Cataract & Corneal Associates, P.C.

Registration Form

Last Name:_____First Name_____

Address: _____

City:_____State:_____Zip Code:_____

Home Phone:_____Work Phone_____ Cell Phone:_____

Date of Birth:_____ Social Security #_____

Occupation:_____Emergency Contact:_____

Male( ) Female( ) Marital Status: Single( ) Married( ) Divorced ( ) Widowed ( )

Referred By_____Primary Care Physician_____

Primary Insurance:_____Policy #_____

Subscriber Name: _____Subscriber Date of Birth:_____

Secondary Insurance:_____ Policy #_____

Subscriber Name:_____Subscriber Date of Birth_____

*Do you need a referral? NO ( ) YES ( ) *Do you have a referral? NO ( ) YES ( )

Chief Complaint:_____

Past Medical History_____

Past Ocular History include surgery and dates:_____

Family Medical History:_____

Consent for release of information:

Occasionally, insurance companies require additional information from your file in order to pay claims. To ensure that claims are paid in a timely manner, please read and sign the following:

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished to me. I authorize Cataract & Corneal Associates, P.C. to release to the Health Care Financing Administration, and its agents, or any other insurance carrier I may have, any information needed to determine these benefits payable for related services.

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 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:_____Date:_____

*****I acknowledge receipt of the Medical Records Privacy Policy*****

Review of Systems

Patient's Name:_____Date:_____

Circle Yes (Y) or NO (N). For any Yes responses, please describe.

No	Yes	Constitutional Symptoms (e.g., fever, weight loss)_____
N	Y	Problems with Ears, Nose, Throat, Sinus Disease_____
N	Y	Cardiovascular (hypertension, heart attack, coronary bypass, stents, etc.)_____
		_____
N	Y	Do You Take Blood Pressure Medications?_____
N	Y	Respiratory (emphysema, asthma, etc.)_____
N	Y	Gastrointestinal (ulcer, inflammatory bowel disease, etc.)_____
N	Y	Musculoskeletal (arthritis, osteoporosis, etc.)_____
N	Y	Skin (dermatitis, basal cell carcinoma, etc.)_____
N	Y	Neurological (headache, multiple sclerosis, etc.)_____
N	Y	Endocrine (diabetes, thyroid disease, etc.)_____
N	Y	Hematologic (anemia, lymphoma, leukemia, etc.)_____
N	Y	Immunologic (lupus, rheumatoid arthritis. Polymyalgia, etc.)_____
N	Y	Other Medical Conditions_____

Social History

N	Y	Smoking
N	Y	Heavy Alcohol Use

List of Daily Medications

1.	2.	3.
4.	5.	6.
7.	8.	9.
10.	11.	12.
13.	14.	15.

Notice of Privacy Practices for Protected Health Information

Cataract & Corneal Associates, P.C. makes efforts to respect patient's need for privacy and individual dignity. We treat patients' protected health information (PHI) as confidential, and we use and disclose PHI only in conformance with state and federal laws.

For purposes listed below, this practice may share patients' PHI with providers and health insurance plans:

1. To another physician who is treating patient.
2. To insurance carrier to make sure patient is eligible for benefits and to obtain reimbursement for services.
3. To insurance carrier for purpose of obtaining pre-authorization for medical or surgical care.
4. To evaluate the quality of care the patient receives.
5. Within this practice, for purposes of treatment, payment and healthcare operations.
6. To communicate with family: Using our best judgment, we 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 in payment for such care, or in an emergency.

Cataract & Corneal Associates, P.C., its physicians and staff does not make certain disclosures of patients' PHI without the patient's authorization to such outside entities as employers, life or disability insurances companies, drug companies and journalists, for marketing, research or fund raising.

Cataract & Corneal Associates, P.C., will disclose PHI without patients authorization for certain situations, some of which are listed below:

1. In response to a court order, court-ordered warrant, subpoena or summons.
2. Disclosure to law enforcement to identify or locate a suspect or witness.
3. As required by law for public health activities and disease prevention or control.
4. As required by law to social or protective services with respect to victims of abuse or domestic violence.

As a patient, you have the right under HIPPA to:

1. Inspect and copy your medical record.
2. Request an amendment in PHI, in writing.
3. Request restrictions on certain PHI uses and disclosures, in writing.
4. Obtain from practice an accounting of any PHI disclosures made after April 14, 2003 (with exceptions such as disclosures for treatment, payment or healthcare operations and disclosures to the patient).
5. Request changes or restrictions in the way our practice communicates protected health information to you (e.g. by mail. To what address, and so forth), in writing.
6. Receive a copy of your practice's privacy policy.
7. Complain about any alleged violations of the HIPPA privacy rules to practice's Privacy Officer or the U.S. Dept. of Health & Human Services.

Patient Name:_____Signature/Date:_____

*** I acknowledge receipt of the Notice of Privacy Practices ***

CATARACT & CORNEAL ASSOCIATES, P.C.
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ANDREA T. JUE, M.D.

AUTHORIZATION OF BENEFITS AGREEMENT

I request that payment of all authorized Medicare/other Insurance Company benefits may be made on my behalf to this office for any services provided by the physician to me. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents, if I have Medicare and/or my insurance company, any information needed to determine these benefits or the benefits payable for related services.

If my coverage is under a Group Contract held by an employer, an association, trust fund, union or similar entry, this authorization also permits disclosure to them for purposes of utilization review or audit.

I understand that I am responsible for my yearly deductible to be paid directly to the physician.

I also have been informed that Medicare/other Insurance Company may or may not pay for certain services (including, but not limited to, refractions, topographies, contact lenses, contact lens fitting, punctal plugs, surgical assistant's fee, etc.) , and I am responsible for direct payment to the physician for these non-covered services.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage.

_____

Name of Patient of Guardian (please print)

_____

Authorized Signature

Date:_____ DOB:_____