Chen Eye Center

(Form>Chart>Patient_informaton_2013_Part IV_HIPPA)

PATIENT PRIVACY ACT NOTICE

HIPPA is an acronym for Health Insurance Portability & Accountability Act of 1996 (Federal Law). Of significant concern to healthcare organizations is the Administrative Simplication Section of the Act, which requires healthcare organizations to comply with specific rules regarding:

Unique Identifiers for health plans, providers, individuals, employers.
Healthcare Transactions & Codes Sets for transmitting data electronically.
Privacy regulations over disclosure and use the health information.
Security regulations over protections of electronic information.

It is our policy to not release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, and/or cell phone. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or the telephone number is not on the recorded message to identify the residence. Information will also not to be left with an unauthorized person who may answer the telephone. If you would like to have information released to someone other than yourself please complete the following.

I,_____ hereby authorized Chen Eye Center staff and physicians to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Home Phone: Yes___No___

Answering Machine: Yes___No___

Work Phone: Yes___No___

Voice Mail: Yes___No____

Cell Phone: Yes___No____

Voice Mail: Yes____No____

E-Mail: Yes___No____

Please list the names of people our staff can discuss your medical issues with:

Spouse:

_____Yes_____No___

Parent (Father)

_____Yes_____No___

Parent (Mother)

_____Yes_____No___

Other:

_____Yes_____No___

Financial Policy Agreement and Others (Chen Eye Center) (under patient information_2013_part II)

You are welcome to go to demandforce.com and leave your comment on our service and we will continue to do our best to meet your expectation.

Please check the circle and sign in the bottom if you agree with the policy.

By completing the agreement, we will proceed to render the service.

◯ *I hereby authorize the undersigned physician to release to insurance carriers any information to process claims regarding services and treatments provided.*

◯ *I hereby assign payment to the undersigned physician, I understand that I am financially responsible for the non-covered services and if I failed to pay, the account will be referred to credit of bureau and collection service.*

◯ *All co-payments and deductible are due at time of service; I understand that if I failed to reschedule or cancel future appointment within 24 hours prior to the appointment time. I will be responsible for $ 50 financial charge for no show.*

◯ *I understand that not all medical insurance cover glasses or contact lens prescription. If I choose to have vision prescription without vision insurance an additional $ 30 glasses prescription or $ 100 contact lens prescription (sphere, non-toric, non-multifocal prescription) will be charged. If you were self pay patient the glasses prescription is included in your comprehensive examination fee.*

◯ *I will be responsible for any and all services in excess of my insurance limits as well as non-covered services. I understand if Dr. Chen is not my insurance provider, full payments is due at the time of services, unless prior arrangements have been made. I will submit the insurance claim myself to insurance company for reimbursement.*

◯ *I authorize employee from Chen Eye Center to leave a message to me or my family members in answering machine or voicemail to confirm an appointment.*

◯ *I hereby acknowledge that I have been made aware that Chen Eye Center has a privacy policy in place in accordance with health insurance policy portability and accountability act of 1996 (HIPPA). I can get a copy of the privacy policy from Chen Eye Center if I choose to.*

◯ *I agree to turn off my cellular phone and pager in the examination room, if I have to answer important phone call then I will return to waiting room to do so.*

◯ *In order to keep Chen Eye Center as a clean environment, I agree not to eat (including chewing gum) or drink beyond the waiting room.*

Signature (patient or parent if minor)

_____

Date_____/_____/_____

Social History (check accordingly) patient information_2013

◯ I do not use tobacco, alcohol or narcotic and reports no history of STD or blood transfusion.

◯ Tobacco use, ◯ Alcohol use, ◯ Narcotic use, ◯ Sexual Transmitted Disease (STD), ◯ Blood transfusion history

Family History

◯ Glaucoma ◯ Diabetes, ◯ Macular degeneration

◯ Others _____

Medical History

Name of condition	Month/Year

Surgical History

Name of Surgery	Month/Year
Non-Ocular Surgical History	
Ocular Surgical History (including which eye)	

Contact Lens History

◯ None ◯ Yes, Since _____

Current Brand	How many hours a day

Allergy History: ◯ None, Allergy: ◯ Yes

Name of Allergan	Type of Reaction

Current Systemic Medication

Name	Dose/Frequency

Current Eye drops or ointment

Name	Dose/Frequency /Which eye

What is your purpose of your visit today?

_____

_____

◯ Routine eye examination

◯ Glasses prescription ◯ Contact lens prescription

◯ Failed screening test ◯ Diabetes screening

Patient Information MR#_____

Guarantor: ◯ Self or_____

Last Name_____

First Name_____

Address_____

City_____

State: ◯ GA or_____

Zip code_____

Home phone_____

Work phone_____

Cell phone _____

Email address_____

Referred by ◯ Patient or _____

Physician _____

Primary Care Physician (Name)

_____

Address_____

_____

Insurance Information:

Primary Medical Insurance_____

ID#_____

Secondary Medical Insurance_____

ID#_____

Vision Insurance_____

ID#_____

Policy holder: ◯ Self or Spouse Name

_____

Other_____

Personal Information: (under patient_informaton_part1)

Sex: ◯ Male ◯ Female

Date of Birth_____/_____/_____

SS# _____

Marital status ◯ S, ◯ M, ◯ D, ◯ W

Employer_____

Occupation _____

◯ Unemployment, ◯ Retired, ◯ Student

Preferred language ◯ English or_____

Race: ◯ American Indian, ◯ Asian, ◯ Black or African American, ◯ Hispanic, ◯ Pacific Islander, ◯ White

Ethnicity: _____

Communication Preference:

◯ Cellular phone, ◯ Home phone

◯ Text message, ◯ E-mail

Pharmacy information *(For Electronic Prescription):*

Name_____

Address_____

City _____Code_____

Phone_____