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.

What is this Notice and Why Is It Important?
By law, Riverside Eye Center, P.C. must protect the privacy of your identifiable medical and other health information ("health information").

We are also required by law to give you this notice to tell you how we may use and give out ("disclose") your health information. This notice is effective as of July 1, 2013.

How Riverside Eye Center, P.C. May Use Your Health Information
As a general rule, you must give written permission before your health information can be used or released. There are certain situations where we are not required to obtain your permission. This section explains those situations where your health information may be used or disclosed without permission. Records may also be disclosed electronically as necessary.
Except with respect to Highly Confidential Information (described below), **"Riverside"** is permitted to use your health information for the following purposes:

• **Treatment:** We use and disclose your health information to provide you with medical treatment or services. This includes uses and disclosures to:

- treat your illness or injury, including disclosures to other doctors, practitioners, nurses, technicians or medical personnel involved in your treatment, or
- contact you to provide appointment reminders, or
- give you information about treatment options or other health related benefits and services that may interest you.

• **Payment:** We may use and disclose your health information to obtain payment for health care services that we or others provide to you. This includes uses and disclosures to:

- ***submit health information and receive payment from your health insurer, HMO, or other company that pays the cost of some or all of your health care (payer), or***
- ***verify that your payer will pay for your health care.***

• **Health Care Operations:** We may use and disclose your health information for our health care operations, such as internal administration and planning that improve the quality and cost effectiveness of the care we provide you. This also includes uses and disclosures to:

- evaluate the quality and competence of our health care providers, nurses and other health care workers,
- to other health care providers to help them conduct their own quality reviews, compliance activities or other health care operations,
- train students, residents and fellows, or
- identify health-related services and products that may be beneficial to your health and then contact you about the services and products.

We may also disclose your health information to third parties to assist us in these activities (but only if they agree in writing to maintain the confidentiality of your health information).
In addition, we may use and disclose your health information under the following circumstances: .

• **Relatives, Caregivers and Personal Representatives:** Under appropriate circumstances, including emergencies, we may disclose your health information to family members, caregivers or personal representatives who are with you or appear on your behalf (for example, to pick up a prescription). We may also need to notify such persons of your location in our facility and general condition. If you object to such disclosures, please notify your health care provider. If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, we may exercise professional judgment to determine whether a disclosure is in your best interests. If information is disclosed to a family member, other relative or a close personal friend, we would disclose only information believed to be directly relevant to the person's involvement with your health care or payment related to your health care.

• **Public Health Activities:** We may disclose your health information for the following public health activities:

- To report to public health authorities for the purpose of preventing or controlling disease, injury or disability;
- To report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports;
- To alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease; or
- To report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

• **Victims of Abuse, Neglect or Domestic Violence:** If we reasonably believe that you are a victim of abuse, neglect or domestic violence, we may disclose your health information as required by law to a social services or other governmental agency authorized by law to receive such reports.

• **As Required by Law:** We may disclose health information when required to do so by any other law not already referred to in the preceding categories.

Your Written Authorization
FOR ANY PURPOSE OTHER THAN THE ONES DESCRIBED ABOVE WE MAY ONLY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION WHEN YOU GIVE US YOUR WRITTEN AUTHORIZATION.

Highly Confidential Information
Federal and state law require special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including your health information that is maintained in psychotherapy notes or is about: (1) mental health and developmental disabilities services; (2) alcohol and drug abuse prevention, treatment and referral; (3) HIV/AIDS testing, diagnosis or treatment; (4) communicable disease(s); (5) genetic testing; (6) child abuse and neglect; (7) domestic or elder abuse; or (8) sexual assault. In order for your Highly Confidential Information to be disclosed for a purpose other than those permitted by law, your written authorization is required.

Your Rights Regarding Your Health Information:

Right to Request Access to Your Health Information: You have the right to inspect and maintain a copy of the patient records we maintain to make decisions about your treatment and care, including billing records. All requests for access must be made in writing. Under limited circumstances, we may deny you access to your records. If you would like access to your records, please ask your healthcare provider for the appropriate form to complete. If you request copies, we will charge you a reasonable fee for copies. We also will charge you for our postage costs, if you request that we mail the copies to you. If you are a parent or legal guardian of a minor, certain portions of the minor's medical record may not be accessible to you under state law.

Right to Request Amendments to Your Health Information: You have the right to request that we amend your health information maintained in your medical record file or billing records. If you wish to amend your records, please obtain an amendment request form from your healthcare provider. All requests for amendments must be in writing. We will comply with your request unless we believe that the information that would be amended is already accurate and complete or other special circumstances apply.

Right to Revoke Your Authorization: You may revoke (take back) any written authorization obtained by us for use and disclosure of your protected health information, except to the extent that we have taken action in reliance upon it. Your revocation must be in writing.

Right to Request how Information is Provided to You: You may request, and we will try to accommodate, any reasonable written request for you to receive health information by alternative means of communication or at a different address or location.

Right to Request Restrictions on the use of your Health Information: YOU MAY REQUEST THAT WE RESTRICT THE USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION. ALL REQUESTS FOR SUCH RESTRICTIONS MUST BE MADE IN WRITING.
While we will consider a request for additional restrictions carefully, we are not required to agree to a requested restriction, except for requests to restrict disclosure of information to a health plan in cases where you have paid for the service out of pocket and in full.

Right to be Notified of Breach: You have the right to be notified by us if we discover a breach of your unsecured protected health information.

Right to a Paper Copy of this Notice: Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such information electronically.

RIVERSIDE EYE CENTER, P.C.

Patient Registration

Today's Date _____ First, Middle, Last Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Email Address _____ Social Security Number _____

Home Phone _____ Work Phone _____ Cell Phone _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Gender: ☐ Male ☐ Female

Preferred Language: ☐ English ☐ Other _____

Race: ☐ White ☐ Native American ☐ Asian ☐ African American ☐ Pacific Islander ☐ Hispanic or Latino ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown _____

Primary Insurance Information

Name of Insurance Company _____

Subscriber's Name _____ Date of Birth _____

Subscriber's Employer _____

Secondary Insurance Information

Name of Insurance Company _____

Subscriber's Name _____ Date of Birth _____

Subscriber's Employer _____

Referring Physician

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Primary Care Physician

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Patient Employment

Name _____

Position _____

Emergency Contact

Name _____

Phone _____

☐ Have you seen another provider for this condition? If so, what is the provider's name?

_____

How did you hear about our clinic?

☐ Referring Provider ☐ Family or Friend

☐ Insurance Company ☐ Internet Search

☐ Other _____

Provider Agreement

☐ Patient received a copy of patient provider agreement

RIVERSIDE EYE CENTER, P.C.
You'll see the difference with expert vision care

4050 River Road
East China, MI 48054
Phone: (810) 329-9045

4656 24th Avenue
Fort Gratiot, MI 48059
Phone: (810) 385-3600

Patient Health Information

Name: (*Last, First, M.I.*)	Birthdate	Today's Date

Thank you for taking your time to carefully complete the patient health information form. This information will be reviewed by the doctor during your examination. All information provided will be held in strict confidence.

PERSONAL MEDICAL/EYE HISTORY

Please note if you have any of the following conditions.

☐ None ☐ Diabetes ☐ High Cholesterol ☐ Macular Degeneration
☐ Cancer ☐ Arthritis ☐ Cataracts
☐ Heart Disease ☐ Dry Eye ☐ Lazy Eye
☐ High Blood Pressure ☐ Glaucoma ☐ Eye Injury
☐ Thyroid Disease ☐ Other_____

- List major injuries and surgeries you have had. _____
  _____
- List all medications you are currently taking (prescription and over-the-counter). _____
  _____
- Do you have any allergies to medications/Latex/Dyes? ☐ Yes ☐ No If yes, please list and describe reaction.
  _____
- Date of your last physical exam _____ Are you pregnant / nursing? ☐ Yes ☐ No
- Have you had your eyes dilated? ☐ Yes ☐ No If yes, were there any problems? _____
- Do you wear glasses? ☐ Yes ☐ No If yes, how old are your glasses? _____
- Date of last complete eye exam _____

FAMILY MEDICAL/EYE HISTORY

Please note any family members with the following conditions. Please also note on the line next to the condition how that person is related to you.

☐ None ☐ Diabetes _____ ☐ High Cholesterol_____ ☐ Macular Degeneration_____
☐ Cancer _____ ☐ Arthritis _____ ☐ Retinal disease_____
☐ Heart Disease _____ ☐ Glaucoma _____ ☐ Lazy Eye _____
☐ High Blood Pressure_____ ☐ Cataracts _____ ☐ Other_____

PERSONAL SOCIAL HISTORY

- Please list your hobbies/recreational activities. _____
- Do you use an electronic device at work/home? ☐ Yes ☐ No If yes, how many hours/day?_____
- Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No
- Do you use tobacco products? ☐ Yes ☐ No ☐ Previously: If yes, amount/how long?_____
- Do you drink alcohol? ☐ Yes ☐ No If yes, how often?_____
- Do you use illegal drugs? ☐ Yes ☐ No If yes, how often?_____
- Have you had a blood transfusion? ☐ Yes ☐ No If yes, how often?_____
- Have you ever been infected with the following: HIV? ☐ Yes ☐ No TB? ☐ Yes ☐ No Hepatitis? ☐ Yes ☐ No
- **Influenza vaccine received? ☐ Yes ☐ No Pneumococcal vaccine received? ☐ Yes ☐ No**
- **Have you fallen in the past 12 months? ☐ Yes ☐ No**

REVIEW OF SYSTEMS

Please indicate below if you currently have or have in the last month, had any of the following health signs and symptoms:

Eyes

☐ None ☐ Blurred vision ☐ Burning ☐ Eye injury ☐ Light sensitivity/glare
☐ Loss of vision ☐ Dryness ☐ Eye pain ☐ Eye turn
☐ Redness ☐ Excessive tears ☐ Flashes/floaters ☐ Double vision
☐ Itching ☐ Tired/sore eyes ☐ Vision disturbance ☐ Other_____

Constitution

☐ None ☐ Fever ☐ Weight loss ☐ Chills ☐ Other_____

Cardiovascular

☐ None ☐ Chest pain ☐ Palpitations ☐ Lightheaded ☐ Other_____

Ear, Nose, Mouth, Throat

☐ None ☐ Hearing loss ☐ Sinus congestion ☐ Sore throat ☐ Other_____

Respiratory

☐ None ☐ Shortness of breath ☐ Pain when breathing ☐ Chronic cough ☐ Other_____

Gastrointestinal

☐ None ☐ Nausea ☐ Constipation ☐ Diarrhea ☐ Other_____

Genitourinary

☐ None ☐ Increased frequency ☐ Increased urgency ☐ Burning/itching ☐ Other_____

Muscles/Bones/Joints

☐ None ☐ Joint pain ☐ Joint swelling ☐ Restricted motion ☐ Other_____

Skin

☐ None ☐ Rashes ☐ Rosacea ☐ Sores ☐ Other_____

Neurological

☐ None ☐ Headaches ☐ Seizures or Convulsions ☐ Dizziness ☐ Other_____

Psychiatric

☐ None ☐ Anxiety ☐ Depression ☐ Memory loss ☐ Other_____

Endocrine

☐ None ☐ Frequent urination ☐ Elevated blood sugar ☐ Excessive thirst ☐ Other_____

Blood / Lymph

☐ None ☐ Bleeding disorder ☐ Swollen lymph nodes ☐ Low blood count ☐ Other_____

Allergic / Immunologic

☐ None ☐ Seasonal allergies ☐ Suppressed immune system ☐ Allergic rhinitis ☐ Other_____

Please explain any of the signs and symptoms that you checked above:

_____

_____

_____

Riverside Eye Center, P.C.

Advanced Beneficiary Notice (ABN)

4050 River. Rd.
East China, MI 48054
Ph. 810-329-9045
Fx. 810-329-8732

4656 24th Ave
Fort Gratiot, MI 48059
Ph. 810-385-3600
Fx. 810-385-0603

Patient Name _____ **Date**_____

Privacy Policy Statement

I have received a copy of the office's privacy policy. I have had an opportunity to review it and have had any questions answered. I also understand that by signing below, I gave Riverside Eye Center, P.C., and its staff permission to call regarding health care, insurance, or billing information, normal test results, and appointment dates. A message may be left with/on my answering machine, voice mail, sent by fax or left with a family member.

One Time Authorization Agreement

Statement to permit payment of insurance benefits to providers, physicians, and patients.

I request that payment of authorized insurance benefits be made to Riverside Eye Center, P.C. for any services furnished to me by this provider. I authorize any holder of medical or other information about me to be released to my insurer and their agents. This includes any information needed to determine these benefits for related services. I permit a copy of the authorization to be used in place of the original. If my insurance fails to pay for a service, even if you or your doctor feel it is beneficial I understand that I may be responsible for those charges.

Refraction Agreement

A refraction is the part of the eye exam that determines your eyeglass prescription. Although this test is a very important part of your exam and is required for certain surgical procedures (such as cataracts), it is not considered a "medical procedure". Therefore most medical insurances, including Medicare will not cover the cost of the refraction.

If you have "optical insurance" it may cover the refraction fee. Ask the receptionist for more information.

The charge for this service is $35.00. Indicate below if you would like this service.

☐ **I want to receive this service.** I understand that payment is due when service is rendered or I may be charged a $2.00 collection fee.

☐ **I have decided not to receive the service.**

Patient Signature _____ **Date**_____