NORTHWEST EYE SURGEONS

NORTHWEST EYE SURGEONS, P.C. – PATIENT RIGHTS & RESPONSIBILITIES

As a patient of Northwest Eye Surgeons P.C., you have the right to:

- Receive care in a safe setting regardless of race, color, sex, national origin, religion, or sexual preference.
- Be treated with respect and dignity, free from abuse, neglect or harassment, and be given access to protective services.
- File grievances without fear of discrimination, reprisal, or denial of care.
- Be provided appropriate personal privacy, spiritual care and communication, and be informed if communication restrictions are necessary for the care and safety of yourself or others in the facility.
- Expect disclosures, information and records to be treated confidentially and, except when required by law, be given the opportunity to approve or refuse their release.
- Review your records and receive a copy of them. You may also ask to amend your healthcare record.
- Know the names, professional status and responsibilities of your healthcare providers.
- Seek another medical opinion and change primary or specialty healthcare providers.
- Receive, to the degree known, complete information concerning your diagnosis, evaluation, treatment and expected, or unanticipated, outcomes. When medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
- Make informed decisions about your treatment and care. When patient participation or exercise of any right is contraindicated due to medical incapacity or adjudged incompetence, a legally authorized person may participate in decision making and act on the patient's behalf to exercise any and all rights.
- Refuse a recommended treatment or plan of care, to the extent permitted by law, and to be informed of any medical consequences related to that decision.
- Be informed if you will be part of research, investigational or clinical trials. Access to care will not be denied or hindered if you refuse to participate in research or trials.
- Know that Northwest Eye Surgeons P.C. has an Advance Directives Policy. Questions about our policy may be directed to the physician performing your procedure or to our surgical coordinating staff.
- Resolve problems with care decisions and voice grievances regarding care or service which is (or fails to be) provided without fear of reprisal or discrimination. Grievances will be investigated and a response provided within 14 days. Complaints and grievances may be verbal or written and directed to:
  - Spencer Michael, CEO 206-528-6000 ext. 3880
- Know the following physician shareholders who practice at NWES have an ownership interest in all of NWES's facilities.
  - Kristi Bailey
  - Brett Bence
  - Werner Cadera
  - Bruce Cameron
  - Aaron Kuzin
  - Audrey Talley Rostov

As a Northwest Eye Surgeons P.C. patient, you have the responsibility to:

- Provide complete and accurate medical information.
- Participate with providers in making decisions about your treatment or plan of care.
- Follow the treatment plan to which you agreed or let us know if you do not understand or cannot follow your healthcare instructions.
- Arrive for scheduled appointments on time or give notice at least 24 hours in advance if you must cancel or reschedule an appointment (NWES reserves the right to terminate services if you miss two or more appointments without calling in advance to cancel).
- Know your health plan benefits, provide complete insurance information and timely notification of any changes.
- Pay your bill in a timely fashion or seek assistance for discussing payment options.
- Treat our staff and physicians with respect and dignity and respect the rights of others.
- Let us know if you have concerns or complaints about any aspect of your care.
- Respect that we prohibit smoking, the use of alcohol or illegal drugs, and carrying firearms or other weapons in our facilities.

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PATIENT INFORMATION

Last: _____ First: _____ Middle: _____

Social Security #: _____ Date of Birth: _____ Sex: ❑Male ❑Female

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone Number: _____ ❑Home ❑Cell ❑Work ❑Caregiver

Other Phone Number: _____ ❑Home ❑Cell ❑Work ❑Caregiver

Email Address: _____

Emergency Contact Name: _____ Relation: _____

Emergency Contact Phone Number: _____

Race (optional): ❑American Indian ❑Asian ❑Black ❑Pacific Islander ❑White ❑Other

Ethnicity (optional): ❑Hispanic ❑ Not Hispanic

Do you speak English? ❑Yes ❑No *If no, what language do you speak? _____

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed

Person Responsible for Payment (if different from patient): _____

Date of Birth: _____ Social Security #: _____ Relationship: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Do you have an <u>active</u> Healthcare Power of Attorney? ❑Yes* ❑No
**If yes, please bring a copy so we can have it on record.*

Primary Care Physician: _____ Phone: _____

Referring Physicians: _____ Phone: _____

How did you hear about us? _____

NORTHWEST EYE SURGEONS

Personal Medication Record

Name: _____ **Date form completed:** _____

Date of Birth: _____ **Height:** _____ **Weight:** _____

If the patient is 18 or younger: Were they born full term? _____; Birth Weight: _____; Any complications for baby? _____

Primary Care Physician (name and location if known): _____

Phone: _____ **Fax:** _____

Pharmacy Name: _____ _____

Pharmacy Address: _____

Phone: _____ **Fax:** _____

PAST MEDICAL HISTORY

- ❑ Allergies (environmental/seasonal)
- ❑ Anemia [D64.9]
- ❑ Anxiety [F41.9]
- ❑ Arthritis [M19.9]
- ❑ Asthma [J45.9]
- ❑ Atrial fibrillation [I48.91]
- ❑ Blood clots [D68.9]
- ❑ COPD [J44.9]
- ❑ Cancer _____
- ❑ Coronary artery disease [I25.9]
- ❑ Depression [F32.8]
- ❑ Diabetes
- ❑ Hepatitis C
- ❑ High blood pressure [I10]
- ❑ High cholesterol [E78.5]
- ❑ Heart Attack [I25.2]
- ❑ Kidney disease [N18.9]
- ❑ Liver disease [K74.6]
- ❑ Migraine headaches [G43.009]
- ❑ Seizure disorder [F44.5]
- ❑ Stroke [G46.4]
- ❑ Thyroid disease
- ❑ Other _____

SURGICAL HISTORY (Including Eye Surgery)

Name of Surgical Procedure	Date of Procedure	Reason for Surgical Procedure (if known)

NORTHWEST EYE SURGEONS

Name: _____ **Date form completed:** _____

FAMILY HISTORY

❑ **Adopted (unknown history)**

Disease	Dad	Mom	Brother	Sister	Daughter	Son	Other
Amblyopia (lazy eye)	❑	❑	❑	❑	❑	❑	❑
Cataracts	❑	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑	❑
Retinal Disease	❑	❑	❑	❑	❑	❑	❑
Strabismus (misalignment of eyes)	❑	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑	❑
Hypertension	❑	❑	❑	❑	❑	❑	❑
Other_____	❑	❑	❑	❑	❑	❑	❑

SOCIAL HISTORY

Tobacco Use ❑ Current ❑ Past Smoker ❑ Never

❑ Cigarettes ❑ Cigar ❑ Chewing ❑ Other

MEDICATIONS *Include prescription medications, over-the-counter medications (examples: aspirin, antacids), vitamins and herbal supplements (examples: ginseng, ginko)*

❑ **Not currently taking any**

Name of Medication	Dose (mg)	Frequency (i.e. daily, twice daily, every Friday, etc.)	Reason for taking this medication

ALLERGIES

❑ **No Known Drug Allergies**

Allergic To / Describe Reaction:	Allergic To / Describe Reaction:
	Are you allergic to latex? ❑ Yes ❑ No
	Are you allergic to iodine? ❑ Yes ❑ No