SOUTHERN INDIANA EYE ASSOCIATES
200 Saint Charles Street Jasper, Indiana 47546
Ph: 812-482-6424 | Toll Free: 800-599-9590 | Fax: 812-634-9701

We look forward to serving you at your upcoming appointment!

If you have any questions or concerns prior to your visit, please do not hesitate to Call our office at **812-482-6424** or **800-599-9590**.

PLEASE BRING THE FOLLOWING WITH YOU TO YOUR APPOINTMENT:

- Attached is the **PATIENT INFORMATION** form filled out with your signature stating you have read the Insurance Authorization and Assignment regarding **YOUR** financial responsibility.
- Attached paperwork - **Medical History Log**
  - Up-to-date medication list or fill out the medication form on back of page 2.
  - *Med list does not need to be filled out for children under the age of 16.
- **Standard Authorization of Use & Disclosure of PHI** with names of family members/friends in which we can disclose patient information to, along with signature of patient or guardian. HIPAA notice of privacy practices signed and dated. **Let us know if you would like a copy.**
- A large print copy of this is available upon request.
- Current pair of glasses
- Insurance Cards and Identification
  - We only accept Medical Insurance Plans (No Vision Plans or VSP)
  - It is the **patient's responsibility** to provide our office with your **most current insurance cards**. Payment in full will be expected at the time of service if you do not provide us with this information.
- A driver if you are not comfortable driving with dilated eyes.
- **Payment:** Co-pays, co-insurance, and deductibles are to be paid at the time of service. We accept cash, check, and all major credit cards. If you do not have insurance, Payment in full is expected at the time of service.

PLEASE NOTE:

Payment in full is required at the time of service for your appointment or it will need to be rescheduled. Although we are contracted with several insurance companies, it is **patient's** responsibility to make sure that our office participates in your specific plan.

Please contact your insurance company at the **customer service phone** number located on the back of your card for questions pertaining to coverage.

We make reminder calls and texts as a courtesy. Regardless of whether you get this call/text or not, it is your responsibility to come at your scheduled appointment time.

If you cannot keep your appointment, please notify our office at least 24 hours in advance. You may be charged a "Missed Appointment Fee" of $25.00 if we do not receive the 24-hour notice from you to reschedule or you fail to show up for your appointment.

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION (PHI)

Southern Indiana Eye Associates

Name & DOB of Patient: _____

Information to be USED or DISCLOSED

Any information in the patient's chart requested by family member/friend who is listed as an authorized person on this form is whom information may be disclosed.

Purpose of Disclosure

To provide family members/friend, upon request, information they are seeking about you as a patient.

This information will **NEVER** be used for marketing.

This information has **NEVER** been previously de-identified.

Persons Authorized to Use or Disclose this Information: **SOUTHERN INDIANA EYE ASSOCIATES**

Persons to Whom Information May Be Disclosed: Please list names of family members/friends that we may talk to if they have questions about your information in this office. If a person's name is not listed, we will NOT disclose information.

(If the patient is a minor, please also include parents' names below)

Name & Relation	Phone Number & Type
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Expiration Date of Authorization

NO Expiration, unless revoked or terminated by the patient/parent or the patient's personal representative.

Right to terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to our office. You should contact the HIPPA Compliance Officer to terminate this authorization.

Potential for Re-Disclosure

Information that is disclosed under this authorization may be re-disclosed by the person or organization to which it is sent. The privacy of this information may not be protected under the Federal Privacy Rule depending on whom the information is disclosed to.

Our practice will not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs this authorization.

Signature of Patient/Parent: Date:

Patient Demographics

Name:		DOB / /
Full SSN - -	Referring Dr:	
Referring Doctor		
Primary Doctor:	Optometrist:	
Occupation	Employer	Phone

Address

Street:	City, State ZIP
Primary Phone:	Cell Phone:
Alternate # (include description):	
Do you accept text messages? Yes ☐ No ☐	This information will be verified at each appointment.

We only accept Medical Plans or Self Pay. We do not accept vision insurance.

Spouse Information	If Child, Parent Information	
Name:	Father:	Mother:
DOB:	DOB:	DOB:
SSN:	SSN:	SSN:
Employer:	Employer:	Employer:
Work #:	Work #:	Work #:

Private or Commercial Insurance Company

Primary		Secondary		Other	
Carrier:		Carrier:		Medicare ID:	
Policy Holder:		Policy Holder:			
Group #:		Group #:		Supplement Name:	Plan:
Plan #:	Specialist Copay **$**	Plan #:	Specialist Copay **$**		
Member ID:		Member ID:		Medicaid:	

INSURANCE AUTHORIZATION & ASSIGNMENT: I request that payment of authorized Medicare and/or any insurance benefits be made either to me or on my behalf to Southern Indiana Eye Associates for any services furnished for me by that physician supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or _____ any information needed to determine these benefits payable to related services. I understand that I am responsible for all financial obligations of health services, and for the reimbursement and payment of claims from my insurance company. If any unpaid balance is assigned for collection with a third-party collection agency or placed with an attorney to obtain judgment or otherwise satisfy payment of my account, I agree to pay all cost of collection, including attorney fees, collection fees, and contingent fees to collection agencies of not less than 40% - such contingency fee to be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency. I am aware that my eyes may be dilated as part of my exam and that this may affect my driving. I understand and agree to the above terms.

Signature: Date:

MEDICAL HISTORY LOG

PATIENT NAME: _____ **DATE OF EXAM:** _____

Family Doctor's Name: _____

Allergies to Medications: _____

MEDICAL HISTORY (Check all that apply)

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Arthritis
- ☐ Stroke
- ☐ Sinusitis
- ☐ Kidney disease
- ☐ Blood disorders
- ☐ Asthma
- ☐ Stomach/digestive
- ☐ Thyroid
- ☐ Cancer

Other _____

Are you currently having any problems in the following areas? (Check all that apply)

- ☐ Unexplained weight loss
- ☐ Chills
- ☐ Sweats
- ☐ Fever
- ☐ Loss of consciousness
- ☐ Headaches
- ☐ Hearing loss
- ☐ Sinus
- ☐ Cough
- ☐ Shortness of breath
- ☐ Pain in lungs
- ☐ Sputum
- ☐ Angina
- ☐ Heart attack
- ☐ Irregular heartbeat
- ☐ Heartburn
- ☐ Nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Rash
- ☐ Itching
- ☐ Easy bruising
- ☐ Tremors
- ☐ Weakness
- ☐ Numbness
- ☐ Dizziness
- ☐ Swelling of extremities
- ☐ Pain in extremities

PREVIOUS SURGERIES (circle all that apply and list type)

Heart _____ Kidney _____ Prostate _____

Stomach _____ Hysterectomy _____ Thyroid_____

Colon _____ Ovaries _____ Breast _____

Bone _____ Other _____

_____

FAMILY MEDICAL HISTORY (Check all that apply)

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Stroke
- ☐ Cancer

SOCIAL HISTORY

Occupation _____

Do you smoke, chew or use tobacco products? Y N

Packs per day or week? _____

Do you drink alcohol? Y N

Drinks per day or week? _____

Prescription Medication List

NAME:	DOSE:	FREQUENCY:	DATE STOP:

Patient Name: _____ DOB: _____

HIPAA NOTICE OF PRIVACY PRACTICES - SOUTHERN INDIANA EYE ASSOCIATES

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.

LARGE PRINT COPY OF THIS FORM IS AVAILABLE UPON REQUEST

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI)to carry out treatment, payment of health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information, "Protected health information" is information about you, including demographic information, that may identify you that relates to your past, present, or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information (PHI)

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law. **Treatment:** We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a pharmacy that fills your prescriptions. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives to your care. Also, we may contact you about health-related benefits and services offered by our office. **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include activities your health insurance plan undertakes before it approves or pays for the health care services recommended such as deciding of eligibility or coverage for insurance benefits. **Healthcare Operations:** We may use or disclose, as needed, your protected health information to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to students that observe physicians at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may be showing you informational videos concerning your health care condition in areas where other patients may be waiting. We may use or disclose your protected health information, as necessary, to contact you or your appointment. **To Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care, general condition, or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed. **Business Associates:** We may disclose your protected health information to outside individuals and businesses that help us with our business operations so they can perform the tasks they are hired to do. Our business associates must promise that they will respect the confidentiality of your protected health information. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donations, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates. **Required Uses and Disclosures:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule. Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

2. Your Rights Following: is a statement of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information, except under certain circumstances. For example, under federal law, you may not inspect or copy the following records, psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. You have the right to authorize other use and disclosure. This means you have the right to authorize or deny any other use or disclosure of protected health information that is not specified within this notice. You have the right to designate a personal representative. This means you may designate a person with the delegated authority to consent to or authorize the use or disclosure of protected health information. You have the right to request a restriction of your protected health information. This means you may ask us in writing not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. In certain cases, your request may be denied. You have the right to request confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternately, i.e. electronically. You have the right to request an amendment to your protected health information. This means you may request an amendment to your protected health information for as long as we maintain this information. In certain cases, your request may be denied. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information, to entities or persons outside of our office other than for the purposes of treatment, payment healthcare operations, or a purpose authorized by you or disclosures made before April 14, 2003, among others. We reserve the right to change the terms of this notice at any time. You then have the right to object or withdraw as provided in this notice. In the event there is a material change to this notice, the revised notices will be posted. In addition, you may request a copy of the revised notice at any time. **Complaints:** You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact or your complaint. We will not retaliate against you for filing a complaint. **Consent to Email or Text Usage for Communications:** I consent to receive text messages from the practice at my cell phone or any number forwarded or transferred to that number or emails to receive communication from your office. I understand that this request to receive emails and text messages will apply to all future appointment reminders, feedback, health information unless I request a change in writing. I authorize to receive text messages for appointment reminders, feedback, and general health reminders. The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our Privacy Officer in person or by phone at our telephone number, (812) 482-6424. This notice was published and becomes effective on April 14, 2003. Updated April 21, 2023.

Signature below is only acknowledgement that you have received this Notice of our Privacy (Copy available upon request):

Signature of Patient/Parent _____ Date _____

Signature of Patient Representative (if patient unable to sign) _____ Relationship to Patient _____ Date _____