



Tri County Eye Physicians Surgeons PC

319 Second Street Pike
Southampton, PA 18966
(215) 355-4428

PATIENT INFORMATION

NAME (Last, First Middle)				MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS		CITY, STATE ZIP		REFERRING PHYSICIAN		SECONDARY/BILLING ADDRESS (if Applicable)		
HOME PHONE	DAY PHONE	EMAIL ADDRESS		PRIMARY CARE PROVIDER		CITY, STATE ZIP		
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME		CONTACT PHONE	HOME PHONE	
PRIMARY EMPLOYER				SECONDARY EMPLOYER (if Applicable)				
ADDRESS				ADDRESS				
CITY, STATE ZIP				CITY, STATE ZIP				
WORK PHONE				WORK PHONE				

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)				SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS		CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (if Applicable)			
HOME PHONE	DAY PHONE	EMAIL ADDRESS		CITY, STATE ZIP			
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER		HOME PHONE	
RELATIONSHIP TO PATIENT							

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY				POLICY#			
NAME OF INSURED				GROUP#			
ADDRESS OF INSURANCE COMPANY				COPAY AMT \$			
CITY, STATE ZIP		PHONE		DEDUCTIBLE \$			
RELATIONSHIP TO PATIENT				EFFECTIVE DATE		EXPIRATION DATE	

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY				POLICY#			
NAME OF INSURED				GROUP#			
ADDRESS OF INSURANCE COMPANY				COPAY AMT \$			
CITY, STATE ZIP		PHONE		DEDUCTIBLE \$			
RELATIONSHIP TO PATIENT				EFFECTIVE DATE		EXPIRATION DATE	

I request that payment of any and all authorized Insurance benefits be made either to me or on my behalf to Tri-County Eye Physicians & Surgeons. PC for professional services rendered. 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 payable for related services.

SIGNATURE OF PATIENT/GUARDIAN

DATE



Eye Physicians & Surgeons, PC

Patient Name: _____

DOB: _____

Reason for today's visit: _____

If New, Date of Last Eye Exam: _____

Current Medical Conditions: _____

Current Medications: (including eye drops): _____

Medication Allergies: _____

Past Medical History (including surgeries): _____

Family Past Medical/ Ocular History: _____

Social History: (circle answer) Drink Alcohol: yes/no
If yes, amount: _____

Drug Use: yes/no
If yes, type _____

Preferred Pharmacy:

Pharmacy name: _____

Address/Location: _____

Phone number: _____



TRI-COUNTY

Eye Physicians & Surgeons, PC

NOTICE OF PRIVACY POLICIES AND PRACTICES

Effective Date: Sept. 1, 2002

Tri-County Eye Physicians & Surgeons, PC is committed to protecting our patients' privacy. The confidentiality of our patients has always been of greatest concern to our physicians and employees alike. This notice details how our practice collects, handles and protects personal information about our patients. This policy will be distributed to all patients and will also be available for viewing at our web site: www.tricountyeye.com. We will review this policy on an annual basis and monitor our compliance with this policy. Should it be necessary to revise this policy more often, due to circumstances, we will do so in a timely fashion.

Information we collect and maintain: We collect nonpublic personal information with regards to:

- Past medical and ocular history
- Review of systems
- History of the present illness/complaint
- Family and social history
- Medications and allergies
- Insurance and billing information
- Patient demographics

How we protect our information: Our staff is trained to adhere to the following privacy measures with regards to Protected Health Information (PHI):

- There are only three (3) reasons why an employee needs to have access to a patient's chart or computer information
 1. Treatment or care of a patient (to include surgery scheduling and back to work certification)
 2. Process billing for services
 3. Medical records request
- Our patient medical charts are located in a staff business area, out of the patient flow area. Patients do not have access to this area. Charts are not to be left lying about at the tech stations nor other unsecured areas.
- Computer display terminals are to be exited out to a menu when the operator leaves the station. Entry into the system is password protected. Passwords are not to be shared.
- Confidential patient information is not placed anywhere but in the patients' charts.
- Appointment schedules are not posted in the exam rooms, rather in the physicians' private offices.

- Employees will not discuss any patient in a public area. We will not make curious inquiries or pull a chart of a friend or relative, out of curiosity unless we have the permission of the patient.
- **Information we may disclose and the purpose:** No PHI will be released without the proper written consent from the patient or parent or guardian of the minor patient, unless the request is during an emergency. Occasions for release of PHI are the following:
- Workman's Compensation – the patient signs a record release at the time of the visit, as the chart notes must accompany the insurance billing.
- Legal pursuit:
 1. Attorney request (to also include medical record service)
 2. Subpoena
- Patient request:
 1. Moving
 2. Transfer records to another physician
- Disability documentation
- Auto accident
- Insurance company chart audit
- Driver's form
- Insurance claim adjudication

Patients' Rights:

- Our patients have the right to privacy and respect regarding their personal information.
- The patient has the right to access and copy health records with reasonable notice.
- The patient has the right to *request* amendment or correction.
- The patient has the right to an accounting of disclosures.
- The patient has the right to specify how confidential information is communicated.
- The patient has the right to request a restriction on how health information is disclosed or used.
- The patient has the right to file a complaint if they believe that our safeguards and procedures have not been followed. Any privacy issue complaints should be directed to the Privacy Officer of Tri-County Eye Physicians & Surgeons, PC or to any manager. If satisfaction is not received, the patient may notify the Department of Health & Human Services.

Patient Record of Disclosures

In general, the HIPAA privacy rule gives the individual the right to request restriction on uses and disclosures of the protected health information (PHI) for the purpose of continuity of my care or to adjudicate my account. This Authorization does not take the place of our standard record release authorization.

I authorize my PHI to be disclosed to the following individuals: _____
(signature)

Spouse _____ Adult Child _____
(name) (name)

Other _____ _____
(name) (name)

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to any authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information entered in our electronic healthcare records, if completed properly will constitute an adequate record.

Note: uses and disclosures for treatment may be permitted without prior consent in an emergency.

Financial Policy

Tri-County Eye Physicians & Surgeons is dedicated to providing you with the best possible care and service while keeping the charges to you at a reasonable level. We ask your help by understanding and cooperating with our financial policy.

Insurance:

We participate with most medical insurances as well as a variety of vision plans. It is important to understand that insurance is an agreement between **you** and your insurance carrier and that your physician's bill for services provided is an agreement between **you** and your physician.

If we do participate with your insurance, all services will be submitted to your carrier for you, unless we have received prior notification of non-covered services. **We will be collecting all applicable co-pays, deductibles, co-insurances and fees for non-covered services at the time of the visit.** (The refraction is often non-covered.)

HMO insurances may require a referral from your primary care physician for medical services, with the exception of routine eye exams. It is your responsibility to obtain the referral prior to the time of service. If the required referral is not presented at the time of service you may do one of the following:

- Reschedule appointment
- Contact PCP by use of the courtesy phone for visit authorization
- Leave a copy of a credit card or check if referral is not secured, which will be returned when a valid referral is presented. If no referral is received in 30 days your charge card will be charged or check cashed.

If we do not participate with your insurance, payment is expected at the time of service. We will provide you with an itemized bill so that you may submit the charges to your carrier for reimbursement.

Payment for Services:

We accept Visa, Master Card, Discover as well as cash or check. Your account is not satisfied until your check clears the bank; there will be a \$20 fee for returned checks. All payments are expected **at the time of the service**, unless arrangements are made with the patient account manager prior to the visit. If you are unprepared to pay your patient due portion at the time of the visit, a billing charge of \$10 will be added to your balance to cover the cost of creating and sending a statement to you. In addition, interest in the amount of 3 % per month will be applied to balances over 30 days in arrears. All balances that reach 120 days will be sent to a collection agency. Should your account be sent to a collection agency you will be financially responsible for all fees incurred.

Payment in full of *any past due balance* is expected prior to being seen in our office in the future. In addition, payment in full will be expected at the time of service for any future services.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY TRI-COUNTY EYE PHYSICIANS AND SURGEONS AND I AGREE TO THE TERMS OF THIS FINANCIAL POLICY

Signature of Patient and/or Guardian

Date



TRI·COUNTY
Eye Physicians & Surgeons, PC

ACKNOWLEDGEMENT OF RECEIPT OF FORMS

Name _____ Record # _____
Address _____
_____ DOB _____

I have received the Privacy and Financial Policies of Tri-County Eye Physicians & Surgeons and have been provided an opportunity to review it at my leisure.

(Signature)

(Date)