Print

New Patient Information

Personal Information (Please Print)

Name _____ Date _____
Date of Birth _____ Male / Female (Circle one) Age _____
Social Security # _____ Email address _____
Address _____
Street City State Zip

Phone: Home (____) _____ Work (____) _____
Occupation: _____ Employer: _____
Address: _____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Spouse Name _____ Employer: _____
Address _____ Phone (____) _____

Complete if under 18 years or a student

Name of Father _____ Employer _____
Address _____ Phone (____) _____
Name of Mother _____ Employer _____
Address _____ Phone (____) _____
Referred by: ☐ Friend / Relative _____ ☐ Doctor _____
☐ Yellow Pages ☐ Television ☐ Newspaper ☐ Other _____

Insurance Information

☐ Medicare# _____ ☐ Medicaid# _____
☐ Workers Compensation (job injury) to whom is bill to be sent? _____
☐ Other Medical Insurance _____
Group# _____ ID# _____
Name / Address 2nd Insurance _____
Are you personally responsible for the payment of your fees? ☐ Yes ☐ No If not, who is? _____
Name _____ Relationship _____ DOB _____
Who to notify in emergency (nearest relative or friend)? _____
Name _____ Relationship _____
Address _____
Phone: Home (____) _____ Work Phone (____) _____

Financial Assignment and Agreement:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for a payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-payment, co-insurance, or any other balance not paid for by your insurance upon each visit.**
2. Refractions (the measurements taken for spectacle prescriptions) are not covered by Medicare and most insurance plans unless you have routine vision coverage. The cost for a refraction is $25.00. **It is your responsibility to pay the $25.00 refraction fee at the time service is rendered.**
3. I request that payment of authorized Medicare and / or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed (Patient or parent if minor) _____ Date _____

Northshore Eye Associates, LLC.
Patient History Form

Patient Name_____ Date _____
Birth Date_____ Referred by _____

Review of Systems **Do you currently have any of the following problems?**					
					If yes, please explain.
Please list medications you are taking, including eye drops.					
Do you have any allergies to any medication?	Yes		No		
Constitutional (Fever, Weight Loss, Other)	Yes		No		
Eyes (Glaucoma, Cataract, Lazy Eye, Retina Problems, Other – please Specify)	Yes		No		
Ear / Nose / Mouth / Throat (Hearing Loss, Sinus Problems, Sore Throat)	Yes		No		
Cardiovascular (Heart Problems, Chest Pain, Irregular Heart Beat)	Yes		No		
Respiratory (Asthma, Shortness of Breath, Wheezing, Coughing)	Yes		No		
Gastrointestinal (Heartburn, Abd. Pain, Diarrhea, Vomiting)	Yes		No		
Genitourinary (Urinary Problems, Blood in Urine)	Yes		No		
Integumentary (Skin Rashes, Excessive Dryness)	Yes		No		
Musculoskeletal (Muscle Aches, Joint Pain, Swollen Joints)	Yes		No		
Neurological (Numbness, Weakness, Headaches, Paralysis)	Yes		No		
Hematologic / Lymphatic (Blood Disorders, Leukemia)	Yes		No		
Allergic / Immunologic (Hay Fever, Allergies)	Yes		No		
Endocrine (Thyroid Problems)	Yes		No		
Psychiatric (Depression, Anxiety)	Yes		No		

Family and Social History: Do any medical or eye diseases run in your family. If YES, please note relationship to patient.

___ Glaucoma
___ Diabetes
___ High Blood Pressure
___ Macular Degeneration
___ Other

Do you smoke? If YES, how much? Yes ☐ No ☐
How much: _____
Drink alcohol? If YES, how much? Yes ☐ No ☐
How Much: _____

Comments: _____

Physician's Signature: _____ Date: _____

Notice of Health Information Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction

At Northshore Eye Associates, LLC, we are committed to treating and using protected health information about you responsibly. This notice of Health information Practices describes the personal information we collect, and how and when we sue or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective April 14, 2003, and applies to all protected information as defined by federal regulations.

Understanding Your Health Record / Information

Each time you visit Northshore Eye Associates, LLC, a record of your visit is made. Typically, this record contains your symptoms, examination, and test results, diagnosis, treatment, and a plan for future care of treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third party can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this state and the nation
- A source of data for our planning and marketing
- A tool with which we can access and continually work to improve the care we render and the outcomes we archive

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Northshore Eye Associates, LLC, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request
- Inspect and copy your health record as provided for in 45 CFR 164.524
- Amend your health record as provided in 45 CFR 164.528
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- Request communications of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

Northshore Eye Associates, LLC, is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested Restriction
- Accommodate reasonable requests you may have to communicate health information by alternate means or alternate locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the Privacy Officer at 985-370-8585.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office of Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosure for Treatment, Payment, and Health Operations

We will use health information for treatment.

For Example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the

members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from his clinic.

We will use your health care information for payment.

For Example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For Example: Members of the medical arts staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates: there are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third party payer for services rendered. To protect your health information however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professional, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directions consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purposes of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternative or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as a part of a fund raising effort.

Food and Drug Administration (FDA): we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensations: We may disclose health information relative to the extent authorized by and to the extent necessary to comply with laws relating to works compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charge with preventing or controlling disease, injury, or disability.

Correctional Institution: Should you be an inmate of a correctional institute, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a work force member of business associates believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

NORTHSHORE EYE ASSOCIATES, LLC
(985) 375-1111

Northshore Eye Associates, LLC.
Acknowledgement of
Receipt of Privacy Notice

I have been presented with a copy of Northshore Eye Associates, LLC's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ Witnessed by: _____

Internal Use Only:

If patient or patient's representatives refuses to sign acknowledgment of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): _____
By (name and title): _____

Hammond Office
17170 S. I-12 Service Rd.
Hammond, LA 70403
Phone: (985) 375-1111
Fax: (985) 542-0733

Baton Rouge Office
4460 Bluebonnet Blvd., Suite A
Baton Rouge, LA 70809
Phone: (225) 291-5533
Fax: (225) 291-5444

Mandeville Office
1011 N. Causeway Blvd., Suite 1
Mandeville, LA 70471
Phone: (985) 727-0008
Fax: (985) 727-0178

Northshore Eye Associates, LLC
Patient Consent to Release Medical Information

Patient Name:_____
Date of Birth: _____

Do we have permission to release:

All information (this includes appointments, medications, current medical statues, billing, and all other information about yourself)	☐ Yes	☐ No
Appointments:	☐ Yes	☐ No
Medication	☐ Yes	☐ No
Billing	☐ Yes	☐ No

I give my permission to share this information with the person(s) listed below:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____

_____ _____
Patient Signature Date

_____
Witness

If not signed by the patient, please indicate name and relationship to patient:

_____ _____
Name Relationship

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Northshore Eye Associates, LLC
Information Regarding Dilating Eye Drops

Dilating 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, it's best if you make arrangements not to drive yourself.

Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Griener and / or such assistants as may be designated by him / her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____ _____
Patient (or person authorized to sign for patient) Date

_____ _____
Witness Date

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Northshore Eye Associates, LLC
Medical Vs. Vision Insurance

Do you have vision / optical coverage? Yes ☐ No ☐

One of the most challenging billing issues in an ophthalmology office is whether we should be billing the medical or vision plan.

An ophthalmologist is a medical doctor (just like your family doctor or cardiologist) and provides comprehensive, medical eye exams. However, ophthalmologists also provide routine vision exams for people with no eye disorders.

For Patients with both Medical and Vision Coverage
Your visions insurance is intended to provide you with a baseline eye evaluation. If you are being evaluated for medical reasons (corneal disorders, diabetes, cataracts, glaucoma suspect, double vision, etc.), you are being provided with medical care.

Your vision company doesn't provide coverage for medical care.
Therefore, we will be billing your medical insurance for visits related to medical complaints and problems.

For patients with no Vision / Optical Coverage
If you are being seen for a routine eye evaluation and don't have vision / optical coverage, your medical insurance will not pay for an eye exam. However, if you have medical problems (corneal disorders, diabetes, a lazy eye, cataracts, glaucoma suspect, double vision, etc.), your visit is considered a medical problem and can be billed to your medical plan(s).

Also, please be aware that many plans are no longer paying for eye exams because of a diagnosis of blurred vision or headache. They are considering this a routine vision exam and are often not paying for the visit.

Even though our billers will determine the appropriate plan to bill after your evaluation, we'd like to know which paln you would prefer us to bill.

Which plan would you prefer billed? ☐ Medical ☐ Vision

_____ _____
Signature Date

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Northshore Eye Associates, LLC
Refraction Service and Fee

A refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contacts lenses.

Most medical insurance plans, including Medicare, do NOT cover routine refractions or routine eye examinations (when no medical eye problem is known or suspected). Medicare allows that we charge separately for that portion of the examination since it is not a covered service.

If you have a separate **vision plan** that covers routine or annual eye examinations and / or glasses, please let us know. Your vision plan may assist you with your eye care needs that are not covered by your medical plan.

Our office fee for a refraction is $25.00 and 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.

If you have any questions regarding Medicare and insurance policies and procedures, please do not hesitate to ask. We will do our best to assist you.

Patient Acknowledgement
I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand it is due at time of service. I understand that any co-payment, co-insurance, or deductible I may have separate from and not included in the refraction fee.

_____ _____
Patient Signature (Parent for Minor) Date

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Northshore Eye Associates, LLC.

Medications

Please list all current medications that you are taking.

Medication	Dosage	Frequency	By Mouth, Eye, or Other