7405 Shallowford Road Suite #420
Chattanooga, TN 37421

Phone: 423-855-8522 Fax: 423-855-8533

Monday-Thursday 8:00AM-5:00PM
Friday 8:00AM-1:00PM

Patient Registration Form

Please fill out form completely.

Patient's First Name: ___________________________________M.I.________ Last Name:_______________________________________

Date of Birth:__________________________ Sex: Male Female Social Security #:_________________________________

Marital Status: Single Married Divorced Widowed Separated

Address:____City/State/Zip:____

Home Phone:__________________________ Okay to leave message Cell Phone: _________________________ Okay to leave message

Email:____ How did you hear about us?____

Primary Care Physician:____

Emergency Contact: ____________________________Relationship: _____________________Phone #_____________________________

Based on government regulations we are required to ask the following information: I prefer not to answer

Race: American Indian or Alaska Native Asian Black Native Hawaiian or Other Pacific Islander White Other

Ethnicity: Hispanic or Latino Not Hispanic or Latino **Preferred Language**: ____________________________________

Guarantor Information: Check if same as patient information. **Relationship to Patient:**___________________________________

Name:__________________________________ Sex: Male Female Date of Birth: ________________SSN:_____________________

Street Address:____City/State/Zip:____

Insurance Policy Holder

Policy Holder's Name: ____Policy Holder's Date of Birth: __________________

Your relationship to the Policy Holder: Child Spouse Other

Primary Insurance Name: ____ Subscriber ID Number: _____________________________

Secondary Insurance Name: ____ Subscriber ID Number: _____________________________

Vision Insurance Carrier: ____ Subscriber ID Number: _____________________________

Authorization (Optional)

By providing this authorization release my Personal Health Information (PHI) to the following individual(s), I understand that the authorization is voluntary and is being done at the request of the patient. I understand that I also may refuse to sign this authorization and my treatment and/or payment obligation with not be affected. I understand that the health information to be obtained and released may be subject to re-disclosure by the recipient of the health information and no longer protected by the Federal Privacy rules. I understand that I may revoke this authorization at any time by notifying Allied Eye in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation. I understand that this authorization is for six (6) years until specified otherwise. I hereby authorize Allied Eye to use and disclose health information to the following:

Name: ____ Relationship: ____

Name: ____ Relationship: ____

Consent for Treatment: I, the undersigned, consent to the care and treatment by the attending physician, his/hers associates or assistants. I acknowledge that no guarantees have been made as to the effect of such treatment.

X: ____ Date: ____________________________________

Patient/Guardian Signature

*Pharmacy Name & Phone Number: ____

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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 IT CAREFULLY.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). We must follow the privacy practices that are described in this Notice (which may be amended from time to time). For more information about our privacy practices, or for additional copies o this Notice, please contact us using the information listed at the end of this Notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:

a. **Your PHI may be used and disclosed by the physician, our office staff and others outside our offices that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the business, and any other use required by law. We may use and disclose PHI without your written authorization for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.**

i. **Treatment:** We may use and disclose PHI in order to provide treatment to you. For example, we may use PHI including your medication history, to diagnose, treat, and provide medical services to you. In addition, we may disclose PHI to other health care providers involved in your treatment.

ii. **Payment:** Under federal law we may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from your health plan. By way of example, we may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services. We may contact the Guarantor for your visit in order to obtain payment.

iii. **Health Care Operations:** We may use or disclose your PHI in order to support our business activities. These activities include, but are not limited to business associates, quality assessment activities, internal investigations, performance reviews, and training employees. In addition, we will use a sign in sheet at the registration desk where you will be asked to provide your first and last name. We may also call you by name in the waiting room when the physician is ready to see you. We may use or disclose your PHI to contact you to remind you of an appointment, to notify you of test results, to inform you of health-related services that may be of interest to you, and to check on your treatment, progress, and satisfaction with our services.

iv. **Required of Permitted by Law:** As required by law, Public Health issues as required by law, Communicable diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement Concerns, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity, National Security, Worker's Compensation, Inmates and other required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services.

b. **Permissible Uses and Disclosures That May Be Made Without Your Authorization, But For Which You Have An Opportunity to Object**

i. **Family and Other Persons Involved in Your Care.** We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience to make reasonable inference of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

ii. **Disaster Relief Efforts.** We may use or disclose protected health information to a public or private entity authorized by law or it's charter to assist in disaster relief efforts for the purpose of coordinating notification of family members of your location, general condition, or death.

c. **Other Permitted and Required Uses and Disclosures:** Use or Disclose of your PHI for marketing or sale of your PHI to third parties will be made only with your authorization. Once given, you may withdraw authorization at any time in writing.

II. YOUR INDIVIDUAL RIGHTS

a. **Right to Inspect and Copy.** You may request access to your medical records and billing records maintained by us in order to inspect and request copies of the records. All requests to access must be made in writing. Under limited circumstances, we may deny access to your records. Under federal law, you may not inspect or copy psychotherapy notes, information complied in anticipation of, or use in a legal proceeding, and PHI that is otherwise prohibited. We may charge a fee for the costs of copying and sending you any records requested.

b. **Right to Alternative Communications.** You may request, and we will accommodate, a reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

c. **Right to Request Restrictions.** You may ask us not to disclose any part of your PHI for the purposes of treatment, payment, or health care operations. Your request must be in writing and state the specific restriction requested and to who you want the restriction to apply. If you have paid for your services in full and ask us not to disclose your visit to your insurance company, we will honor that request. We are not required to agree to any other restriction that you may request.

d. **Right to Accounting of Disclosures.** Upon written request, you may obtain an accounting of certain disclosures of PHI made by us in the last six years. This right applies to disclosures for purposes other than treatment, payment, or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject t other restrictions and limitations. We are required by law to notify you if your unsecured PHI is breached.

e. **Right to Request Amendment.** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we deny your written request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and provide you with a copy of any such rebuttal.

f. **Right to Obtain Notice**. You have the right to obtain a paper copy of this Notice by submitting a request to the center's Compliance Officer at any time.

g. **Questions and Complaints.** If you desire further information about your privacy rights, or are concerned that we have violated your privacy rights, you may contact the center's Compliance Officer. You may also file a written complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint with the Director or with our office.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

a. **Effective Date**. The Notice is effective on June 23, 2020.

b. **Changes to this Notice.** We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in the waiting area of our office and on our website. You may also obtain any revised notice by contacting the center's Compliance Officer.

I have reviewed the Allied Eye Notice of Privacy Practices and understand that I may request a copy of the policy at any time.

SIGNED: ____DATE: ______________________

Notifications and Releases

Refraction Policy: One of the most important parts of your eye exam today is the refraction. That is the part of the exam by which we determine whether you can be helped in any way by a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and look for problems. There are some eye conditions which require the doctor to make the refraction measurements, even if you don't end up changing your eye glasses. It is NOT a covered service by Medicare and many other health insurance plans. These plans consider refraction a "vision" service not a "medical" service. Our office fee for refraction is $51.00 and unless your plan automatically covers the refraction charge, this fee is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

Appointment Policy: No shows and cancellations with less than 2 business days' notice are a significant problem for our small practice. Many practices overbook on purpose so that no-shows and last-minute cancellations won't limit access for other patients as well as cause financial hardship for the practice. In our office please schedule an appointment by calling, (423) 855-8522. If you need to reschedule an appointment and have multiple appointments booked, it is important that you tell this to the receptionist. Some doctor appointments are meant to occur after testing or after a procedure so the sequence of your scheduled appointments matter and may need to be adjusted.

We will attempt to confirm your appointment beginning ten (10) days prior to your scheduled visit. If you do not respond to the automated calls and emails, then we will attempt to reach you personally two days prior to your visit. Our software tracks whether or not you cancel or confirm on our automated system.

If you cancel twice within the 2 business days' time period, you will be sent a letter to inform you that you have one final attempt to reschedule your missed appointment. Should you late-cancel or no-show for a third time within the 2 business days' time period, you will be dismissed from our practice as your care is our responsibility. We cannot care for you if you do not keep your appointments.

Financial Policy: We collect co-pays, co-insurance, deductibles and non-covered services at the time of your visit. We have found that doing so reduces the burden on our billing department and protect patients from accruing balances that can impede us from providing care. Please be prepared to pay at the time of service.

All surgery payments need to be collected two weeks prior to a scheduled surgery date to cover our costs and reserve the time at the surgery center. If you are in need of surgery, our surgery scheduler will inform you of your payment amount and due date.

Cell Phones: Cell phones are a distraction to our staff and doctor. Please turn off your phone and take calls outside, if necessary.

Tardiness/Last Minute Cancellations: If you are running late for your appointment or have to miss it at the last minute, please call us. We start to worry about you when you have confirmed and then do not make it in on time.

Patient Dismissal: Allied Eye will dismiss patients that:

- cancel with less than 2 business days' notice three times within the same year.
- do not show up for an appointment three times within the same year.
- cause disruption by their behavior, including but not limited to in-office cell phone use.

General Consent for Treatment: The undersigned hereby gives permission for the physician to examine, provide treatments for, and perform diagnostic studies as necessary. If more invasive procedures are deemed necessary, the risks and benefits will be explained to the undersigned and a more detailed consent will be provided.

Financial Policy/Assignment of Benefits: As a courtesy and convenience to patients, Allied Eye accepts assignments from most commercial insurance programs and Medicare, and will file the primary insurance claim. Once the primary claim has been paid, Allied Eye will file the secondary insurance claim, if the information has been provided. Insurance coverage is a contract between the patient and the insurance company; therefore, the patient carries final responsibility for the payment of services rendered.

Payment Guarantee: The patient, or person acting on behalf of the patient as guardian, agent, representative, or guarantor, agrees, in consideration of services rendered, to pay the amount owed to Allied Eye. If the insurance company denies coverage, disallows a service, or otherwise does not settle the claim, may include the costs of a collection agency, attorney, and court, as well as other related fees.

By signing below, I hereby confirm that I have read this document and understand it. I have had any questions answered to my satisfaction. Furthermore, I certify that I am the patient, guarantor, agent, or representative of the patient, duly authorized to accept and fulfill the terms of this document.

______________________________ ______________

Patient Name Date of Birth

______________________________ ______________

Signature of Patient/ Responsible Party Today's Date