Westchester Eye Surgeons, S.C.
10439 West Cermak, Westchester, IL 60154

Patient Name: _____ Date: _____

Address _____

City _____ State _____ Zip _____

Home Tel _____ Work Tel _____ Patient D.O.B. ___ /___ /____

Age _____ Minor___ Male ___ Female ___ Marital Status _____

GOVERNMENTAL MEANINGFUL USE QUESTIONS: Language _____ English

Other _____ Race_____ Ethicity _____

I DECLINE TO ANSWER (circle which) the Language, Race, Ethnicity, ALL THREE questions (initial here) _____

Patient's Social Security # _____

Employer _____

Address_____Tel_____

E-Mail Address _____ Spouse's Name _____

Emergency Contact Name_____ Tel_____ Relationship _____

Primary Care Physician _____ Referring Physician _____

How did you hear about us? _____

If internet: ___Google ___Yahoo ___Yellowpages.com ___Yellowbook.com

___Insurance website __Other_____

IF PATIENT A MINOR

Parent(s) Name_____

Parent Social Security # _____

X _____
Signature of Patient or Personal Representative

INSURANCE INFORMATION

Name of Primary Insurance_____ Name of Secondary Insurance_____

Insurance carrier's relationship to patient: Self ( ) Spouse ( ) Parent ( ) Other ( )_____

Do you need a paper referral to be seen here? Yes ( ) No ( )

Do you have Co-payment? No ( ) Yes ( ) $ _____

Deductible No ( ) Yes ( ) $_____

If this is a work injury what is **EXACTLY** the date of the injury?

_____

VERIFICATION OF INFORMATION

I certify that the identifying information, addresses, and telephone information I have provided is correct and agree to inform the practice if such information changes or becomes outdated.

X_____ X_____ Date: ___

Printed Name or Power of Attorney Patient's Signature or Power of Attorney

AUTHORIZATION TO RELEASE PATIENT RECORDS TO INSURER

I hereby authorize Westchester Eye Surgeons, S.C. to release any and all of my records to my insurer, or any other third party payor, legally responsible for the payment of medical expenses for care provided, as is required by Insurance Regulations. I understand that this authorization allows Westchester Eye Surgeons, S.C. to release to my insurer or financial payor any information concerning me, including but not limited to confidential information, financial records, and the records of any treatment or examination rendered me. I understand that this release, and any future general release that I may sign, specifically allows for the release of information to my insurer or financial payor concerning HIV test results and/or related data that may be a part of my medical records. This general release and authorization shall remain in effect until revoked by me in writing.

X_____ X_____ Date: _____

Printed Name or Power of Attorney Patient's Signature or Power of Attorney

ASSIGNMENT OF BENEFITS List Insured's Name: _____

To: Third-Party Payer / Insurance Carrier / Supplemental Insurance

In consideration of service rendered Westchester Eye Surgeons, S.C., their agents and staff, I hereby assign to Westchester Eye Surgeons, S.C. the benefits due to me under my health insurance plan. I agree that I shall be responsible for all portions of payments due to Westchester Eye Surgeons, S.C. for services received that are not covered by the above such as annual deductible, co-payments, and co-insurance. I agree that I shall be solely responsible for the entire bill for services or any balances that may be determined to be not covered by my health plan. This assignment of benefits shall remain in effect, even if my insurance carrier changes, until revoked in writing.

X_____ X_____ Date:_____

Printed Name or Power of Attorney Patient's Signature or Power of Attorney

Written Acknowledgment of Receipt
Of Westchester Eye Surgeons Notice of Privacy Practices

Patient or guardian name:

_____

I hereby express acknowledgment of my receipt of Westchester Eye Surgeons' Notice of Privacy Practices.

X_____
Patient, or Legal Representative, Signature

X_____
Printed Patient, or Legal Representative, Name **Date _____**

Acknowledgement NOT obtained because:

____ Patient, or legal representative, declined Notice of Privacy Practices;

____ Other (briefly describe)_____

_____

X_____
Patient Printed Name

X_____
Patient Signature **Date _____**

Permission for dilation for driving adults without recent acute eye issues

It is usually necessary for Dilation Drops to be used in the evaluation and treatment of ocular problems. Dilation drops can TEMPORARILY cause haze, halos, and loss of depth perception resulting in HAZARDOUS DRIVING VISION. As a result we need your permission to use dilation drops in which case we recommend you let some other individual drive for you. We cannot assume any responsibility for your driving after any dilated exam. If you

I agree to have my eyes dilated when the doctor thinks it is medically necessary.

X_____

I decline to have my eyes dilated when the doctor thinks it is medically necessary.

X_____

Date _____

WESTCHESTER EYE SURGEONS, S.C.
10439 WEST CERMAK
WESTCHESTER, IL 60154
708 531 1030

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

This was prepared personally for you. Please review it carefully!

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your Health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Westchester Eye Surgeons. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Individual Rights

You have certain rights under the federal privacy standards. These include:

. the right to request restrictions on the use and disclosure of your protected health information
. the right to receive confidential communications concerning your medical condition and treatment
. the right to inspect and copy your protected health information
. the right to amend or submit corrections to your protected health information
. the right to receive an accounting of how and to whom your protected health information has been disclosed
. the right to receive a printed copy of this notice

Westchester Eye Surgeons Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.
We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information
As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our Receptionist or Office Manager.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Office Manager
Westchester Eye Surgeons, S.C.
10439 W Cermak
Westchester, IL 60154

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices is:

Office Manager
Westchester Eye Surgeons, S.C.
10439 W Cermak
Westchester, IL 60154
(708) 531-1030

Effective Date
This Notice is effective on or after April 14, 2003.