BUCKLEY CHANG EYE INSTITUTE PATIENT REGISTRATION FORM **DATE:**

How were you referred to us?..... _____
Personal Physician…… _____
Family members who are patients
Of Buckley Chang Eye Institute. _____
_____

PATIENT INFORMATION (PLEASE PRINT) E-mail address: _____

PATIENT LEGAL NAME (LAST, FIRST, MIDDLE INITIAL) DATE OF BIRTH AGE MARITAL STATUS SEX SOCIAL SECURITY NBR

MAILING ADDRESS CITY AND STATE ZIP CODE TELEPHONE NUMBER
Area Code
( )

PATIENT'S EMPLOYER OCCUPATION (INDICATE IF STUDENT) BUSINESS PHONE
Area Code
( )

EMPLOYER'S STREET ADDRESS CITY AND STATE ZIP CODE CELL PHONE
Area Code
( )

SPOUSE'S NAME (LAST, FIRST, MIDDLE INITIAL)

SPOUSE'S EMPLOYER OCCUPATION (INDICATE IF STUDENT) BUSINESS PHONE
Area Code
( )

EMPLOYER'S STREET ADDRESS CITY AND STATE ZIP CODE CELL PHONE
Area Code
( )

STREET ADDRESS (IF DIFFERENT THAN MAILING ADDRESS)

PERSON TO REACH IN CASE OF EMERGENCY
NAME _____
STREET ADDRESS _____
CITY AND STATE _____
PHONE NUMBER ( ) _____

IF THE PATIENT IS A MINOR OR STUDENT/RESPONSIBLE PARTY

MOTHER'S NAME STREET ADDRESS, CITY, STATE ZIP CODE TELEPHONE NUMBER

MOTHER'S EMPLOYER OCCUPATION SOCIAL SECURITY NUMBER BUSINESS PHONE

EMPLOYER'S STREET ADDRESS CITY AND STATE ZIP CODE

FATHER'S NAME STREET ADDRESS, CITY, STATE ZIP CODE TELEPHONE NUMBER

FATHER'S EMPLOYER OCCUPATION SOCIAL SECURITY NUMBER BUSINESS PHONE

EMPLOYER'S STREET ADDRESS CITY AND STATE ZIP CODE

PRIMARY LANGUAGE: _____ RACE: _____ ETHNICITY: _____

TURN OVER

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR THIS ACCOUNT

NAME_____

MAILING ADDRESS_____

CITY AND STATE_____

PHONE NUMBER ( )_____

PLEASE MARK BELOW IF APPLICABLE

NAME OF PRIMARY INSURANCE	NAME OF SECONDARY INSURANCE
POLICY ID #	POLICY ID#
GROUP #	GROUP #
EFFECTIVE DATE	EFFECTIVE DATE
SUBSCRIBER NAME	SUBSCRIBER NAME
SUBSCRIBER DATE OF BIRTH	SUBSCRIBER DATE OF BIRTH
SUBSCRIBER SOCIAL SECURITY #	SUBSCRIBER SOCIAL SECURITY #

STATEMENT OF PERMIT

I request that payment of authorized Medicare or other insurance carrier benefits be made either to me or on my behalf to the Buckley Chang Eye Institute, Eye Surgery Center, or Anesthesia Services for any services furnished me by the physicians at the Institute. I authorize any holder of medical information about me to release to the Health Care Finance Administration (Medicare) or any other insurance carrier that I have contracted with, or their agents, any information needed to determine those benefits or the benefits payable for related services. I have received a copy of the Notice of Medical Information Privacy Rights for the Buckley Chang Eye Institute.

Patient's Signature **Date**

_____ _____

I REALIZE IF INSURANCE INFORMATION IS INCORRECT AT TIME OF SERVICE, I WILL BE RESPONSIBLE FOR PAYMENT AND BILLING.

_____ _____

Patient Signature **Date**

BUCKLEY CHANG EYE INSTITUTE

Patient History Questionnaire

Name_____ Date of Birth_____

Home Phone Number_____ 2nd Phone Number_____

Primary Physician Name:_____ Phone_____

Current Medications _____

_____

ALLERGIES TO MEDICINES _____

Review of Systems: Please check YES or NO in boxes, if yes please give explanation on line provided

Eyes	Yes	No	Explanation of Problem (If no proceed to next topic)
Blurry Vision	□	□	
Burning/Dryness	□	□	
Double vision	□	□	
Excess tearing/watering/scratchy sensation	□	□	
Glare/light sensitivity	□	□	
Itching	□	□	
Loss of side vision	□	□	
Loss of Vision	□	□	
Pain or soreness	□	□	
Redness	□	□	
Reading in general	□	□	
Seeing at a distance	□	□	
Are you satisfied with your present vision?	□	□	

Eye History	YES	NO	When diagnosed	Treatment	Family member (relationship)
Cataract	□	□			
Glaucoma	□	□			
Eye muscle problems	□	□			
Retina problems	□	□			
Eyelid	□	□			
Other	□	□			

Current Eye Medications _____

_____

Constitutional Symptoms	Yes	No	EXPLANATION OF PROBLEM (If no proceed to next topic)
Fever	□	□	
Weight Loss	□	□	

Ears, Nose, Mouth, Throat			(If No proceed to next topic)
Hearing problems	□	□	
Sinus Congestion	□	□	
Chronic cough/bronchitis	□	□	

Cardiovascular			(If no proceed to next topic)
Congestive heart failure	□	□	
Heart attacks	□	□	
Irregular/fast heartbeat	□	□	
High Blood pressure	□	□	

Respiratory			(If no proceed to next topic)
Asthma	□	□	
Emphysema	□	□	
Tuberculosis	□	□	
Lung cancer	□	□	

TURN OVER

	Yes	No	EXPLANATION OF PROBLEM
Gastrointestinal (Stomach/Intestines)			(If no proceed to next topic)
Hepatitis	□	□	_____
Ulcers/Bleeding	□	□	_____
Cancer	□	□	_____
Genitourinary (Genital/Kidney/Bladder)			(If no proceed to next topic)
Kidney disease	□	□	_____
Prostate cancer	□	□	_____
Cervical/Uterine/Ovarian/Breast Cancer	□	□	_____
Pregnant now?	□	□	_____
Integumentary (Skin/Breast)			(If no proceed to next topic)
Skin disease/Shingles	□	□	_____
Skin cancer	□	□	_____
Breast cancer	□	□	_____
Musculo-Skeletal			(If no proceed to next topic)
Degenerative arthritis	□	□	_____
Rheumatoid arthritis	□	□	_____
Lupus	□	□	_____
Neurological			(If no proceed to next topic)
Fainting/Dizziness	□	□	_____
Migraines/headaches	□	□	_____
Convulsions/Seizures/Epilepsy	□	□	_____
Stroke/Paralysis	□	□	_____
Tumor	□	□	_____
Alzheimer's	□	□	_____
Psychiatric			(If no proceed to next topic)
Depression	□	□	_____
Schizophrenia	□	□	_____
Hematologic/Lymphatic			(If no proceed to next topic)
Anemia	□	□	_____
Sickle cell disease	□	□	_____
Bleeding disorder	□	□	_____
Leukemia/Blood Cancer	□	□	_____
Allergic/Immunologic			(If no proceed to next topic)
Seasonal/General Allergies	□	□	_____
Hay fever symptoms	□	□	_____
Immune Disorders	□	□	_____
Endocrine			(If no proceed to next topic)
Diabetes	□	□	_____
Thyroid problems	□	□	_____

Family and Social History

Family History: Describe any major illness or hereditary problems of parents, grandparents, brothers or sisters:

_____

Social History	Yes	No	
Drugs	□	□	_____
Alcohol	□	□	_____
Smoking	□	□	_____

Date_____ Patient Signature _____

Date_____ Physician Signature _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Effective Date: September 1, 2013

I hereby acknowledge the receipt of Notice of Privacy Practices from Buckley Chang Eye Institute on _____(Date)

I request removal from lists that initiate promotional or marketing communications. Yes_____ Initials_____

_____

(Signature of the Patient, Guardian or Legal Representative)

_____

(Relationship to patient)

In caring for our patients, it may be necessary for Buckley Chang Eye Institute staff to contact you by phone. When we are not available to speak to you directly, we like to leave messages when possible. In order to protect your privacy, it is Buckley Chang Eye Institute's policy to:

- **Not leave messages with anyone except the patient or legal guardian.**
- **Not leave specific information on an answering machine/voice mail system, unless we have your written permission to do so.**

****

Please review the information below and consider carefully whom you choose to have access to your medical information such as exams, labs/radiology results, appointments and your insurance or billing information. Please check the applicable ways for us to reach you.

Consent:

☐ Home phone or answering machine (detailed message)

☐ Office phone or office voice mail (detailed Message)

☐ Spouse (detailed message) Spouses name: _____

☐ Other (please specify): _____

OR

Denial:

I _____ wish to be contacted personally and do not authorize Buckley Chang Eye Institute to leave messages with any other person.
Please provide Buckley Chang Eye Institute with a contact phone number: _____

_____

You have the option to change your preferences of how we contact you by completing a new Patient Contact Consent at any time.

_____ _____

Patient/Guardian Signature is Required **Date**

Authorization Form – Use or Disclosure of PHI

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the person or entity authorized to receive the information is not a health plan or health care provider, the released information may not longer be protected by federal privacy regulations.

Patient Name

Patient ID (Office Use)

Entity Authorized to Provide Information

Person/Entity Authorized to Receive Information

Specific description of information (including dates):

The purpose of the use or disclosure is:

Will the person or entity requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes _____ No _____

I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials _____

I understand that I may see and copy the information describe on this form if I ask for it, and that I will receive a copy of this form after I sign it. Initials _____

I understand that this authorization will expire on _____ .

Initials _____

I understand that I may revoke this authorization at any time by written notice to Buckley Chang Eye Institute. I also understand that if I revoke this authorization, the revocation will not have any effect on actions taken by Buckley Chang Eye Institute before Buckley Chang Eye Institute received the revocation. I also understand that more information regarding revocation of this authorization may be covered in Buckley Chang Eye Institute's Notice of Privacy Practices.

Signature of Individual or Guardian or Individual's Legal Representative

Date

Printed Name, Relationship of Legal Representative to Individual

FORM OF NOTICE

NOTICE OF PRIVACY PRACTICES

Effective Date: September 1, 2013

1. Notice

"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."

Our organization values you as a customer, and protection of your privacy is very important to us. In conducting our business, we will create and maintain records that contain protected health information about you and the health care services provided to you

"Protected health information" or "PHI" is information about you, including individually identifiable information about where you live, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We protect your privacy by:

1. limiting who may see your PHI;
2. limiting how we may use or disclose your PHI;
3. Informing you of our legal duties with respect to your PHI;
4. Explaining our privacy policies; and
5. Adhering to the policies currently in effect.

This Notice describes our privacy practices, which include how we may use, disclose, collect, handle, and protect individual's protected health information. We are required by certain federal and state laws to maintain the privacy of your protected health information. We also are required by the federal Health Insurance Portability and Accountability Act (or "HIPAA") Privacy Rule to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information.

This Notice takes effect on September 1, 2013 and will remain in effect until we replace or modify it.

2. Copies of this Notice

You may request a copy of our Notice at any time. If you want more information about our privacy practices, or have questions or concerns, please contact us using the contact information at the end of this Notice.

3. Changes to this Notice

The terms of this Notice apply to all records that are created or retained by us which contain your PHI. We reserve the right to revise or amend the terms of this Notice. A revised or amended Notice will be effective for the entire PHI that we already have about you, as well as for any PHI we may create or receive in the future. We are required by law to comply with whatever Privacy Notice is currently in effect. You will be notified of any material change to our Privacy Notice before the change becomes effective.

4. Potential Impact of State Law

The HIPAA Privacy Rule generally does not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

5. How We May Use and Disclose Your Protected Health Information (PHI)

We are permitted to use and disclose your PHI, to provide treatment to you, to be paid or request payment for our services, and to conduct health care operations. This section of this Notice discusses each of these types of uses and disclosures of PHI.

1. **For Treatment**. We may use PHI about you to provide you with health care treatment or services. For example, we may use your PHI when performing medical procedures. We may disclose PHI about you to our Organization workforce, as well as to doctors, nurses, hospitals, clinics, or other health care providers who are involved in your care. For example, a doctor treating you for a medical condition may need to know the medications which have been prescribed for you, or the services and items that have been provided to you.
2. **For Payment**. We may use and disclose PHI about you so that the services and items that you receive may be billed to and payment may be collected from you, an insurance company, or a third party payer. We may need to give your health plan information about the services or items that you received so that your health plan will pay us or reimburse you for the services or items.
3. ***For Health Care Operations***. *We may use and disclose PHI about you for health care operations. These uses and disclosures are necessary to make sure you receive quality care. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff in providing services to you. We may also disclose information to doctors, nurses, hospitals, clinics, and other health care providers, for review and learning purposes. We may remove information that identifies you from this set of PHI so others may use it to study health care and health care delivery without learning the names of the specific individuals.*

Other Uses and Disclosures of PHI Listed below are a number of other ways that we are permitted or required to use or disclose PHI. This list is not exhaustive and hence not every use or disclosure in a category is listed.

1. **Appointment Reminders.** We may use and disclose protected health information to contact you as a reminder that you have an appointment with us.

2. **Individuals Involved in Your Care or Payment for Your Care.** We may release PHI about you to a friend or family member who is involved in your medical care. We may share PHI about you with family members or friends who accompany you or to someone who helps pay for your care. In addition, we may disclose PHI about you to a person or entity assisting in an emergency so that your family can be notified about your condition, status and location.

3. **As Required By Law.** We will disclose PHI about you when required to do so by federal, state, or local law.

4. **Public Health Risks.** We may disclose PHI about you for public health activities, including preventing or controlling disease or, when required by law, to notify public authorities concerning cases of abuse or neglect.

5. **Health Oversight Activities.** We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure.

6. **Lawsuits and Disputes.** If you are involved in a lawsuit or dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

7. **Law Enforcement.** We may release PHI if asked to do so by a law enforcement official as permitted by law.

8. **Coroners and Medical Examiners**. We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

9. **Research.** Under certain circumstances, we may use and disclose PHI about you for research purposes. For example, we might disclose PHI to be used in a research study. In some cases, we might disclose PHI for research purposes without your knowledge or approval. However, such disclosures will be made only if approved through a special process. This process evaluates a proposed research project and its use of PHI, trying to balance the research needs with an individual's need for privacy of their PHI.

10. **To Avert a Serious Threat to Health or Safety.** We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

11. **Military and Veterans.** If you are a member of the armed forces, we may release PHI about you as required by military command authorities.

12. **Health-Related Benefits and Services.** We may use and disclose PHI to tell you about health-related benefits or services that may be of interest to you.

13. **Workers' Compensation.** We may release PHI about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

14. **Fundraising**. We may disclose PHI about you for fundraising purposes. Any such disclosure of PHI will be limited in scope and disclosed only to our business associates or to a charitable organization which is obligated to act for the benefit of this Organization. In case you do not want us to contact you about fundraising, you must notify our Privacy Officer in writing and you will be removed from our contact list.

15. **Parents as Personal Representatives of Minors**: In most cases, we may disclose your minor child's PHI to you. However, we may be required to deny a parent's access to a minor's PHI according to applicable state law.

Authorization for Other Uses and Disclosures

1. Other uses and disclosures of your PHI that are not described above will be made only with your written authorization.
2. You may give us written authorization permitting us to use your PHI or disclose it to anyone for any purpose.
3. We will obtain your written authorization for uses and disclosures of your PHI that are not identified by this Notice, or are not otherwise permitted by applicable law.
4. Any authorization that you provide to us regarding the use and disclosure of your PHI may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization.
5. We may also be required to disclose PHI as necessary for purposes of payment for services received by you prior to the date when you revoke your authorization.
6. Your authorization must be in writing and contain certain elements to be considered a valid authorization.

6. Privacy Rights Concerning Your Protected Health Information (PHI)

You have the following rights regarding the PHI that we maintain about you. Requests to exercise your rights must be in writing.

1. **Right to Access Your PHI**: You have the right to inspect or get copies of your PHI contained in a designated record set. Generally, a "designated record set" contains medical, enrollment, claims and billing records we may have about you, as well as other records that we may use to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

2. **Right to Copy:** You may request that we provide copies of your PHI in a format other than photocopies. We will use the format you request unless we cannot practicably do so. We may charge a reasonable fee for copies of PHI (based on our costs), for postage, and for a custom summary or explanation of PHI. You will receive notification of any fee(s) to be charged before we release your PHI, and you will have the opportunity to modify your request in order to avoid and/or reduce the fee. In certain situations we may deny your request for access to your PHI. If we do, we will tell you our reasons in writing, and explain your right to have the denial reviewed. If you seek a review, , a licensed health care provider chosen by us will review your request and the denial. The person conducting the review will not be the person who originally denied your request. We shall comply with the outcome of the review.

3. **Right to Request an Amendment to PHI**: You have the right to request that we amend your PHI if you believe there is a mistake in your PHI, or that important information is missing. To request an amendment to your PHI, your request must be made in writing. In addition, you must provide a reason that supports your request. We will generally make a decision regarding your request for amendment no later than 60 days after receipt of your request. However, if we are unable to act on the request within this time, we may extend the time for 30 more days but shall provide you with a written notice of the reason for the delay and the approximate time for completion. If we deny your requested amendment, we will provide you with a written denial. Approved amendments made to your PHI will also be sent to those who need to know. We may also deny your request if, for instance, we did not create the information you want amended. If we deny your request to amend your PHI, we will tell you our reasons in writing, and explain your right to file a written statement of disagreement.

4. **Right to an Accounting of Certain Disclosures**: You may request, in writing, that we tell you when we or our Business Associates have disclosed your PHI (an "Accounting"). Any accounting of disclosures will not include those we made:

    a) for payment, or health care operations

    b) to you or individuals involved in your care;

    c) with your authorization;

    d) for national security purposes;

    e) to correctional institution personnel

    f) To request accounting of such disclosures, your request must be submitted in writing. Your request must also state a time period, which may not be longer than six (6) years. Your request should also specify the format in which you prefer to receive the accounting, i.e. on paper or electronic format. We may charge you for the costs of providing the accounting. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

5. **Right to Request Restrictions**: You have the right to request, in writing, that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to your request. However, if we do agree, we will be bound by our agreement except when required by law, in emergencies, or when information is necessary to treat you. An approved restriction continues until you revoke it in writing, or until we tell you that we are terminating our agreement to a restriction.

   You have the right to request a restriction on disclosure of your PHI to a health plan (for purposes of payment or health plan operations) in cases where you've paid out of pocket, in full, for the items received or services rendered.

   You have the right to request removal from lists that initiate promotional or marketing communications. We must obtain your authorization before removing your name from these lists. If you do not wish to be contacted, please notify us in writing.

6. **Right to Request Confidential Communications**: You have the right to request, in writing, that we use alternate means or an alternative location to communicate with you in confidence about your PHI. For instance, you may ask that we contact you by mail, rather than by telephone, or at work, rather than at home. Your written request must clearly state that the disclosure of all or part of your PHI at your current address or method of contact we have on record could be an endangerment to you. We will require that you provide a reasonable alternate address or other method of contact for the confidential communications. In assessing reasonableness, we will consider our ability to continue to receive payment and conduct health care operations effectively, and the subscriber's right to payment information. We may exclude certain communications that are commonly provided to all members from confidential communications. Examples of such communications include benefit booklets and newsletters.
7. **Right to a Paper Copy of This Notice**: You have the right to receive a paper copy of our Notice of Privacy Practices. You can request a copy at any time, even if you have agreed to receive this Notice electronically. To request a paper copy of this Notice, please contact our reception desk.
8. ***Your Right to File a Privacy Complaint:*** *If you believe your privacy rights have been violated, or if you are dissatisfied with our privacy practices or procedures, you may file a complaint with Buckley Chang Eye Institute's Privacy Office and with the Secretary of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.*
9. To file a privacy complaint with us, you may contact the Privacy Office as follows:

   Organization:
   Buckley Chang Eye Institute
   Contact Details:
   3155 N Union Blvd, Colorado Springs, CO 80907
   (719) 444-3000
   Barbara Cole, Privacy and Security Official