Baptist Eye Surgeons, PLLC

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PATIENT INFORMATION

ACCOUNT NUMBER_____ DATE_____ UPDATE_____

LAST NAME_____ FIRST_____ MI_____

MAILING ADDRESS _____

EMAIL ADDRESS _____CELL #_____

CITY_____ STATE_____ ZIP_____ PHONE_____

EMPLOYER_____ EMPLOYER PHONE_____

SEX_____ MARITAL STATUS_____ BIRTHDATE_____

SOCIAL SECURITY NUMBER_____

PHARMACY NAME: _____ PHONE #: _____

DO YOU HAVE: LIVING WILL ☐ YES ☐ NO POWER OF ATTORNEY ☐ YES ☐ NO

SOME EYE DISEASES ARE MORE PREVALENT IN CERTAIN RACES AND/OR ETHNIC GROUPS. WHILE THIS INFORMATION IS OPTIONAL, PROVIDING THIS INFORMATION MAY HELP YOUR PHYSICIAN PROVIDE BETTER EYE CARE.

RACE: ☐ ASIAN ☐ BLACK ☐ CAUCASIAN ☐ HISPANIC ☐ OTHER _____

PRIMARY LANGUAGE _____

SPOUSE/GUARDIAN INFORMATION

SPOUSE/GUARDIAN NAME_____ SPOUSE/GUARDIAN SS#_____

SPOUSE/GUARDIAN EMPLOYER_____ EMPLOYER PHONE_____

SPOUSE/GUARDIAN DATE OF BIRTH_____

PERSON OR NEAREST RELATIVE TO CONTACT IN CASE OF EMERGENCY_____

_____ PHONE NUMBER_____

DID SOMEONE SEND YOU TO US?_____ WHO?_____

IF NOT, HOW DID YOU HEAR ABOUT US?_____

FAMILY PHYSICIAN_____ PHONE NUMBER_____

FAMILY PHYSICIAN ADDRESS_____

OVER

I am financially responsible to pay Baptist Eye Surgeons, PLLC for services the doctors and ancillary personnel provide. Payment in full is due at the time service is rendered.

If I am a Health Plan enrollee, I will be responsible for paying all charges the insurance plan does not allow, such as non-covered services (Refractions), deductibles, co-insurance, and co-payment amounts. I will make these payments at the time of service. If the insurance claim is rejected, I will be responsible for paying the entire amount, depending on the plan's contractual obligations.

_____

Patient Signature

_____

Date

RELEASE OF INFORMATION AND INSURANCE BENEFIT AUTHORIZATION

I hereby authorize and direct Baptist Eye Surgeons, PLLC, when and as requested, to disclose any or all of the information in my medical records needed to determine benefits or the benefits for related services to any person such as any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf. This assignment will remain in effect until revoked by me in writing. I further authorize the Baptist Eye Surgeons, PLLC to disclose such information to its insurance carrier or carriers when so requested by the carrier.

I also authorize and direct the named insurer to pay directly to the Baptist Eye Surgeons, PLLC any or all benefits up to the amount of my bill accruing to me in connection to my treatment. For Medicare/Medicaid recipients: I certify that the information given by me for payment under title XVIII or XIX of the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf.

_____

Patient Signature

_____

Date

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Nickname: _____ Date of Birth: ____/____/_____

Primary Care Physician: _____ Referring /Specialty Dr._____

Pharmacy:_____ Location(street & city) _____

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

Ethnicity: ◻ Hispanic ◻ Not Hispanic

Preferred Language: ◻ English ◻ French ◻ Italian ◻ Japanese ◻ Portuguese
◻ Russian ◻ Spanish

Allergies:	**Reaction**	**Severity**
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe

Past Ocular History: (Please mark all that apply) ◻ No history of eye problems

◻ Cataracts ◻ Hyperopia (Far sighted) ◻ Myopia (Near sighted) ◻ Amblyopia (Lazy eye)
◻ Diabetic Retinopathy ◻ Iritis ◻ Optic Neuritis ◻ Aphakia
◻ Dry Eyes ◻ Keratoconus ◻ Retinal Detachment ◻ Astigmatism
◻ Glaucoma ◻ Macular Degeneration

Other_____

Ocular Surgeries: (Please mark all that apply) ◻ No prior ocular surgery

R - L	R - L	R - L	R - L
◻ ◻ Foreign Body Removal	◻ ◻ Punctal Plugs	◻ ◻ Laser	◻ ◻ Cataract Surgery
◻ ◻ Blepharoplasty	◻ ◻ Retinal Laser Surgery	◻ ◻ RK	◻ ◻ LASIK/PRK
◻ ◻ Strabismus Surgery	◻ ◻ Vitrectomy	◻ ◻ Corneal Transplant	◻ ◻ Eye Muscle Surgery

Other_____

Current Eye Medications: (Please list)

_____ _____ _____

_____ _____ _____

Are you currently pregnant? Yes_____ No_____

Other Medical History: ◻ No history of illnesses

◻ Thyroid Disease ◻ Congestive Heart Failure ◻ Headache ◻ Lung Disease
◻ Anemia ◻ COPD ◻ High Blood Pressure ◻ Lupus
◻ Arthritis ◻ Diabetes Type 1 ◻ High Cholesterol ◻ Migraine
◻ Arrhythmia ◻ Diabetes Type 2 ◻ HIV/ AIDS ◻ Polymyalgia
◻ Asthma ◻ Eczema ◻ Kidney Disease ◻ Psychiatric Disorder
◻ Bleeding Disorder ◻ Fibromyalgia ◻ Kidney Stones ◻ Skin Cancer
◻ Cancer ◻ Hearing Loss ◻ Liver Disease ◻ Stroke
◻ Chicken Pox ◻ Herpes Zoster / Shingles ◻ Meningitis ◻ Toxoplasmosis
◻ Hepatitis A / B / C ◻ Histoplasmosis ◻ MRSA ◻ Wound Infection
◻ Herpes Simplex ◻ Syphillis

Other_____

General Surgeries / Operations: (Please list)

_____ _____ _____

_____ _____ _____

All Other Medications: (Please list)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please continue on the back side of this page →

Family History:

- ◻ Arthritis
- ◻ Blindness
- ◻ Cancer
- ◻ Cataracts
- ◻ Diabetes
- ◻ Glaucoma
- ◻ Heart Disease
- ◻ High Blood Pressure
- ◻ Kidney Disease
- ◻ Lazy Eye
- ◻ Macular Degeneration
- ◻ Retinal Disease
- ◻ Stroke
- ◻ TB

Other_____

Social History: (Please mark all that apply)

Smoking: ◻ current every day smoker ◻ current some day smoker ◻ former smoker ◻ never smoked

Alcohol Use: ◻ Yes ◻ No If yes how much and how often?_____

Drug Use: ◻ Yes ◻ No If yes what and how often?_____

Review of Systems

Eyes *

Previous Surgery	☐ YES	☐ NO
Contact Lens	☐ YES	☐ NO
Pain	☐ YES	☐ NO
Double Vision	☐ YES	☐ NO
Glaucoma	☐ YES	☐ NO
Cataracts	☐ YES	☐ NO
Macular Degeneration	☐ YES	☐ NO
Dry Eyes	☐ YES	☐ NO
Flashes	☐ YES	☐ NO
Floaters	☐ YES	☐ NO

Ear, Nose, and Throat *

Hard of Hearing	☐ YES	☐ NO
Ringing in Ears	☐ YES	☐ NO
Vertigo	☐ YES	☐ NO

Cardiovascular *

Chest Pain	☐ YES	☐ NO
Dizziness	☐ YES	☐ NO
Fainting Spells	☐ YES	☐ NO
Shortness of Breath	☐ YES	☐ NO
Irregular Heart Beat	☐ YES	☐ NO
Difficulty Lying Flat	☐ YES	☐ NO

Constitutional *

Fatigue/Weakness	☐ YES	☐ NO
Fever	☐ YES	☐ NO
Weight Gain/Loss	☐ YES	☐ NO

Respiratory *

Cough	☐ YES	☐ NO
Congestion	☐ YES	☐ NO
Wheezing	☐ YES	☐ NO
Asthma	☐ YES	☐ NO

Gastrointestinal *

Heartburn	☐ YES	☐ NO
Nausea/Vomiting	☐ YES	☐ NO
Jaundice/Hepatitis	☐ YES	☐ NO

Genito-Urinary *

Pain/Difficulty	☐ YES	☐ NO
Blood in Urine	☐ YES	☐ NO
History of Kidney Stones	☐ YES	☐ NO
History of STD's	☐ YES	☐ NO

Psychiatric *

Anxiety/Depression	☐ YES	☐ NO
Mood Swings	☐ YES	☐ NO
Difficulty Sleeping	☐ YES	☐ NO

Endocrine *

Increased Thirst	☐ YES	☐ NO
Increased Hunger	☐ YES	☐ NO
Increased Urination	☐ YES	☐ NO
Increased Sweating	☐ YES	☐ NO
Fingernail Changes	☐ YES	☐ NO

Blood/Lymphnodes *

Easy Bruising	☐ YES	☐ NO
Gums Bleed Easily	☐ YES	☐ NO
Prolonged Bleeding	☐ YES	☐ NO
Heavy Aspirin Use	☐ YES	☐ NO

MusculoSkeletal *

Stiffness	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO
Joint Pain/Swelling	☐ YES	☐ NO
More than 2 falls in last y	☐ YES	☐ NO

Skin *

Rash/Sores	☐ YES	☐ NO
Lesions	☐ YES	☐ NO
Hives/Eczema	☐ YES	☐ NO

Neurological *

Seizures	☐ YES	☐ NO
Weakness/Paralysis	☐ YES	☐ NO
Numbness	☐ YES	☐ NO
Tremors	☐ YES	☐ NO

Immunologic *

Hives	☐ YES	☐ NO
Itching	☐ YES	☐ NO
Runny Nose	☐ YES	☐ NO
Sinus Pressure	☐ YES	☐ NO
Influenza vaccination?	☐ YES	☐ NO
Pneumonia vaccination?	☐ YES	☐ NO

Baptist Eye Surgeons, PLLC

Medical Records Release – Patient Authorization for Use/Disclosure of Protected Health Information

Patients Name: _____ Date of Birth: _____

Patients Address: _____

Email Address: _____

I, the undersigned patient or legal representative, herby authorize Doctor _____ (Provider) to release my entire medical record or designated portions in provider's possession to _____ for all dates of service indicated.

I understand that my decision to sign this form is voluntary, and the provider may not condition treatment, payment, enrollment or eligibility for benefits whether I sign this authorization. I understand that I may revoke this authorization, in writing, at any time by following the directions in the Provider's Notice of Privacy Practices, except to the extent that the provider has already acted, based on this authorization.

I understand this authorization shall expire, without my express revocation, 60 days from the date written below. I understand that the information disclosed under this authorization may no longer be protected by HIPAA privacy regulations and may be subject to redisclosure by the recipient. A photocopy or facsimile of this form shall be valid as the original.

Dates of service to release: _____

____ This release is being made at my request, for the purpose of transferring my care

____ The entire medical record is being requested

**** Psychiatric records or infectious diseases (i.e. HIV, Hepatitis C, TB, etc.) must be clearly marked or checked before they will be released and MUST be physician approved.**

The following portions of the Medical Record are being requested or approved to release:

___ Record/Dictation ___ History & Physical ___ Labs ___ X-Ray Reports
___ Pathology Report ___ Doctors Orders ___ Medications ___ Itemized Bill
___ Other ___ Psychiatric or infectious disease records ___ Photos, digital, video images

Form/Format: ___ Paper Records ___ Fax ___ Email
*Sending medical records via email has risks, including the individuals PHI being ready or otherwise intercepted by a third party while in transit. File size may limit ability to send by email. Your records will be sent via encrypted email.

I ACCEPT THESE TERMS AND AUTHORIZE THE ABOVE DESCRIBED DISCLOSURE.

_____ _____
Patient Signature Date

_____ _____
Patient's Legal Representative Date
Legal representative is authorized to act for the patient as the patient's: ___ Parent ___ Legal Guardian ___ Other

_____
Printed Name

Locations:

Downtown Knoxville
4528 Chapman Highway
Knoxville, TN 37920
865-579-3920 Phone
865-579-3925 Fax

West Knoxville
140 Capital Drive, Suite 110
Knoxville, TN 37922
865-579-3920 Phone
865-251-0730 Fax

Morristown
3001 W Andrew Johnson Hwy
Morristown, TN 37814
423-581-0360 Phone
423-585-4244 Fax

Consent to the Use and Disclosure of Health Information

I understand that as part of my health care, Baptist Eye Surgeons, PLLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment, I understand that this information serves as:

A basis for planning my care and treatment,
A means of communication among the many health professionals who contribute to my care,
A source of information for applying my diagnosis and surgical information to my bill
A means by which a third-party payer can verify that services billed where actually provided, and A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a ***Notice of Privacy Policies*** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

The right to review the notice prior to signing this consent,
The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Baptist Eye Surgeons, PLLC is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Baptist Eye Surgeons, PLLC reserves the right to change their notice and practices and to make the new provisions effective for all protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice", viewing our website at www.baptisteye.com or by visiting our office and picking up a copy.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures transmitted by electronic transmission, fax transmittal, or e-mail.

Please print the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care options).

Printed Name_____Relationship_____DOB_____Phone_____

Printed Name_____Relationship_____DOB_____Phone_____

Can confidential messages be left on your answering machine or voicemail? YES____ NO__

_____
Patient's Name Printed

_____ _____
Patient's Signature Date

NOTICE OF PRIVACY POLICIES FOR

Baptist Eye Surgeons, PLLC

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 Baptist Eye Surgeons, PLLC 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 use or disclose that information. It also describes your rights as they relate to your protected health information.

Understanding Your Health Record/Information
Each time you visit Baptist Eye Surgeons, PLLC, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or 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 payer 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 assess and continually work to improve the care we render and the outcomes we achieve,

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 disclosures to others.

Your Health Information Rights
Although your health record is the physical property of Baptist Eye Surgeons, PLLC, the information belongs to you. You have the right to:

- Obtain a copy of this notice of information practices upon request as provided in 45 CFR 164.524
- 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. We will honor any request to restrict disclosures of your PHI to health plans if the disclosure is only for the purpose of carrying out payment or health care operations, is not otherwise required to be disclosed by law, and the cost of the health care item or services provided has been paid in full by a person other than the health plan.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities
Baptist Eye Surgeons, PLLC 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, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right change our privacy practices and to make the new provisions effective for all protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy. We will post a copy of the revised Notice in our office in the public areas.

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 practice's Privacy Officer, at 865/579-3920.
If you believe your privacy rights have been violated you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer of the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights, DHHS
61 Forsyth Street, SW. – Suite 16T70
Atlanta, GA 30303-8909

Examples of Disclosures for Treatment, Payment and Health Operations
We will use your 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 primary care physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you.

We will use your health information for payment.

(Additional Information on other side)

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 health care operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to access 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: Unless you notify us that you object, 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 professionals 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 directors 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 purpose of tissue donation and transplant.

Fundraising: We may contact you as part of a fundraising effort. (You have the right to opt out of receipt of fundraising information.)

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 compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with the laws relating to workers 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 charged with preventing or controlling disease, injury, or disability.

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 provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believers 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.

Disclosures-Written Authorization Required:

Psychotherapy Notes: We must obtain your written authorization prior to releasing any information from your mental health professional documenting or analyzing the contents of a conversation during a counseling session that are separated from the rest of your medical records. If you provide us authorization to use or disclose your psychotherapy notes, you may revoke that authorization, in writing, at any time.

Marketing Activities: We must obtain your written authorization prior to using your protected health information for marketing activities. Marketing activity is a communication about a product or service that encourages recipients of the communication to purchase or use the product or service. This includes any communications regarding alternative treatments, therapies, health care providers, or products or services. If we receive any direct or indirect **payment** as a result of the use or disclosure of your protected health information, we will explicitly state in your signed authorization that we received such payment. If you provide us authorization to use or disclose your information for marketing activities, you may revoke that authorization, in writing, at any time.

Sale of Protected Health Information: We must obtain your written authorization prior to using your protected health information for any sale of your protected health information. This would include receiving any financial remuneration from the recipient of the protected health information we provided. We will explicitly state in your signed authorization that we received such payment. If you provide us authorization to use or disclose your information for the sale of your protected health information, you may revoke that authorization, in writing, at any time.

Notifications of Breach: We will notify affected individuals of a breach of unsecured protected health information, if that should occur. Individuals shall be notified in a timely manner, within 60 days of discovery of breach. We will take steps to mitigate harm that is reasonably anticipated by such an event.

Original Effective Date: April 1, 2003
Revised NPP Effective Date: 09/30/2013

Baptist Eye Surgeons, PLLC
Patient Waiver for Refraction

Patient Name: _____ Date: _____

Patient DOB: _____

Your insurance does not pay for all of your health care costs. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for these services.

The refraction is an essential part of an eye examination. This is the process used to determine if you need glasses or contacts and the strength that you need. It is also necessary to help your doctor determine the health and function of your eyes.

Medicare does not cover refractions, and most insurance companies follow Medicare's policy. Medicare and other insurance requires us to charge you for this service, in addition to your co-pay and/or deductible.

The total cost for the services/items that may be recommended by your physician are: **$25.00**

I acknowledge that I have been informed in advance of receiving these services, that these services are not covered by my health insurance plan. I have chosen to receive these services and understand that I will be financially responsible for the charges indicated above. **I also understand if I choose to not have this service performed I will not be able to receive a prescription for glasses or contacts.**

Print Patient Name: _____

Patient or guardian Signature: _____

Date: _____