Patient Registration

Pacific ClearVision Institute **Clinic:** **Eugene** **Oakridge** **Cottage Grove** **Cottonwood, AZ**

Patient Information

Last Name:_____ First Name:_____ Middle Initial:_____

Nickname:_____Maiden name:_____Acct Number(patient #):_____

Address:_____City/State/Zip:_____

Home #:_____Work#:_____Cell#:_____

Patient SSN:_____Date Of Birth (mo/d/yr):_____Gender: M◯F◯Married: Y◯N◯W◯D◯

Employment Information (School information if a student)

Employee/School Name:_____ Occupation/Major:_____Phone:_____

Address:_____City/State/Zip:_____

Responsible Party Information

Last Name:_____ First Name:_____ SSN: _____/_____/_____

Address:_____City/State/Zip:_____

Home #:_____Work#:_____Cell#:_____

Date Of Birth (mo/d/yr):_____ Relationship to Patient _____

Emergency Contact Person

Last Name:_____ First Name:_____Relationship to Patient:_____

Home #:_____Work#:_____Cell#:_____

Primary Insurance Information

Insurance Company:_____

Address:_____City/State/Zip:_____

Subscriber Name: _____ Subscriber DOB (mo/d/yr) _____/_____/_____

ID #:_____Group#:_____

Subscriber SS#:_____ Employer: _____Effective Date: _____/_____/_____

Secondary Insurance Information

Insurance Company:_____

Address:_____City/State/Zip:_____

Subscriber Name: _____ Subscriber DOB (mo/d/yr) _____/_____/_____

ID #:_____Group#:_____

Subscriber SS#:_____ Employer: _____Effective Date: _____/_____/_____

Primary Care Physician

Name: _____ Phone: _____

Specific Disclosure Consent: voluntary consent to disclosure of health information to the following people:

Name: _____ Name: _____ Name: _____

I authorize the doctors and staff of PCVI to use and disclose my health information as necessary in order to provide treatment, obtain payment, and conduct healthcare operations. I acknowledge that I have received the notice of Privacy Practices from Pacific ClearVision Institute (PCVI).

Signature: _____ Date: _____

Version: 08.13.10

BUSINESS AND CREDIT POLICY

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

As a service to our patients, we bill primary and secondary insurance directly. Please understand that insurance coverage is an agreement between you and your insurance company. We will assist in resolving any problems that may arise for payment of your claims but do require you to be the lead advocate in the process.

If you are a new patient to our office, please note that our office will call to verify your insurance benefit package prior to your first appointment. We will notify you of the patient portion due at the time of your visit based on your individual insurance policiy. Co-payments are due at the time of each visit. Our office accepts VISA, MasterCard, American Express and Discover cards for your convenience. We request that the balance be paid within 30 days of your receipt of our statement.

If a primary physician referral is required by your insurance policy to see a specialist in our practice, we ask that you ensure ALL information (name of referring physician, insurance ID#, and name of employer) has been provided, and assist in contacting your primary physician's office to initiate the process. If you do not have a referral in place and choose to still be seen by one of our doctors, we will require you to sign a waiver and pay at the time services are rendered.

If unusual circumstances should make it impossible to meet our credit terms, please call or personally discuss the matter with our business office. This will avoid misunderstandings and enable you to keep your account in good standing. Our business office phone number is (541) 687-9007.

A parent or legal guardian must accompany minor patients to all appointments.

I have read, understand, and agree to the above Business and Credit Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance benefits to be paid directly to the applicable physician that rendered medical services. I also request payment of government benefits either to myself or to the party who accepts assignment.

_____ _____

Responsible/Insured person, Parent or Guardian Date

(IF NOT IN THE PRESENCE OF PARENT OR GUARDIAN)

Any Pracitioner of Pacific Clearvision Institute

May unconditionally treat: _____ **_____/_____/_____**

Patient Name Birth date

in my presence or absence without reservation.

_____ _____

Signature Relationship

NOTICE OF PRIVACY PRACTICES

Pacific ClearVision Institute
1125 Darlene Lane
Eugene, Oregon, 97401
Phone: 541.343.5000
Fax: 541.344.9478

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

General Rule

We respect our legal obligation to keep information that identifies you, private. The law obligates us to give you notice of our privacy policies.

Generally, we can only use your health information in our office, or disclose it outside of our office, without your written permission, for purposes of treatment, payment, or healthcare operations. In most other situations, we will not use or disclose your health information unless you sign a written authorization form. In some limited situations, the law allows us to disclose your health information without written authorization.

Uses or Disclosures of Health Information

Examples of how we use information for **treatment** purposes:

- When we set up an appointment for you.
- When our technician or doctor tests your eyes.
- When the doctor prescribes glasses or contact lenses.
- When the doctor prescribes medication.
- When our staff helps you select and order glasses or contact lenses.
- When we show you low vision aids.

We may disclose your health information outside of our office for **treatment** purposes, for example:

- If we refer you to another doctor or clinic for eye care, or low vision aids, or services.
- If we send a prescription for glasses or contacts to another professional to be filled.
- When we provide a prescription for medication to a pharmacist.
- When we contact you to let you know that your glasses or contact lenses are ready to be picked up.

Sometimes we may ask for copies of your health information from another professional that you may have seen before.

We may use your health information within our office or disclose your health information outside of our office for **payment** purposes. Some examples are:

- When our staff asks you about health or vision care plans that you may belong to, or about other sources of payments for our services.
- When we prepare bills o send to you, or your health or vision care plan.
- When we process payment by credit card, and when we try to collect unpaid amounts due.
- When bills or claims for payment are mailed, faxed, or sent by computer to you, or your health or vision plan.
- When we occasionally have to ask a collection agency or attorney to help us with unpaid amounts due.

We use and disclose your health information for **healthcare operations** in a number of ways. Healthcare operations mean those administrative and managerial functions that we have to do in order to run our office. We may use or disclose your health information, for example, for financial or billing audits, for internal quality assurance, for personnel decisions, to enable our doctors to participate in managed care plans, for the defense of legal matters, to develop business plans, and for outside storage of our records.

Appointment Reminders

We may call to remind you of scheduled appointments. We may also call to notify you of other treatments or services available at our office that might help you.

Uses & Disclosures with an Authorization

In some limited situations, the law allows or requires us to disclose your health information without your permission. Not all of these situations will apply to us; some may never happen at our office at all. Such uses or disclosures are:

- A state or federal law that mandates certain health information is reported for specific purpose.
- Public health purposes, such as contagious disease reporting, investigation, or surveillance; and notices to and from the Food and Drug Administration regarding drugs or medical devices.
- Disclosures to government authorities about victims of suspected abuse, neglect, or domestic violence.
- Uses and disclosures for health oversight activities, such as licensing of doctors, audits by Medicare or Medicaid, or investigation of possible healthcare law.
- Disclosures for judicial and administrative proceeding, such as in response to subpoenas or orders of courts or administrative agencies.

- Disclosures for law enforcement purposes, such as to provide information about someone who is, or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else.
- Disclosure to a medical examiner to identify a dead person, or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations.
- Uses or disclosures for health related research.
- Uses and disclosures for specialized government functions, such as for the protection of the President, or high-ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign services.
- Disclosures relating to workers' compensation programs.
- Disclosures to business associates who perform healthcare operations for us, and who agree to keep your health information private.

Other Disclosures

We will not make any other uses or disclose your health information unless you sign a written **authorization form**. You do not have to sign such a form, but if you do sign one, you may revoke it at any time, unless we have already acted in reliance upon it.

Your Rights Regarding Your Health Information

The law gives you many rights regarding your health information.

- You can ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment, or healthcare operations. We do not have to agree to do this, but if we do agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to **Pacific ClearVision** at the address show at the beginning of this notice.
- You can ask us to communicate with you in a confidential way such as by phoning you at work, rather than at home, by mailing health information at a different address, or by using email to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to **Pacific ClearVision** at the address shown at the beginning of this notice.
- You may ask us to amend your health information if you think it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information, along with any rebuttal statement that we may write. Once your statement of position, and/or rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can

have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information send a written request to Pacific ClearVision at the address shown at the beginning of this notice.

- You can get a list of the disclosures that we have made of your health information within the past six years (or a shorter period, if you want). Except disclosures for purposes of treatment, payment, or healthcare operations, disclosures made with an authorization signed by you, and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law, we can have a 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to Pacific ClearVision at the address shown at the beginning of this notice.

Our Notice of Privacy Practice

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time in compliance with, and as allowed by law. If we change this notice, the new privacy practices will apply to your health information that we already have, as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, having copies available in our office, and at www.PCVI.com.

Complaints

If you think that we have not properly respected the privacy of your health information, you are free to complain to us, or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written request to Pacific ClearVision at the address shown at the beginning of this notice. If you prefer, you can discuss your complaint in person, or by phone.

For more Information

If you want more information about our privacy practices, call or visit Pacific ClearVision, at the address or phone number shown at the beginning of this notice.