



NORTHWEST EYE SURGEONS

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Dear _____,

Thank you for choosing Northwest Eye Surgeons for your eye care needs.

Your appointment is scheduled: Date: _____

Appointment Time: _____

Please arrive 15 minutes before your appointment time.

Dr.: _____

- ❖ Please bring your insurance cards and photo ID with your current address; they are required at each visit. We would like to remind you to call your primary care physician to obtain a referral for your visit, if needed.
- ❖ Please fill out the enclosed Patient Information sheet and Personal Medication Record with a black pen and bring the completed forms with you to your scheduled appointment.
- ❖ It is our policy to ask for payment on the date of service. Please be prepared to pay any copay, coinsurance, or deductible at the time of your visit. If you do not have insurance, please be prepared to pay in full on the day of services.
- ❖ If you do not speak English and need the services of an interpreter to communicate with our staff, we encourage you to bring someone to assist you.
- ❖ If you have a friend or family member that will be signing as Power of Attorney for you, then we will need a copy of the legal document that authorizes them as Power of Attorney.
- ❖ Your eyes may be dilated for examination at each visit. You may wish to bring a driver. Please bring a pair of sunglasses for your comfort.
- ❖ Ask a staff member about enrolling in our secure online patient portal. It will help you manage your eye health information and connect with our providers.

Thank you,

Northwest Eye Surgeons
Patient Services Department



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
 - Werner Cadera
 - Aaron Kuzin
 - Brett Bence
 - Bruce Cameron
 - 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.



NORTHWEST EYE SURGEONS

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 Other Pacific Islander White

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 active Healthcare Power of Attorney? *Yes No
 *If yes, please bring a copy so we can have it on record.

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

How did you hear about us? _____



NORTHWEST EYE SURGEONS

Financial Policy

USUAL AND CUSTOMARY RATES: Northwest Eye Surgeons is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

PAYMENT FOR SERVICES RENDERED: Northwest Eye Surgeons will require payment towards co-pays and co-insurance during the check-out process after that day's appointment. You are also encouraged to pay towards any past-due balances on your account at this time as well. If you are unable to pay in full, we are happy to set up a payment plan between you and our Billing department. We accept most major credit cards, cash, check, and Care Credit. There is a standard fee of \$30 for every returned check.

REGARDING INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will bill your insurance plan for you as long as you provide us with the correct information. You, as the patient, are ultimately responsible for payment of all services provided by Northwest Eye Surgeons. While payment is your responsibility, we will assist you in negotiating a settlement with your insurance company for any disputed claim.

MEDICALLY NECESSARY CARE: We will only provide you with a service if we consider it medically necessary. *Please be aware that some, and perhaps all, of the services provided may be a non-covered service and/or not considered medically necessary under your insurance plan.* We routinely perform diagnostic tests, such as **refractions** or **topography**, which some insurance carriers, including Medicare, will not cover. We use refraction as a diagnostic tool rather than to prescribe glasses, and topography to determine appropriate cataract treatment options. Therefore, if your insurance company arbitrarily determines that a service we have rendered to you is not a covered benefit, you will be responsible for the bill.

Assignment of Benefits

I request the payment of authorized Medicare or other insurance company benefits, including Medigap, be made on behalf of me or my dependent (s) to Northwest Eye Surgeons for any services furnished. Regulations pertaining to Medicare assignment of benefits apply. Northwest Eye Surgeons accepts Medicare Part B assignment. I authorize Northwest Eye Surgeons to release medical or other information pertaining to me or my dependent(s) to insurance carriers for related Medicare or other insurance company claims. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for me or my dependent (s) treatment. I agree to pay all fees and charges for such treatment. I agree that I will not withhold or delay payments if Medicare or other insurance companies deny payment on any of my or my dependent (s) charges.

Patient Signature: _____ Date: _____

Printed Name: _____



NORTHWEST EYE SURGEONS

HIPAA

PATIENT NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS & RESPONSIBILITIES – ACKNOWLEDGEMENT

We keep a record of the health care services we provide to you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the clinic manager, surgical center manager or the Compliance Coordinator at Northwest Eye Surgeons.

Our ***Patient Notice of Privacy Practices*** describes in more detail how your health information may be used and disclosed, and how you can access your information.

Our ***Patient Rights & Responsibilities*** provides guidelines for your care in our facility and contact information for concerns.

By my signature below I acknowledge receipt of the Patient Notice of Privacy Practices and Patient Rights & Responsibilities.

Patient or legally authorized individual signature

Date

Printed Name

Relationship (parent, legal guardian, personal rep.)

This form will be retained in your medical record.



NORTHWEST EYE SURGEONS

CONSENT FOR DISCLOSURES

I understand that my healthcare information at Northwest Eye Surgeons is protected and I have received a copy of their Patient Notice of Privacy Practices.

In order for Northwest Eye Surgeons to leave detailed messages on my voicemail or answering machine, I need to give permission to Northwest Eye Surgeons to do so.

Consent for Leaving Messages

I consent to information regarding my or my child’s (under the age of 18) test results or detailed appointment reminders/instructions be left on my voicemail or answering machine. I understand that “sensitive” information as noted below will be excluded.

Consent to Observe

I consent to allow trained medical personnel and/or prospective surgical candidates to briefly observe my exam or surgery.

Consent for Use of Photographic Materials

I hereby give consent to use photographs of my eyes and face for educational purposes or scientific publication.

Consent for Shared Information with Family and Friends

I wish family members or friends to have access to my health care information. Name(s) listed below are family members or friends to whom I grant access to my healthcare information through limited verbal disclosures.

I understand that some information is considered “sensitive.” I understand that I must check the specific boxes in order for my provider, or his/her designee, to release any “sensitive” information.

- Mental Health/Psychiatric Disorders (including depression)
Chemical Dependency (drug and/or alcohol abuse/treatment)
Pregnancy Information
Sexually Transmitted Diseases
HIV / AIDS Virus

Table with columns NAME and RELATIONSHIP. Includes fields for Patient Name, Date of Birth, Patient/Parent Signature, and Date.

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information up-to-date, as I recognize that relationships and friendships may change over time.



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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

- Checkboxes for various medical conditions: Allergies, Blood clots, High blood pressure, Seizure disorder, COPD, Cancer, High cholesterol, Stroke, Anxiety, Coronary artery disease, Heart Attack, Thyroid disease, Arthritis, Depression, Kidney disease, Liver disease, Asthma, Diabetes, Migraine headaches, Atrial fibrillation, Hepatitis C.

SURGICAL HISTORY (Including Eye Surgery)

Table with 3 columns: Name of Surgical Procedure, Date of Procedure, Reason for Surgical Procedure (if known). Contains 12 empty rows for data entry.



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Name: _____ Date form completed: _____

FAMILY HISTORY Adopted (unknown history)

Disease	Dad	Mom	Brother	Sister	Daughter	Son	Other
Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strabismus (misalignment of eyes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you allergic to iodine? <input type="checkbox"/> Yes <input type="checkbox"/> No