eyedoctors

Board Certified Eye Specialists
Surgical, Medical, & Neurological

Patient Information

Name:	Nickname:
Birthdate:	SS#:
Address:	
Phone:	Alternate Phone:
Email:	Preferred Contact Method(Please circle all that apply) Text - Email - Phone
Primary Doctor:	Referring Doctor:
Pharmacy:	Optometrists:
Primary Insurance:	Secondary Insurance:
Employer/Occupation:	Employer Address:
How did you hear about us?	Parent/Guardian:

Emergency Contact

Name:	Phone:
Address:	Relationship:

Patient Medical/Eye History(Circle all that apply)

Glasses/Contact	Allergic Conjunctivitis	Hypotension	Hypertension
Glaucoma	Seizures	Stroke	Tuberculosis
Diabetic Retinopathy	Lung Disease	Thyroid Disease	Osteoporosis
Strabismus	Cancer _____	Kidney Disease	HIV
Dry Eyes	Anemia	Anemia	Depression
Narrow Angles	Back Trouble	Arthritis	Anxiety
Floaters	Heart Disease	Hepatitis	Hypothyroidism
Ocular Hypertension	Cataract	Diabetes	
Retinal Tear	Migraine Headaches	High Cholesterol	
Blepharitis	Iritis	Hyperlipidemia	
Macular Degeneration	Strabismus	Hyperthyroidism	

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Medications
(Please list or provide a copy of your Medications including dosage and Frequency)

Allergies (Please list any allergies & reactions)Are you allergic to Sulfa or Doxycycline?

Surgical History(List Procedure and Date)

Family Medical History
(Please list family with medical history, Example: Mother, Father, Etc)

Diabetes	Heart Disease	Cancer	Glaucoma	Macular Degeneration
Hypertension	Stroke	Migraine	Cataract	

Social History (Please circle all that apply)

Tobacco Use: Yes/No	If yes, How many packs a day?
Alcohol Use: Yes/No	If yes, How often?
How many times in the past year have you had 4 or more drinks a day?	
Drive in the Daytime? Yes/ No	Drives night time? Yes/ No
Do you drink Caffeine? Yes/No	If yes, How many cups a day?
Have you had any problem with outpatient surgery or Anesthesia?	
If yes, Please explain:	
Comments:	
Patient Signature:	

Web: wwww.eyedoctorshawaii.com **Tel:** (808) 373-9373 **Fax:** (808) 373-9373
Hawaii Kai Towne Center (Next to Roy's): 6600 Kalanianaole Hwy #114c. Honolulu, HI 96825

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6600 Kalanianaole Hwy. #114C
Honolulu, HI 96825
Tel: 808-373-9373 Fax: 808-373-9370

Patient Name:_____ Date of Birth:_____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, or any other health plans to Eye Doctors Hawaii. I hereby authorize said assignee to release all information necessary to secure payment. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.
I understand that I am financially responsible for all charges not paid by my insurance, including non-covered services—such as refraction and cosmetic procedures.

AUTHORIZATION FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use and disclosure of individually identifiable health information relating to me, which is called Protected Health Information (PHI), under a federal health privacy law. I further understand that my PHI may be used to carry out treatment, payment, or healthcare operations.
I understand that I may revoke this authorization at any time by notifying Eye Doctors Hawaii in writing.
I have received a copy Eye Doctor's Hawaii Center's Notice of Privacy Practices prior to signing this consent.
I understand I have the right to restrict how my PHI is used or disclosed by notifying Eye Doctors HAwaii Center of my wishes in writing.

PATIENT FINANCIAL RESPONSIBILITY

I understand that I am ultimately responsible for all payment obligations arising out of my treatment or care and guarantee payment for these services.
I understand that I am responsible for deductibles, co-payments, coinsurance amounts or any other patient responsibility indicated by my insurance carrier, which are not otherwise covered by my primary or supplemental insurance.

RESCHEDULE FEE

Patients are required to contact the office 24 hours prior to an appointment, to be able to accommodate other patients. We appreciate our patients time here at EYE DOCTORS HAWAII, as we hope our time is also valued. If notice of cancellation and or rescheduling is not given 24 hours prior to appointment scheduled, there will be a $40.00 fee that will need to be collected at that time. This will be patients responsibility.

_____ **Date:** _____/_____/_____

Patient (or Guardian's) Signature

Welcome to Eye Doctors Hawaii, where we are committed to being transparent with costs.

By law, insurance companies require medical offices to collect 10-30% of total costs. Your insurance may cover only a portion of your costs. Your cost is determined by your individual insurance plan and examination details. These costs are in addition to your monthly premiums and yearly deductions.

Just like blood work, we perform diagnostic tests to determine your eye health. Your visual system is extremely delicate. We rely on testing to help make an accurate diagnoses and track any problems.

- Total Cost of Office Visit = Office Visit + Testing + Treatments + Annual Deductible (if not met)
- The cost of testing is in addition to the cost of your office visit.
- The estimated cost of your visit can range between $40.00-$150.00, but may be more or less depending on your insurance.
- A co-pay will not be collected at check out from patients with dual coverage

Please feel free to ask for information on your financial liability and an explanation of charges, including services that will be charged to your insurance.

_____

Your Signature & Date

A typical examination consists of the following tests.

	New Patient	New Glaucoma	New Watery Eyes	Est. Glaucoma	Est. Retina	Est. Macular Degeneration	Est. Dry Eye	Preop Cataract
Extended Dilated Exam	x	x			x			
Fundus Photo	x	x						
Slit Lamp Photo	x						x	
Visual Field				x				
Retina /Optic Nerve Mapping				x	x	x		
Gonioscopy		x		x	x			
Tear Osmolality			x				x	x
Punctal Plugs			x				x	
Biometry								x
Punctal Dilation								
Topography								x

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Appointment Reminders

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you.

Other Uses and Disclosures

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form". The content of said form is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if you wish for us to send your information to someone else. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization form, we cannot make the use or disclosure. If you do sign an authorization form, you may revoke it at any time. Revocations must be in writing. Send them to the office contact person at the beginning of this notice.

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 this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address or fax shown at the beginning of this notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home or by mailing health information to a different 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 the office contact person at the address or fax at the end of this notice.
- ask to see or get photocopies of your health information. By law, there are a few situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (60 days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address or fax at the beginning of this notice.
- ask us to amend your health information if you think that 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, as well as others that you specify. If we do not agree, you can write a statement of your position that we will include in your health information along with any rebuttal statement that we may write. Once your statement of position and/or our 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, including your reasons for the amendment, to the office contact person at the address or fax at the beginning of this notice.
- get additional paper copies of this Notice of Privacy Practices upon request. If you want additional paper copies, send a written request to the office contact person at the address or fax shown at the beginning of this notice.

Our Notice of Privacy Practices

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 any time 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 any future information. If we change our Notice of Privacy Practices, we will post the new notice in our office and have copies available in our office.

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 for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address or fax shown at the end 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, write or call Eye Doctors Hawaii, 6600 Kalanianaole Hwy, #114c, Honolulu, HI 96821 w: 808-373-9373, f: 808-373-9370.

I have read and understand the notice of Privacy Practices

_____ **Date:** _____/_____/_____

Patient (or Guardian's) Signature stating that you have reviewed and understand this document

Scan: Initial_____ Date_____

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Effective Date of Notice: September 1, 2017

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

Treatment, Payment and Healthcare Operations

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses or eye medications and faxing them to be filled; referring you to another doctor or clinic for consultation or treatment; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health and/or vision insurance coverage, preparing and sending bills or claims and collecting unpaid amounts (either ourselves or through a billing service or collection agency). "Healthcare operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for healthcare operations are: financial or billing audits; internal quality assurance; personnel decisions, defense of legal matters, business planning and outside storage of our records. We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

Uses and Disclosures for Other Reasons Without Permission

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

- when a state or federal law mandates that certain information be reported for a specific purpose.
- for public health purposes, such as contagious disease reporting, investigation or surveillance and notices to and from the federal Food and Drug Administration regarding drugs or medical devices.
- disclosures to governmental authorities regarding victims of suspected abuse, neglect or domestic violence.
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or MediCal; or for the investigation of possible violations of health care laws.
- disclosures for judicial and administrative proceedings, 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 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 cause of death, or to funeral directors to aid in burial; or to organizations that handle organ and tissue donations.
- uses or disclosures for health related research.
- uses and disclosures to prevent a serious threat to health or safety.
- disclosure of de-identified information.
- disclosures relating to Workers' Compensation programs.
- incidental disclosures that are an unavoidable by-product of permitted uses and disclosures.
- disclosures to "Business Associates" who perform health care operations for us and who commit to respect the privacy of your health information.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care.

Scan: Initial_____ Date_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name:_____Date of Birth:_____

REQUESTED FROM:_____

I, _____, the patient/patient's guardian (circled) authorize you to release copies of all or any information and medical reports, including diagnostic tests/reports for care and treatment from the period:

_____

___

PROVIDED TO: eyedoctors

6600 Kalanianaole Hwy., Suite 114c, Honolulu, HI 96825

Ph#(808)373-9373; FAX#(808)373-9370

drchang@eyedoctorshawaii.com

SIGNED BY:_____DATE:_____

Printed Name:_____

/jwn121517MedRelAuth