NEW PATIENT REGISTRATION

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Contact Information

First Name _____
Last Name _____
Daytime Phone _____
Mobile Phone _____
Email _____

Street Address _____
Suite/Apt. _____
City _____
State _____
Zip Code _____

Guardian Information *(if patient is under 18 years of age)*

First Name _____
Last Name _____
Daytime Phone _____
Mobile Phone _____
Email _____

Street Address _____
Suite/Apt. _____
City _____
State _____
Zip Code _____

Patient Information

Gender _____
Date of Birth _____
Social Security No. _____

Primary Insurance Information

Provider Name _____
Provider Phone _____
Policy/I.D. No. _____
Group No. _____

Secondary Insurance Information

Provider Name _____
Provider Phone _____
Policy/I.D. No. _____
Group No. _____

Additional Insurance Information

Provider Name _____
Provider Phone _____
Policy/I.D. No. _____
Group No. _____

Financial Assignment Information

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Acknowledgment of Notice of Privacy Practices (NPP)

◯ Yes, I have read or had explained to me by this office the NPP & I wish to continue my care under said terms.

◯ No, I have not read this office's NPP but I was given the opportunity to read it and declined. I wish to continue my care under said terms.

◯ The NPP could not be read due to the emergent nature of the care needed.

Signature agreeing to all above terms _____ Date _____

PATIENT HISTORY

Vision Correction History *(please check any that apply)*

- Amblyopia (lazy eye) ☐
- Blurred vision at a distance ☐
- Blurred vision at near ☐
- Burning ☐
- Double vision ☐
- Drooping eyelid(s) ☐
- Dryness ☐
- Eye pain and/or soreness ☐
- Floaters or spots ☐
- Fluctuating vision ☐
- Foreign body sensation ☐
- Halos ☐
- I experience regular headaches ☐
- I stopped wearing contact lenses ☐
- I stopped wearing glasses ☐
- Infection of eye or lid ☐
- Itching ☐
- Loss of peripheral vision ☐
- Loss of vision ☐
- Mucous discharge ☐
- Redness ☐
- Sandy or gritty feeling ☐
- Sensitivity to light/glare ☐
- Strabismus (crossed eye) ☐
- Tired eyes ☐
- Watery eyes ☐

Glasses History *(check all that apply)*

What glasses do you own?

- Backup pair ☐
- Bifocals ☐
- Distance ☐
- Progressive lens ☐
- Reading ☐
- Other:
- Safety glasses ☐
- Single vision ☐
- Sports glasses ☐
- Sunglasses ☐
- Trifocals ☐

How many hours per day do you spend using a computer? _____

Check any that apply

- Allergic to nickel (frames) ☐
- I do not want to wear glasses ☐
- Incorrect prescription ☐
- Need spare glasses ☐
- Need sunglasses with UV ☐
- Problems with current glasses ☐
- Problems with glare ☐
- Problems with night vision ☐

Contact Lens History *(check all that apply)*

- What brand of contacts do you wear? _____
- How old are your current contacts? _____
- How often do you replace them? _____
- What solution do you use for soaking? _____
- What is your typical wearing schedule? _____

What medications are you currently taking?

Check any that apply

- I do not want to wear contacts ☐
- Incorrect prescription ☐
- Interested in non-surgical correction ☐
- Interested in refractive laser surgery ☐
- Need spare contacts ☐
- Problems with current contacts ☐
- Would like to change my eye color ☐

Family History *(check all that apply)*

- Blindness ☐
- Diabetes ☐
- Eye turn/lazy eye ☐
- Glaucoma ☐
- Hypertension ☐
- Macular degeneration ☐

Allergies *(please list)*

- None ☐

PATIENT HISTORY

General Medical History *(please answer appropriately)*

When (approx.) was your last eye exam? _____

Primary care physician name _____

Primary care physician phone _____

Please list all eye conditions you have experienced:

Surgeries:

Do you have any of the following?

- Arthritis ☐
- Asthma ☐
- Cancer ☐
- Diabetes ☐
- Heart disease ☐
- High cholesterol ☐
- HIV ☐
- Hypertension (high blood pressure) ☐
- Migraines/headaches ☐
- Multiple sclerosis (MS) ☐

Other:

Referral Information

Why did you visit us?

- Referred by your doctor ☐
- Visited our website ☐
- Found us on social media ☐
- Referred directly ☐

Keep in touch

Facebook email _____

@Twitter handle _____

Questions and notes

Do you have a question? Concern? We want to know.

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. Your signature below indicates you have received the NPP either on our website or at our office.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition and billing with any member of your family? YES NO
If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date:_____

Witness: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY. Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice).

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we must carry out in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

For continuity of care with another HIPAA compliant provider; when a state or federal law mandates that certain health information be reported for a specific purpose;

for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;

disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;

uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;

disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;

disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;

disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;

uses or disclosures for health related research;

uses and disclosures to prevent a serious threat to health or safety;

uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;

disclosures of de-identified information;
disclosures relating to worker's compensation programs;
disclosures of a "limited data set" for research, public health, or health care operations;
incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
disclosures to "business associates" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA;
[specify other uses and disclosures affected by state law].

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for health care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your Death.

SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION

The following are some specific uses and disclosures we may not make of your health information without your authorization:
Marketing activities. We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent to such payment.
Sale of health information. We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.
Psychotherapy notes. Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization.
You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.
We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.
We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).
Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoke your authorization.

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right:
To request restrictions on the health information we may use and disclose for treatment, payment and health care operations. We are not required to agree to these requests. To request restrictions, please send a written

request to us at the address below.

To receive confidential communications of health information about you in any manner other than described in our authorization request form. You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.

To inspect or copy your health information. You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.

To amend health information. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:

o was not created by us, unless the person that created the information is no longer available to make the amendment,

o is not part of the health information kept by or for us,

o is not part of the information you would be permitted to inspect or copy, or

o is accurate and complete.

To receive an accounting of disclosures of your health information. You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).

To designate another party to receive your health information. If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

Contact Person:

Our contact person for all questions, requests or for further information related to the privacy of your health information is:
Lindsay Williamson, Operations Director
lwilliamson@youreyeinstitute.org or 919-266-2048 or fax 919-266-4648

Complaints:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown above. If you prefer, you can discuss your complaint in person or by phone.

Changes to This Notice:

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

Notice Revised and Effective: November 05, 2018

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of The Eye Institute OD, PA, Notice of Privacy Practices.

Date _____ Patient name_____

Signature _____

PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for my health insurance deductible, coinsurance, copays or non-covered service. **All Co-payments/Co-insurances are due at the time of service.** If my plan requires a referral, I must obtain it prior to my visit. If my health plan determines a service to be "not payable," I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me **at the time of service.**

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to The Eye Institute OD, PA (formerly Knightdale Eye Care or Good Looks Optometry) on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize The Eye Institute OD, PA (formerly Knightdale Eye Care or Good Looks Optometry) to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in The Eye Institute OD, PA (formerly Knightdale Eye Care or Good Looks Optometry). I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party Date

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient