

***** Signature good for a lifetime *****

RECIPIENTS SIGNATURE ______ DATE ______

FOR COMMERCIAL / SUPPLEMENTAL INSURANCE PATIENTS

I, THEUNDERSIGNED HAVE INSURANCE COVERAGE AND ASSIGN DIRECTLY TO THE EYE CLINIC P.A. ALL MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL MY INSURANCE SUBMISSIONS.

SIGNATURE OF INSURED / GUARDIAN ______ DATE ______ ; ______ ; ______ ; ______

For office use only: UPDATED: ______ ______ ______ ______ ______

MORE INFORMATION ON BACK

(OVER)

PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI may be made by alternative means, such as sending correspondence to the individual work instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone ______________________

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone ______________________

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication

- ☐ OK to mail to my home address
- ☐ OK to mail to my work/office address
- ☐ OK to fax to number indicated

☐ Other (Fax/Cell/Email, etc.) ______________________

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THIS IS TO AUTHORIZE **THE EYE CLINIC P.A.** PHYSICIANS AND STAFF TO SPEAK WITH MY

________________, ______________________________

Relation Name Phone / Cell Number

________________, ______________________________

Relation Name Phone / Cell Number

TO DISCUSS WITH THEM MEDICAL TREATMENT I HAVE BEEN OR WILL BE RECEIVING FROM THIS CLINIC AND OTHER MATTERS RELATED TO SUCH MEDICAL TREATMENT OR MEDICAL CARE OR PERSONAL INSTRUCTIONS.

THIS AUTHORIZATION SHALL REMAIN IN EFFECT UNTIL SUCH TIME AS IT IS WITHDRAWN BY ME, IN WRITING, REGARDLESS OF THE DATE SIGNED.

______________________________ ________________

Patient Signature / Authorized Person Date

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I GIVE PERMISSION TO CONSULTING OR REFERRING PHYSICIANS / CLINICS TO SPEAK WITH **THE EYE CLINIC P.A.** REGARDING MY MEDICAL CARE. I ALSO GIVE PERMISSION TO SEND AND RECEIVE MEDICAL RECORDS TO ASSIST WITH MY MEDICAL CARE.

______________________________ ________________

Patient Signature / Authorized Person Date

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RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________________ have received a copy of The Eye Clinic, P.A.'s Notice of Privacy Practices.

______________________________ ________________

Patient Signature / Authorized Person Date

THE EYE CLINIC, PA

NAME: ______________________

MEDICATIONS YOU ARE TAKING (INCLUDING ANY EYE MEDICATIONS).

______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________
______________________ ______________________

DRUG ALLERGIES.

____
____
____

ANY SURGERIES.

____
____
____

DO YOU SMOKE? YES ☐ NO ☐ Quit ______

DO YOU HAVE PROBLEMS WITH THE FOLLOWING

	YES	NO	
Diabetes	☐	☐	DATE: _____ ☐ INSULIN ___ ☐ ORAL MEDS
High blood pressure	☐	☐	______________
Low blood pressure	☐	☐	______________
High cholesterol	☐	☐	______________
Heart disease	☐	☐	______________
Stroke	☐	☐	YEAR ______________
Seasonal Allergies	☐	☐	______________
Asthma or bronchitis (circle one)	☐	☐	______________
Cancer	☐	☐	TYPE ______________
Muscles, bones, or joints	☐	☐	______________
Thyroid disease	☐	☐	______________
Migraine headaches	☐	☐	______________
Auto immune disease	☐	☐	______________
Cataracts	☐	☐	______________
Glaucoma	☐	☐	______________
Macular degeneration	☐	☐	______________
Retinal detachment or other retinal disease	☐	☐	______________
______________	☐	☐	______________
______________	☐	☐	______________
______________	☐	☐	______________
Are you pregnant?	☐	☐	______________

ANYONE IN YOUR FAMILY (BLOOD RELATIVE) EVERY HAD ANY OF THE FOLLOWING?

	YES	NO	
Diabetes	☐	☐	______________
High blood pressure / Low blood pressure	☐	☐	IF YES, CIRCLE ONE
Glaucoma	☐	☐	______________
Blindness	☐	☐	______________

PATIENT SIGNATURE: ______________________ DATE: ______________

REVIEW DATE/INITIALS OF TECH: _____ _____ _____ _____ _____ _____ _____ _____