Patient Information

Patient's Full Name:_____ Birth Date: _____
Address:_____City:_____
State:_____ Zip:_____ Social Security Number:_____

Referral Source:_____ Primary Care Doctor:_____ Optometrist:_____

Preferred Language: _____Race:_____ Sex:____
Are you Hispanic or Latino? Please circle one: Yes / No

Home Phone:_____ Email:_____ Cell Phone:_____
Work Phone:_____

Occupation:_____ Employer's Name:_____
Employer's Address:_____

Please circle one: Single / Married / Divorced / Widowed

Name of Spouse or Parent Guardian:_____
Name & Phone number of emergency contact:_____

Insurance Information

Please present ALL insurance cards to the receptionist.

Primary Insurer:_____ Policy #:_____ Group #:_____
Policyholder/Relationship:_____ DOB:_____
Secondary Insurer:_____ Policy #:_____ Group #:_____
Policyholder/Relationship:_____DOB:_____

If your injury is work related, please ask the receptionist for additional forms.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled to Paul A. Tarantino, M.D., P.A. for services rendered by Paul A. Tarantino, M.D., P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby assume financial responsibility for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. I understand that Paul A. Tarantino, M.D., P.A. reserves the right to pursue delinquent accounts via third party collection agencies or an attorney and that I am responsible for any collection fees incurred by Paul A. Tarantino, M.D., P.A.

Signature:_____ Date:_____

TARANTINO CHO EYE CENTER FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, any and all financial liability rests with the patient.

Our office participates with most major insurance plans. If you have a managed care plan that requires a referral to see a specialist, **you must obtain a referral in order for your visit in our office to be covered under your medical insurance. If you do not have the valid referral and still wish to be seen, you will be asked to pay for the visit prior to your examination.**

A refractive examination is not a covered service by most insurance companies, including Medicare. This examination is needed to determine your best corrected vision. If we need to perform this test, you will be charged $**58.00**, which is payable at the time of the visit. (REFRACTION FEE UPDATED AS OF 7/1/21)

It is the patient's/parent's/guardian's responsibility to:

1. **Be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles.**
2. **Bring all of your current insurance cards to all visits.**
3. **Provide our office with current information including address, phone numbers and employer.**
4. **In accordance with your insurance contract, you must be prepared to pay your specialist co-pay at each visit.**
5. **If you have no insurance, you are responsible for payment at the time of service.**

We appreciate prompt payment in full for any outstanding balance. If your account is over 60 days past the due date it will be turned over to our collection agency, you agree to pay any overdue amount. For balances under $1000, you will incur a 35% collection fee. For balances over $1000. You will incur a 30% collection fee. Any check payments that do not clear the bank will be subject to a $35.00 returned check fee.

There is a charge for completing various forms, including your MVA form. Pre-payment is required for completing forms, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication.

For all services rendered to minor/dependent patients, we will look to the adult accompanying the patient and/or the parent or guardian with whom the child resides for payment. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth and social security number. We request that you inform the subscriber that their insurance has been used.

There will be a $40 charge if you fail to show for any scheduled appointments or cancel within 24 hours of your appointment.

I have read and understand the above financial policy.

_____ _____

Signature of patient/guardian/parent Date

_____ _____

Printed name of patient Date

Medical Questionnaire

Name:_____ Date:_____

Ocular History (Please check your current or past eye problems.)

____ Glaucoma
____ Cataract Surgery
____ Laser Surgery
____ Eye Trauma
____ Lazy Eye
____ Macular Degeneration
____ Retinal Detachment
____ Retinal Surgery
____ Other

Disease of the eye can be associated with systemic illness. Please respond YES (Y) or NO (N) if you have EVER been diagnosed with any of the following:

____ Diabetes
____ Kidney Disease
____ Thyroid Disease
____ HIV/AIDs
____ Arthritis
____ High Blood Pressure
____ Asthma/Emphysema
____ Cancer
____ Heart Condition
____ Stroke

List all current medications and dosage:

_____

_____

Allergies to medications (if none known, please indicate):

_____

Social History:

Do you smoke? Y / N If so, how much? _____ If not, have you ever smoked? Y/N
Do you drink alcohol? Y / N If so, how much? _____
Do you use drugs? Y / N If so, how much and what? _____

Family History:

____ Glaucoma
____ Hypertension
____ Other (Please indicate)
____ Diabetes
____ Macular Degeneration
____ Retinal Detachment

Please check any symptom or problem that is chronic or persistent. Circle none if nothing in a category applies

Heart Problems: None

___Racing/irregular

___Chest Pain/Angina

___Palpitations

General: None

___Weight Loss

___Weight Gain

___Sleep Disturbance

___Anemia

___Loss of Memory

___Night Sweats

Endocrine: None

___Excess Thirst

___Excessive Urination

___Heat Intolerance

___Cold Intolerance

___Blood Sugar Poorly Controlled

___Blood Sugar Controlled

Stomach Problems: None

___Heartburn

___Constipation

___Diarrhea

___Ulcers

___Hernia

___Colitis/Diverticulitis

___Liver Disease

Urinary: None

___ Frequent Urination

___Blood in Urine

___Prostate Trouble

___Vaginal/Ovarian

___Dialysis

___Kidney Problems

___Infectious Disease

Hematology: None

___Easy Bruising

___Prolonged Bleeding

Head/Neck: None

___Hearing Loss

___Dry Mouth

___Mouth Ulcers

___Pain

___Discharge

Skin: None

___Rash

___Skin Cancer

Muscle/Joint: None

___ Joint Pain

___Muscle Aches

___Difficulty lying flat

Neurological: None

___Headaches

___Numbness/Tingling

___Seizures

___Stroke

Lung: None

___Difficulty Breathing

___Shortness of Breath

___Cough

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

Patient please provide the following information:

Many of our patients allow family members such as their parent(s), grandparents, guardians or others to call and discuss medical information, request prescriptions, surgery information, medical records, and results of tests, pick up forms, etc. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have any of your medical information released to family members you must sign this form. Signing this form will only give consent to release said information to the individuals indicated below.

You have the right to remove this authorization at any time by so requesting in writing.

I, _____, date of birth _____,
(Print your Name)

authorize representatives of Tarantino Cho Eye Center to share and/or release information to:

1) _____ Relationship _____

Check all that apply:

O **All information**

O Regarding appointment, time & date
O Discuss lab results
O Discuss surgery
O Discuss medical care, an issue or concern
O Request and pick up/fax prescriptions/forms

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2) _____ Relationship _____

Check all that apply:

O **All information**

O Regarding appointment, time & date
O Discuss lab results
O Discuss surgery
O Discuss medical care, an issue or concern
O Request and pick up/fax prescriptions/forms

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3) _____ Relationship _____

Check all that apply:

O **All information**

O Regarding appointment, time & date
O Discuss lab results
O Discuss surgery
O Discuss medical care, an issue or concern
O Request and pick up/fax prescriptions/forms

I understand that I have the right to change this authorization, in writing, at any time by sending a written notification to this office.

_____ _____

Patient Name (Print) **Date**

_____

Signature of Patient

If you think we may have violated your privacy rights or you disagree with any action we have taken with regard to your health information we want you, your family or your guardian to speak with us. If you complain to us, your care will not be affected in any way. It is our goal to give you the best care while respecting your privacy.

Thank you,
Tarantino Cho Eye Center

Notice of Privacy Practices

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

rotected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including lemographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, resent or future physical or mental health condition and related healthcare services.

Our practice is legally required to maintain the confidentiality of your PHI, and to follow specific rules when sing or disclosing this information. This Notice describes your rights to access and control your PHI. It also escribes how we follow applicable rules when using or disclosing your PHI to provide your treatment, obtain ayment for services you receive, manage our healthcare operations and for other purposes that are permit-ed or required by law.

Your Rights Under The Privacy Rule

ollowing is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to iscuss any questions with our staff.

ou have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices ve are required by law to follow the terms of this Notice. We reserve the right to change the terms of the olice, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with copy of our current Notice if you call our office and request that a revised copy be sent to you in the mail, or sk for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in ne practice, and if such is maintained, on the practice's web site.

ou have the right to authorize other use and disclosure - This means we will only use or disclose your PHI as escribed in this Notice, unless you authorize other use or disclosure in writing. For example, we would need our written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psy-hotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, xcept to the extent that your healthcare provider, or our practice has taken an action in reliance on the use disclosure indicated in the authorization.

ou have the right to request an alternative means of confidential communication – This means you have the ght to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), nd/or to a destination (i.e., cell phone number, alternative address; etc.) designated by you. You must inform in writing, using a form provided by our practice, how you wish to be contacted if other than the address/ hone number that we have on file. We will follow all reasonable requests.

ou have the right to inspect and obtain a copy your PHI* - This means you may submit a written request to spect or obtain a copy of your complete health record, or to direct us to disclose your PHI to a third party. If ur health record is maintained electronically, you will also have the right to request a copy in electronic for-at. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established federal guidelines. We are required to provide you with access to your records within 30 days of your written quest unless an extension is necessary. In such cases, we will notify you of the reason for the delay, and the pected date when the request will be fulfilled.

ou have the right to request a restriction of your PHI* - This means you may ask us, in writing, not to use or sclose any part of your protected health information for the purposes of treatment, payment or healthcare perations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances hen the information is needed for your treatment. In certain cases, we may deny your request for a restric-n. You will have the right to request, in writing, that we restrict communication to your health plan regarding specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are l permitted to deny this specific type of requested restriction.

u have the right to request an amendment to your protected health information* - This means you may sub-t a written request to amend your PHI for as long as we maintain this information. In certain cases, we may ny your request.

u have the right to request a disclosure accountability* - You may submit a written request for a listing of dis-sures we have made of your PHI to entities or persons outside of our practice except for those made upon ur request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the accounting provided in a 12-month period.

u have the right to receive a privacy breach notice - You have the right to receive written notification if the actice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification equired.

you have questions regarding your privacy rights, or would like to submit any type of written request scribed above, please feel free to contact our Privacy Manager. Contact information is provided at right der Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health-care services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations – We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appoint-ment. We may contact you by phone or other means to provide results from exams or tests, to provide informa-tion that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

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 that you identify, your PHI that directly relates to that person's involvement in your healthcare. 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 PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g., a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain require-ments; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc); with respect to a group health plan, to disclose in-formation to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

You may ask questions about your privacy rights, file a complaint, or submit a written request (for access, restric-tion, or amendment of your PHI or to obtain a disclosure accountability) by notifying our Privacy Manager at:

MICHELE COX SPIVEY, M.S. ADMINISTRATOR

410-590-9260 x202, mcoxspivey@tceyecenter.com

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