New Patient Checklist

Please bring the following on the day of your examination:

-The registration forms you have received. Please complete all forms, front and back. Please arrive 20 minutes early if you have not completed the forms.

-Your current insurance cards. If your health insurance requires a specialist co-pay or if you have not met your deductible, we will collect this at the time of your visit. We accept Visa, Mastercard, Discover and American Express.

-Your driver's license or picture i.d.

-Please bring a list of all medications and supplements you are taking, including strengths, dosages, and the reason you are taking them.

-Please bring your current pair of eyeglasses or contacts.

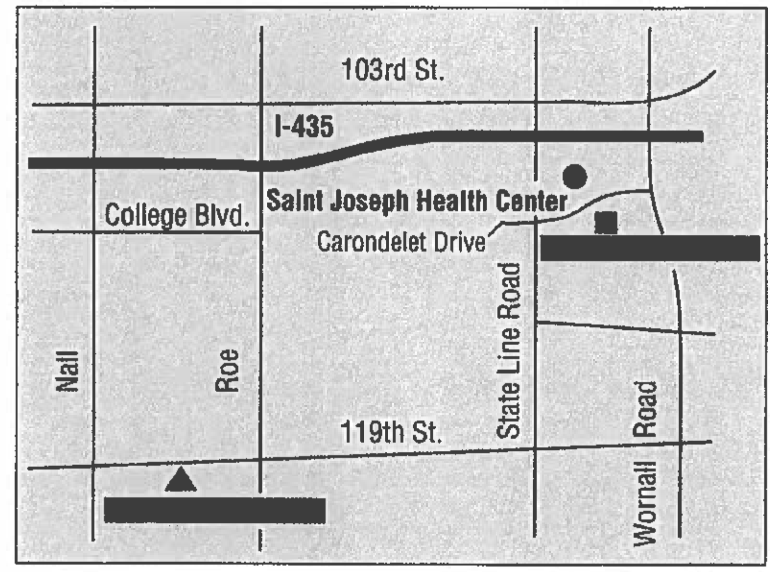
-If you currently wear contacts, we will need your most recent contact lens prescription, and/or contact lens boxes.

-Please arrive 15 minutes prior to your scheduled appointment. This will give our staff time to update your current information.

-Your eyes may be dilated to allow a complete examination by your doctor. This could impair your near vision.

- Please plan to spend approximately one to two hours with us for your comprehensive eye exam.

-If you need to change or reschedule your appointment for any reason, 24 hours' notice would be appreciated.



McElhinney Eye Care, PA
1004 Carondelet Drive, Suite 405
Kansas City, MO 64114

(816) 943-1123

Hospital Entrance "B"
To Glass Elevator
To 4th Floor Suite 405

McElhinney Eye Care, PA

PATIENT INFORMATION

DEMOGRAPHICS

NAME LAST FIRST MI			BIRTHDATE	AGE	SEX
STREET ADDRESS			SOCIAL SECURITY #		
CITY	STATE	ZIP CODE	SPECIAL NEEDS (choose one) WHEEL CHAIR WALKER HEARING IMPAIRED		
PRIMARY PHONE ( ) ☐ CELL ☐ HOME ☐ WORK	ALTERNATE PHONE ( ) ☐ CELL ☐ HOME ☐ WORK	EMAIL ADDRESS	AMERICAN INDIAN/ALASKA ASIAN WHITE AFRICAN AMERICAN HAWAIIAN PACIFIC ISLANDER		HISPANIC/ LATINO YES NO
EMPLOYER/NAME ADDRESS	POSITION/DEPARTMENT		MARITAL STATUS (choose one) MARRIED DIVORCED SINGLE WIDOWED		
SPOUSE			SPOUSE PHONE		
EMERGENCY CONTACT			EMERGENCY PHONE		

BILLING

GUARANTOR (FINANCIALLY RESPONSIBLE PERSON)			RELATIONSHIP TO PATIENT (CIRCLE) SELF SPOUSE PARENT OTHER	
STREET ADDRESS			PHONE ( )	
CITY			STATE	ZIP CODE
PRIMARY INSURANCE	POLICY HOLDER	POLICY ID#	GROUP #	INSURED'S DOB
SECONDARY INSURANCE	POLICY HOLDER	POLICY ID#	GROUP #	INSURED'S DOB
ARE YOU UNDER THE CARE OF A SKILLED NURSING FACILITY? YES NO		IF YES, PLEASE LIST NAME, ADDRESS AND PHONE NUMBER.		

Agreement of Responsibility

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for copays and annual deductibles will be expected at the time of the visit. Glasses prescriptions are considered "routine services" and are not covered by most "medical" insurance policies. I understand a payment of $25 for this service will be collected at the time of the appointment. I understand that I am financially responsible for charges not covered by my insurance company.

Consent to Treat

I voluntarily consent to care and treatment prescribed by the physician that is necessary in her judgement.

Release of Information/Assignment of Benefits

I authorize use of this form for all my insurance submissions and authorize release of information needed to process a claim to my insurance companies. I assign all rights for reimbursement of expenses allowed by my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a statement for any balance on my account.

I understand that if I do not have insurance or if the doctor I see today does not participate with my insurance plan, I am responsible for the payment at the time of the visit. I agree to make a down payment of $75.00 upon check in and will pay the balance of the visit upon check out. I will be given a summary of my charges and diagnoses so that I may file with my insurance company to be reimbursed.

Signature:____Date:_________________

Printed Name:____

Medicare Authorization

I request payment of authorized Medicare benefits be made on my behalf to McElhinney Eye Care, PA, for services furnished to me by that physician/supplier. I authorize the holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the Medicare allowable as the full charge, and the patient is responsible for the deductible, co-insurance and any uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Medigap Authorization

A Medigap or Medical Supplemental policy is a health insurance policy or other health plan offered by a private company to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. I request that payment of authorized benefits be made on my behalf to McElhinney Eye Care, PA, for any services furnished to me by my physician/supplier. I authorize that any of my medical information be released to my secondary or Medigap insurance carrier, in order to determine and pay benefits for any related services.

This agreement remains in effect until revoked in writing by the patient.

Signature:____Date:_________________

Printed Name:____

HIPAA PATIENT NOTICE

It is our policy not to release confidential and/or unauthorized information on a home telephone, answering machine, work telephone, voice mail, or cell phone. When returning phone calls, we will not leave a detailed message on an answering machine if the identifying name or telephone number is not stated in the recorded message. We will not leave information with an unauthorized person who may answer the telephone. If you would like information released to someone other than yourself, please complete the following:

I authorize McElhinney Eye Care, PA, to leave detailed medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever the information changes.

Home telephone	yes	no
Answering machine	yes	no
Work telephone	yes	no
Cell phone	yes	no
Voice mail	yes	no

I hereby authorize McElhinney Eye Care, PA, to disclose appointment times, treatment, and test results (protected health care information) to the following people:

Name____Relation______________________ Phone #______________

Address____

Name____Relation______________________ Phone#_______________

Address____

Name____Relation______________________ Phone#_______________

Address____

Name____Relation______________________ Phone#_______________

Address____

____

Signature Patient/Guardian Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEGEMENT FORM

I, ___________________________________, have received a copy of the Notice of Privacy Practices.

Patient's Name

McElhinney Eye Care, PA
Financial Policy

Thank you for choosing McElhinney Eye Care, PA. We strive to provide the highest quality eye care possible. Paying for our services in a responsible and timely manner is appreciated by our practice.

Our financial policy is listed below. We ask that each patient read and sign a copy of this policy. Please read this statement, sign the bottom, and should you have any questions please feel free to contact our billing department.

Acceptable Payment Methods:
We accept cash, checks, Visa, MasterCard, Discover and American Express. Payment is expected at the time of service.

Insurance: Our office accepts assignment of benefits from many insurance companies, HMO and PPO programs. However, we do not participate with all benefit programs. Please contact the customer service department of your insurance company to verify that our physician participates with your plan.

Affordable Care Act Insurance: Our office participates with a limited number of plans from the Affordable Care Act. Please call the customer service department of your insurance company to verify that our physician participates with your plan.

We do require that co-payments, deductibles and any non-covered services, which include refractions and contact lens charges, be made at the time of service. If our practice does not participate with your insurance plan we require payment in full at the time of service.

Your bill is your responsibility: Most insurance companies do not provide full coverage and it is your responsibility to pay the balance. Payment in full is due within 90 days of being notified of any balance. It is our policy to mail out three billing statements. Failure to pay the balance in full or contact our office regarding a payment plan will result in your account being transferred to a collection agency.

I have read and understand the "Financial Policy" and agree to all terms and conditions stated above. I understand it is my responsibility to verify my medical coverage with my insurance company. I understand that I am responsible for any unpaid balances by my insurance company.

Signature:____**Date:**______________

Print Name:____

09/19

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect immediately and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created, and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our office. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other healthcare professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends, and/or persons you choose to involve in your care, only if you agree that we may do so.

(a)Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of our protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. To request this listing or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $0.52 per page and the staff time charge will be $22.01 including the time required to locate and copy your health information. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

(b)Right to Request Restriction of PHI: You may request a restriction on our use and disclosure of PHI, but we are not required to agree to your request. The HITECH Act restricts a providers refusal of an individual's request not to disclose PHI in instances where the disclosure is to a health plan for purposes of carrying out payment or health operations (and is not for purposes of carrying out treatment); and the PHI pertains solely to a healthcare item or service for which our facility has been paid out of pocket in full.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays, or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request, or other lawful process). We will use and disclose your information when requested by national security, intelligence, and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose our health care information to report problems with products, reactions to medications, product recalls, disease, infection exposure, and to prevent and control disease, injury, and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to the military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence, or other national security activities we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $0.52 per page and the staff time charged will be $22.01 including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/ or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosure: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep records of routine disclosures: therefore these are not available). You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available).

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies). Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

Breach Notification Requirements: Beginning September 23, 2009, in the event unsecured protected information about you is "breached" and the use of the information poses a significant risk of financial, reputable, or other harm to you, we will notify you of the situation and any steps you should take to protect yourself against harm due to the breach. We will inform HHS and take any other steps required by law.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaints should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a formal complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

McElhinney Eye Care, PA

1004 Carondelet Dr., Suite 405, Kansas City, MO 64114

New Patient Information

NAME: ____ **DATE** ______________________

DOB: ___________________

Eye History:

Please describe the reason for your visit:

____

____

____

Please list any and all previous eye problems and eye surgeries:

____

____

____

Please list current eye medications:

____

____

Do you wear glasses? Yes No **Age of current/preferred pair**: ______________

Do you currently wear contact lenses? Yes No

Date of last contact lens prescription: ____

Review of Symptoms: Eyes *(circle all that apply and describe as needed)*

Loss of vision	**Yes**	**No**	_____________________________________
Blurred vision	**Yes**	**No**	_____________________________________
Double vision	**Yes**	**No**	_____________________________________
Dry or red eyes	**Yes**	**No**	_____________________________________
Sandy or gritty eyes	**Yes**	**No**	_____________________________________
Itching or burning	**Yes**	**No**	_____________________________________
Foreign body sensation	**Yes**	**No**	_____________________________________
Excess tearing	**Yes**	**No**	_____________________________________
Infection of eyelids	**Yes**	**No**	_____________________________________

Over

Referring Physician____

Address____
City/State/Zip____________________________________**Phone**(_____)___________________

Primary Care Physician____
Address____
City/State/Zip____________________________________**Phone**(_____)___________________

Name of other physician specialists that you regularly see:____________________________
____

Pharmacy Information

Pharmacy Name ____
Pharmacy Address____
Pharmacy Phone Number____

Please list any and all known medication allergies:
____ *or circle* NONE

If you do not have a list of your current medications, please list below. Also include vitamin supplements and over the counter remedies.

Medication **Dose** **Reason for Use**

____
____
____
____
____
____
____
____
____
____

Do you take aspirin? **YES** (if yes, _____mg) **NO**

Please list any major illnesses and surgeries that you have had in the past:

____

____

____

____

____

____

____

Occupation /former occupation________________________________ **Retired** Yes No

Smoking now? Yes No **Cigarettes** **Cigars** **Pipe** Packs/day**?** _________

Have you ever smoked? Yes No

Do you drink alcohol? Yes No **If yes, how many glasses per day?** ______

Are you currently using any recreational drugs? Yes No __________________

Are you currently or could you be pregnant? Yes No Unknown N/A **Trimester**_____

Family History: (Circle) Yes or No			**List their relationship to you:**
Blindness	**Yes**	**No**	________________________
Cataract	**Yes**	**No**	________________________
Glaucoma	**Yes**	**No**	________________________
Macular Degeneration	**Yes**	**No**	________________________
Retinal Detachment	**Yes**	**No**	________________________
Diabetes	**Yes**	**No**	________________________
Heart Disease	**Yes**	**No**	________________________

Review of systems. Please circle all that apply.

Cardiovascular Chest pain	***HEENT*** Dizziness	***Musculosketal*** Back pain	***Respiratory*** Cough	***Blood Pressure Control*** Good BP control
Irregular heart beat	Hoarseness	Joint pain	Trouble breathing	Borderline BP control
Shortness of breath	Ringing in ears	Muscle aches	Wheezing	Poor BP control
	Sore throat	Stiffness		Unknown BP control
		Swelling		

Constitutional Fatigue	***Hematologic*** Bleeding	***Neurological*** Balance problems	***Skin*** Hair loss	***Diabetes Control*** Good DM control
Fever	Bruising	Headache	Rash	Borderline DM control
Night sweats	Tender nodes	Numbness	Skin lesions	Poor DM control
Weakness		Tingling		Unknown DM control
Weight loss				

Genitourinary Genital discharge	***Metabolic*** Cold intolerance	***Psychiatric*** Anxiety	***Allergy*** Itching	***Pregnancy*** Pregnancy-first trimester
Genital lesions	Excess hunger	Depression	Hives	Pregnancy-second trimester
Painful urination	Excessive thirst	Insomnia	Chronic runny nose	Pregnancy-third trimester
Urgency	Frequent urination	Irritability	Seasonal allergies	Not pregnant
	Heat Intolerance	Nervousness		

None of the above

McElhinney Eye Care, PA

The Medical Mall at St. Joseph Medical Center
1004 Carondelet Drive, Suite 405
Kansas City, MO 64114
(816) 943-1123 Fax (816) 943-1250

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I ______________________________________, born___________________________
Patient Name Date of Birth

Authorize and request: ____
Specify Practice/Facility or Physician

To release to ____
Specify recipient of patient records

The following information ____
Specify all or what portion of records

Purpose of Disclosure: ____
This information is released for this purpose and this purpose only

I understand that if my medical record contains information concerning HIV (AIDS) or drug or alcohol abuse, those portions of my medical record are protected by state or federal law. I hereby release and forever discharge Associated Ophthalmologists of Kansas City, P.C., its physicians and employees, or agents from any liability arising out of the release of my medical record as specified above and pursuant to this signed authorization.

This consent is subject to written revocation at any time*, except to the extent that the disclosure has already taken place in reliance on it. If not previously revoked, this consent will terminate on ______________________________. If left blank, this consent expires in one year.

____ ______________________
Signature of Patient Month Date Year

____ ________________________________
Signature of parent, guardian or authorized representative Nature of relationship

____
Witness

Information disclosed as requested in this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPAA rule. Treatment may not be conditioned on signing this authorization unless treatment is research related and the authorization is for use or disclosure for such research. *Written revocation must be submitted to: Privacy Official, McElhinney Eye Care, P.C., 1004 Carondelet Dr., Suite 405, Kansas City, MO 64114.

PRIVILEGED AND CONFIDENTIAL INFORMATION

This transmission contains CONFIDENTIAL information which may also be LEGALLY PRIVILEGED and which is intended only for the use of the individual or entity named above. If the reader of this transmission is not the intended recipient, you are hereby on notice that you are in possession of confidential and privileged information. Any dissemination, distribution, or copying of this transmission is strictly prohibited. If you have received this transmission in error, please notify us immediately by telephone and return the entire transmission to the appropriate address via the post