Welcome to Long Family Eye Care!

Our patient information sheet will allow us to get to know you better and assist in billing & insurance filing procedures. All information is strictly confidential. **Thank you and we hope you enjoy your visit!**

Patient Name:_____ **Nickname**:_____ **Date:**_____

Address:_____

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

Email:_____ **Social Security #**:_____

Phone (please check preferred number):

☐ (home) _____ ☐ (cell) _____

Sex: Male / Female **Preferred Pronouns:**_____ **Date of Birth:**_____/_____/_____ **Age**:_____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Domestic Partner
Employment Status: ☐ Full time ☐ Part time ☐ Student ☐ Not Employed

Employer:_____ Job Title:_____

Please list the names of immediate family members who are patients here:

_____

Financially Responsible Party (if different from above)

Name_____SS#_____Relationship to Patient_____

Primary Eye Care Insurance_____ ID#_____Group#_____

Secondary Insurance_____ ID#_____ Group#_____

Patient Eye History

Date of last exam: _____ **by whom?** _____
Do you wear Contacts? Yes ☐ **No** ☐ **Contact lens type:** Rigid Gas Perm / Soft **Brand:**_____
Wear schedule: daily / biweekly / monthly

Do you wear glasses? Yes ☐ **No** ☐ If so, mark all things that apply:
☐ Full-time and/or ☐ Distance ☐ Reading ☐ Computer ☐
Other:_____
Do you.... ☐ use a computer? ☐ have Rx sunglasses? ☐ have colored contact lenses?
☐ want information on vision correction surgery? ☐ have an interest in the latest contacts?

Have you had or been treated for... ☐ cataracts ☐ glaucoma ☐ corneal abrasion ☐ eye infection
☐ eye injury ☐ lazy eye ☐ macular degeneration ☐ retinal detachment ☐ diabetic eye problems
☐ dry eye drops/treatment _____

Have you experienced…. ☐ blurred vision ☐ itchiness ☐ tearing ☐ floaters ☐ flashes of light
☐ sun sensitivity ☐ trouble seeing at night ☐ uncomfortable glasses ☐ other:_____
☐ dry eye, and if so, what drops/self-treatment:_____

Family History

Is there a family history of any of the following? Please list family member(s) and age of onset.

Blindness _____
Glaucoma_____
Cataracts_____
Macular Degeneration_____
Retinal Detachment_____
Other_____

Crossed/Lazy Eye_____

Diabetes_____
Cancer _____
Heart Disease _____
High Blood Pressure _____

Patient Medical History

Medical Doctor_____ **Last Physical** _____ **City/State**_____

Medications (including eye drops, vitamins, non-prescription)

_____
_____
_____
_____

Allergies to Medications? Y / N _____

Do you… Use cigarettes/tobacco? Y / N Alcohol? Y / N Other substance(s)? Y / N
Are you currently being treated for the following? ☐ Allergies ☐ Asthma ☐ Arthritis ☐ Cancer
☐ Cholesterol ☐ Diabetes ☐ Heart Disease ☐ High blood pressure ☐ Kidney Disease
☐ Anxiety/Depression ☐ Thyroid Disease ☐ Autoimmune Disease (please specify)_____
☐ Other_____
***Diagnosed condition you are not currently being treated for, please list below with date of diagnosis:**

_____

<u>All Patients Must Sign the Following Consent, Assignment and Release Statement</u>: By my signature below, I authorize Long Family Eye Care, PC to release any information needed to determine my Medicare, Medigap/Supplement, or other insurance benefits to the Social Security Administration, Health Care financing Administration, or any other insurance agent. Payment of authorized benefits will be made on behalf of Long Family Eye Care, PC. My signature on this form acknowledges that I have read and understood the above, and it will also serve as my "***signature on file***".

_____ _____
Signature Date

Acknowledgement of Receipt

By my signature below, I acknowledge that I have either received a copy of, or been advised regarding my right to read or receive a copy of, Long Family Eye Care's Notice of Privacy Practices.

Patient Name: _____ Date: _____

Signature: _____

Authorization to Discuss Your Information with Others

To comply with the HIPAA Federal Privacy Regulations, we must receive your written permission to discuss your case with anyone. By authorizing this, we will be able to, without requiring your presence, discuss your case, answer questions, leave detailed messages, and contact, in the event of an emergency, the person(s) listed below. If you would like us to answer questions or discuss your case with anyone other than yourself, you must include them below.

1) Name_____ 2) Name_____

Relationship_____ Relationship_____

Phone_____ Phone_____

Your Signature: _____

Long Family Eye Care, P.C.

Agreement to Pay for Services

In consideration of Long Family Eye Care, P.C. providing services and supplies to me or the patient designated below, I agree to the following payment terms regarding all services and supplies obtained by me or the below designated patients.

1. I agree to pay for all services at the time they are provided unless Long Family Eye Care, P.C has agreed to bill my insurance company.
2. If supplies or materials are ordered for me, I agree to pay one half (1/2) down when the order is placed and the remaining balance when the supplies or materials are received.
3. I understand Long Family Eye Care, P.C. will charge a $25.00 returned check fee for any checks written and returned for non-sufficient funds or stop payment. I agree to pay this fee as well as collection and attorney fees incurred in collecting the dishonored check as specified below in this agreement.
4. If Long Family Eye Care, P.C. has agreed to bill my insurance company, I agree to provide them with a copy of my insurance card and all necessary information.
5. After my insurance company has been billed, I agree to be responsible for and pay all outstanding amounts including those claims denied by my insurance company or any co-pay amounts or uninsured amounts remaining due after payment by my insurance company to Long Family Eye Care, P.C.
6. All outstanding amounts will be due and payable within thirty (30) days of the service or within thirty (30) days after written notice from my insurance company that the claim has been denied or only partially paid. After these thirty (30) days has expired, all account balances will be past due.
7. All past due account balances will accrue interest at the rate of eighteen percent (18%) per year.
8. I understand that all past due account balances over one hundred twenty (120) days or any dishonored checks will be turned over to an attorney or collection agency for collection. I will be responsible for attorney fees, court costs and any collection agency fees incurred in collecting the debt, as well as any and all pre-judgment and post-judgments accrued interest.

I hereby authorize payment to be made directly to Long Family Eye Care, P.C. for any services, supplies, or materials provided for my benefit or the below designated person's benefit that I may be entitled to from any insurance carrier. This agreement will remain in effect until revoked by me in writing. I also authorize said assignee to release all information acquired in the course of examination or treatment necessary to secure payment for services.

By my signature below, I attest that I have read, understood, and agree to the terms of this Agreement to Pay for Services.

Patient Name: _____ Date: _____

Signature of Responsible Party: _____

NOTICE OF PRIVACY PRACTICES, LONG FAMILY EYE CARE, P.C.

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:

- 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

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 heath 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 revoked 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 the 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:

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

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

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

    - 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:

W. Jarrod Long, OD, Angela S. Long, OD
Phone: 812-332-5090, Fax: 812-332-5092

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 email 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: September 25, 2023