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.
- Be provided appropriate personal privacy.
- 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 unexpected, outcome. 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 involving your treatment and care. When such participation is contraindicated due to medical incapacity, a legally authorized person may participate in the decision making.
- 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.
- Know that Northwest Eye Surgeons P.C. has an Advance Directives Policy.
- 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:
    - Maureen Tipp, Executive Director 206-695-3839
- Know that the physician shareholders who practice at NWES have an ownership interest in all of NWES's facilities.

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.
- Follow facility policies which prohibit smoking, the use of alcohol or illegal drugs and carrying firearms or other weapons.

NORTHWEST EYE SURGEONS

PATIENT INFORMATION FORM

First:_____Middle:_____ Last:_____ Date: _____

Address:_____

City:_____ State:_____ Zip: _____

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

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

*Phone number to use for appointment reminder calls: ❑ Daytime ❑ Other

Email address: _____

Date of Birth:_____ Occupation: _____

Sex: ❑ Male ❑ Female Social Security #:_____

Race: ❑ American Indian ❑ Asian ❑ Black ❑ Hispanic ❑ Other ❑ Pacific Islander ❑ White

Ethnicity: ❑ Hispanic ❑ Not Hispanic

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Domestic Partner

Employed: ❑ Full Time ❑ Part Time ❑ Retired Student: ❑ Full Time ❑ Part Time ❑ None

Employer: _____ Phone: _____

Parent's Employer (if applicable): _____ Phone: _____

Do you live in a nursing home or hospice: ❑ Yes ❑ No Do you speak English? ❑ Yes ❑ No

Emergency Contact (Not living with you):_____ Phone: _____

Primary Care Physician: _____ Phone: _____

Referring Physician:_____ Phone: _____

If different from Patient, Person Responsible for Payment:_____

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

Address: _____ Phone: _____

City:_____ State:_____ Zip: _____

How did you hear about us? _____

Do you have a Healthcare Power of Attorney? ❑ *Yes ❑ No

*If yes, please bring a copy so we can have it on record.

INSURANCE

Primary Insurance:_____ ID#: _____

Group #:_____ Subscriber Name: _____ Date of Birth: _____

Subscriber's Employer:_____ Phone: _____

Secondary Insurance:_____ ID#: _____

Group#:_____ Subscriber Name: _____ Date of Birth: _____

Subscriber's Employer:_____ Phone: _____

Your eyes may or may not be dilated for examination at each visit. If you are dilated, your vision may be affected causing temporary visual impairment therefore, you may wish to make alternative transportation arrangements

-OVER-

FINANCIAL POLICY

Thank you for choosing Northwest Eye Surgeons for your eye care needs. We are committed to providing you with the best treatment available. The following is a statement of our Financial Policy.

All new patients must complete our Patient registration forms before seeing the physician.

- ALL CO-PAYS ARE DUE PRIOR TO SEEING THE PHYSICIAN
- UNLESS WE ARE BILLING YOUR INSURANCE, PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE
- FOR YOUR CONVENIENCE WE ACCEPT CASH, VISA, AND MASTERCARD
- A $30 CHARGE IS ASSESSED ON ALL RETURNED CHECKS

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. ***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.*** 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.

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.

MEDICALLY NECESSARY CARE: We will <u>only</u> provide you with a service if we consider it medically necessary. 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.

Patient Initials _____ Date _____

Assignment of Benefits

<u>Please Read and Sign</u>

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.

Signature_____ **Date**_____

NORTHWEST EYE SURGEONS

HIPAA

PRIVACY POLICY NOTICE AND PATIENT RIGHTS & RESPONSIBILITES – 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 ***Privacy Policy Notice*** 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 Privacy Policy Notice and Patient Rights & Responsibilities.

_____ _____

Patient or legally authorized individual signature **Date**

_____ _____

Printed Name if signed on behalf of the patient **Relationship (parent, legal guardian, personal rep.)**

This form will be retained in your medical record.

Internal use only:
Picture ID Verified: _____

NORTHWEST EYE SURGEONS

CONSENT FOR LEAVING MESSAGES

CONSENT TO LEAVE MESSAGES/SHARE INFORMATION WITH FAMILY/FRIENDS

I understand that my healthcare information at Northwest Eye Surgeons is protected and I have received a copy of their 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 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. I will rely on the professional judgment of my provider and his/her designee to share such information as they deem necessary.

I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information Form.

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

NAME	RELATIONSHIP
1._____	_____
2._____	_____
3._____	_____

(Print) _____ _____
Patient Name Date of Birth

_____ _____
Patient/Parent Signature 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.

NORTHWEST EYE SURGEONS

Personal Medication Record

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

Date of Birth: _____ Height: _____ Weight: _____

Pharmacy Name: _____

Pharmacy Address:_____ Phone:_____

_____ Fax: _____

❑ 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

List ALL medications you are currently taking:

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

❑ Not currently taking any medications, vitamins, or supplements

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