MOORE EYE INSTITUTE

PATIENT DEMOGRAPHICS

UPDATES

____Miss ____Ms. ____Mrs. ____Mr. ____Dr. Date: _____

Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street) (Apt. #) (City) (State) (Zip)

Phone: _____
(Home) (Cell)

Email Address: _____

Date of Birth: _____ Social Security #: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Occupation: _____ Work Phone: _____

Contact Person: _____ Relationship to Patient: _____

Contact's Phone: _____

Insurance: _____ ID #: _____

Referring Doctor/Agency: _____ Phone: _____

Address: _____

Primary Care Physician: _____ Phone: _____

Address: _____

Eye Doctor: _____ Phone: _____

Address: _____

Insurance Subscriber's:

Last Name: _____ First Name: _____ M.I. _____

Social Security #: _____ Relationship to Patient: _____

MOORE EYE INSTITUTE
800 890 0000
www.MooreEye.com

Medical History Questionnaire

Name: _____ Date: _____

Address: _____ SS#: _____

_____ Birth Date: _____

Home Phone: _____ Work Phone: _____

Occupation: _____

Contact Person: _____ Phone: _____

Referred By: _____ Reports To: _____

Review of Systems: (circle Yes, No, or Unsure)

Constitutional:
- Chronic pain Y N U
- Fatigue Y N U
- Lack of appetite Y N U
- Weight loss/gain Y N U
- Cancer Y N U

Integumentary:
- Skin rash Y N U
- Dry skin Y N U

Ear/Nose/Throat/Mouth:
- Hearing loss Y N U
- Smell loss Y N U
- Taste loss Y N U
- Swallowing Y N U

Cardiovascular:
- Heart attack Y N U
- Stent / bypass Y N U
- Rest of Heart Y N U
- Pacemaker Y N U
- High blood pressure Y N U
- High cholesterol Y N U

Gastrointestinal:
- Diet restrictions Y N U
- Stomach pain Y N U
- Diarrhea Y N U
- Constipation Y N U
- Constipation Y N U

Bones/Joints/Muscles:
- Arthritis Y N U
- Joint pain Y N U
- Muscle pain Y N U

Neurological:
- Headaches Y N U
- Migraines Y N U
- Seizures Y N U
- Stroke Y N U
- Paralysis Y N U
- Numbness Y N U
- Memory loss Y N U

Psychiatric:
- Depression Y N U
- Fears/anxiety Y N U
- Drug dependency Y N U
- Alcohol dependency Y N U

Hematology/Lymphatic:
- Anemia Y N U
- Bleeding disorder Y N U
- Lymphatic disorder Y N U
- Frequent bruising Y N U

Genitourinary:
- Genitals Y N U
- Kidney Y N U
- Bladder Y N U

Respiratory:

Lung disease	**Y**	**N**	**U**
Have you ever smoked	**Y**	**N**	
Current cigarette user	**Y**	**N**	
Past cigarette user	**Y**	**N**	
Asthma	**Y**	**N**	**U**
Emphysema	**Y**	**N**	**U**
Diabetes	**Y**	**N**	**U**
Thyroid	**Y**	**N**	**U**

Allergic/Immunologic:

Allergies	**Y**	**N**	**U**
List seasonal allergies: _____			
List food allergies: _____			
List drug allergies: _____			
Hepatitis	**Y**	**N**	**U**
Syphilis	**Y**	**N**	**U**
Gonorrhea	**Y**	**N**	**U**
HIV	**Y**	**N**	**U**

Eyes:

Blurred vision – Distance	**Y**	**N**	**U**
Blurred vision- Near	**Y**	**N**	**U**
Burning eyes	**Y**	**N**	**U**
Poor color vision	**Y**	**N**	**U**
Discharge from eyes	**Y**	**N**	**U**
Double vision	**Y**	**N**	**U**
Dry eyes	**Y**	**N**	**U**
Eye infection	**Y**	**N**	**U**
Eye strain	**Y**	**N**	**U**
Eye pain	**Y**	**N**	**U**
Visual hallucinations	**Y**	**N**	**U**
Loss of side vision	**Y**	**N**	**U**
Floaters	**Y**	**N**	**U**
Glare/Light sensitivity	**Y**	**N**	**U**
Poor night vision	**Y**	**N**	**U**
Seeing halos	**Y**	**N**	**U**
Seeing flashes of lights	**Y**	**N**	**U**
Temporary loss of vision	**Y**	**N**	**U**
Twitching eyelid	**Y**	**N**	**U**
Excessive tearing	**Y**	**N**	**U**
Lazy eye	**Y**	**N**	**U**
Sandy/gritty/itchy	**Y**	**N**	**U**

Please list your <u>eye</u> <u>condition</u>:

_____

_____

_____

Please list any <u>eye</u> <u>surgeries</u>:

_____

_____

_____

1. Do you have difficulties seeing the details on TV?	**Yes**	**No**
2. Do you have problems crossing streets?	**Yes**	**No**
3. Do you have problems with steps/curbs?	**Yes**	**No**
4. Have you fallen recently or do you have a history of falling?	**Yes**	**No**
5. Do you have a fear of falling?	**Yes**	**No**
6. Do you have a mobility (walking safely) concern?	**Yes**	**No**

Please circle problem areas with:

Reading: Mail Newspaper/Magazine Price Tags Menus Food Labels Medications
Writing: Checks Signature Forms Notes Correspondence
Activities: Using Phone Pouring Liquids Using Washer/Dryer/Stove Grooming Cleaning

Family History (parents, grandparents, siblings, children – living or deceased):

Disease	Circle answer below			Relationship to you
Blindness	Yes	No	Unsure	_____
Cataract	Yes	No	Unsure	_____
Crossed Eyes	Yes	No	Unsure	_____
Glaucoma	Yes	No	Unsure	_____
Macular Degeneration	Yes	No	Unsure	_____
Retinitis Pigmentosa	Yes	No	Unsure	_____
Allergies	Yes	No	Unsure	_____
Arthritis	Yes	No	Unsure	_____
Cancer	Yes	No	Unsure	_____
Diabetes	Yes	No	Unsure	_____
Heart Disease	Yes	No	Unsure	_____
High Blood Pressure	Yes	No	Unsure	_____
Stroke	Yes	No	Unsure	_____

Reviewed by Dr. _____

Date:_____

Moore Eye Institute
Low Vision Rehabilitation Services

Name: _____ Date: _____

Please record all medications you are presently taking.

EXAMPLES:

Medication	Dosage	How Often Taken Per Day
Lisinopril	20 mg	1
Aspirin	81 mg	1
Restasis	1 drop	2

YOUR MEDICATIONS:

Medication	Dosage	How Often Taken Per Day

Insurance Authorizations

Medicare

If you have some form of Medicare, we need your signature on the following statement so that we may submit your charge to your insurance company.

I request that payment of authorized Medicare/Medigap benefits be made to me or on my behalf to Moore Eye Care, P.C. for any services furnished to me by that supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

Medicare Beneficiary Signature: _____

Date: _____

Commercial Insurance

If you have a commercial insurance, we need your signature on the following statement so that we may submit your charge to your insurance company.

I authorize any holder of medical information about me to release this information to my insurance company, its intermediates or carriers, to my attorney, or to another physician's office.
I hereby authorize direct payment of medical and/or surgical benefits; to include major medical benefits to which I am entitled, private insurance, and other health plans, to Moore Eye Care. I understand that, as these services were performed for me, I am financially responsible for all charges, whether or not paid by insurance.

Patient's Signature: _____

Responsible Party's Signature: _____

Date: _____

Patient Financial Responsibility Disclosure Statement

Your signature below forms a binding agreement between Moore Eye Institute (MEI- the provider of medical services) and the Patient who is receiving medical services or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills. All charges for services rendered are due and payable at the time of service.

MEDICAL INSURANCE: We have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the Patient as the Responsible Party must:

- Inform MEI of the current address and phone number for the patient and the responsible party.
- Present all current insurance cards prior to each office visit.
- Provide a valid referral from your Primary Care Doctor prior to each office visit, should your Insurance require it
- Verify at each visit that the insurance and patient demographic information is correct
- Pay any required copay at the time of the visit.
- Pay any additional amount owing within 30 days of receiving a statement from our office. (When MEI receives an explanation of benefits (EOB) from your insurance company; any amounts that you need to pay will be billed to you).

Returned Check Policy: If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient or the Patient's Responsible Party will be responsible for the original check amount in addition to a $25.00 Service Charge. Once notice is received of the returned check, MEI will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 30 days from the letter date by the Patient or the Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance – in addition to the $25.00 Check Service Charge.

Non-Payment on Account: Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party, understands that MEI has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to; all court costs, Attorney fees, and a collection fee will be added to the outstanding balance.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name)_____ Date_____
(Please Print)

Patient Signature_____

Patient's Guarantor Name_____ Date_____
(Please Print)

Patients Guarantor Signature_____

Consent for Dilating Eye Drops and Pressure Measurements

Dilating eye drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time, which varies from person to person, and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, you should not drive yourself. I hereby release the practice from any liability.

In the course of examining you or taking your eye pressure on an occasion a scratch can occur in the eye. Please call us immediately after your visit if you have pain, since this can lead to corneal ulcer and possible loss of vision. This occurs very rarely. I hereby agree to allow the staff of Moore Eye Care to take my eye pressure and release the practice from any liability.

Print Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Print Name of Witness:_____

Signature of Witness: _____

I authorize Moore Eye Institute to disclose my protected health information to:

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

The protected health information to be used or disclosed is as follows: *(Please select all that apply or record other information in the space provided.)*

☐ Entire medical record
☐ Medication list
☐ Laboratory results from _____ to _____.
(Date) (Date)
☐ X-ray or other imaging from _____ to _____.
(Date) (Date)
☐ Office notes from _____ to _____.
(Date) (Date)
☐ Other information (please describe): _____

_____

This information is being used/disclosed for the following purpose: ☐ At my request

_____

_____

I understand that I have the right to revoke this authorization, in writing, at any time by giving notice of my revocation to the Privacy Office, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on _____ (insert date or event on the line).

I understand that information disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law. The covered entity may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization except (1) if my treatment is related to research, or (2) if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Print Name of Patient: _____ Date of Birth: _____

Patient/Representative Signature: _____ Date: _____

Print Name of Personal Representative: _____

MOORE EYE CARE, P.C.

(Effective September 23, 2013)

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 THIS NOTICE CAREFULLY AND IF YOU HAVE ANY QUESTONS ABOUT THE NOTICE, PLEASE CONTACT OUR PRIVACY OFFICER.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations 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" (or "PHI" for short) 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 including the payment for your health care.

We are required by law to maintain the privacy of your PHI and to provide you with this notice informing you of our legal duties and privacy practices with respect to your PHI. We are also required by law to notify affected individuals following a breach of their unsecured PHI. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices at the time of your next appointment, as well as, post it in our office and on our website.

A. Confidentiality of Your PHI. Your PHI is confidential. We are required to maintain the confidentiality of your PHI under state and federal law. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") governs our use and disclosure of your PHI. We may not use or disclose your PHI except as required or permitted by the HIPAA Privacy Regulations. The HIPAA Privacy Regulations require us to comply with Pennsylvania laws that are more stringent and provide greater protection for your PHI.

B. Uses and Disclosures of Protected Health Information. We may use and disclose your PHI for treatment, payment and health care operations. Your PHI may be used and disclosed by our staff and others outside our office for the purpose of providing care to you. Your PHI may be used and disclosed to obtain payment for your services including determining eligibility or coverage and to carry out health care operations such as business management and general administrative duties need to support the operation of our organization.

We will disclose identifiable health information only to the extent reasonably necessary to perform the above-mentioned activities of our practice. In some instances, we may need to use or disclose all of the information, while other times, we may need to use or disclose only certain information.

C. Uses and Disclosures Requiring a Written Authorization. We may only use or disclose PHI for purposes when your appropriate authorization is obtained, other than for treatment, payment, and health care operations or as in accordance with Section D. You may revoke an authorization at any time provided it is writing. You may not revoke an authorization if we relied on that authorization and disclosed the PHI.

D. Uses and Disclosures Without An Authorization. We may use or disclose PHI without your authorization in the following circumstances:

- **As Required by Law.** We may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures. Under the law, we must make disclosures of your PHI to you upon your request.

- **We may disclose PHI for disaster relief purposes**. We may use or disclose your PHI to a public or private agency authorized by law or charter to assist in disaster relief efforts such as the American Red Cross.

- **Public Health**. If required by federal or Pennsylvania law, we will disclose your PHI for public health activities in order to: prevent disease, injury or disability; report births or deaths; report child abuse or neglect; report reactions to medications; notify a person who may be at risk for contacting or spreading a disease or condition.

- **Health Oversight**. We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, civil, administrative or criminal investigations, inspections, and licensing activities.

- **Child Abuse:** If we have reasonable cause, on the basis of our professional judgment, to suspect abuse of children with whom we come into contact in our professional capacity, we are required by law to report this to the Child Abuse hotline.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the services we provided you or the records thereof, such information is privileged under state law, and we will not release the information without a written authorization, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Coroners and Funeral Directors.** We may disclose PHI to a coroner or medical examiner for identification purposes to determine cause of death or for the coroner or medical examiner to perform

other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out his duties.

- **Organ Donation.** PHI may be used and disclosed to organ procurement organizations for cadaveric organ, eye or tissue donation purposes.

- **Research.** If we disclose your PHI for research, we will comply with federal and state law regarding such disclosures. An authorization will also be obtained from you.

- **HIPAA Compliance.** We are required to disclose your PHI to the Secretary of Health and Human Services to investigate or determine our compliance with the Privacy Regulations.

E. Your Rights Regarding Your PHI. Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights. Any requests with respect to these rights must be made in writing and sent to our Privacy Officer.

- **Right to Request Restrictions**. You have the right to request restrictions on certain uses and disclosures of protected health information about you such as not disclosing PHI to family members. However, we are not required to agree to a restriction you request.

- **Right to Receive Confidential Communications by Alternative Means and At Alternative Locations.** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, upon your request, we will send your bills to an address other than your own. We will accommodate reasonable written requests.

- **Right to Inspect and Copy.** You have the right to inspect or obtain a copy (or both) of PHI in our records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. At your request, we will discuss with you the details of the request and denial process.

If the record is electronic, we will provide you access to your electronic record in electronic format form so long as it is readily producible in electronic form or format. If not, we will provide you with a paper copy. You may also request/authorize us to send a copy of your record to a third party designated by you when the request is in writing, signed by you, and you provide clear direction as to the person and their location who is to receive the record copy. We may charge you for copying, postage, etc.

- **Right to Amend.** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. At your request, we will discuss with you the details of the amendment process.

- **Right to an Accounting.** You generally have the right to receive an accounting of disclosures of PHI for purposes other than TPO for which you have not provided an authorization.

- **Right to a Paper Copy.** You have the right to obtain a paper copy of the notice upon request, even if you have agreed to receive the notice electronically.

- **Marketing and Sale of your PHI.** We will not engage in any marketing activities, as that term is defined under HIPAA and we will not disclose your PHI to any third party for financial gain (directly or indirectly) without your authorization. We will not sell your PHI without your express written authorization.

F. Complaints. If you are concerned that we have violated your privacy rights, or you disagree with a decision we made concerning access to your records, you may contact:

Privacy Officer
Moore Eye Care, P.C.
Healthplex Pavilion II
100 West Sproul Road, Suite 100
Springfield, PA 19064

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the address.

G. Effective Date, Restrictions and Changes to Privacy Policy. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice by your next visit after the revision has taken place.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have received a paper copy of Moore Eye Institute's Notice of Privacy Practices.

Name: _____

Signature: _____

Date: _____