



Date: _____

Dear: _____

**Your appointment has been scheduled for _____ at _____
With Dr. _____**

100 Physicians Drive, Greer SC 29650

104 Simpson Street, Greenville, SC 29605

We would like to thank you for choosing Southern Eye Associates, P.A. for your eye care. Our new patient information packet is enclosed with documents that require your signature. **You may choose to return the enclosed forms by mail in the self addressed envelope or bring them with you completed to your appointment.**

- a) Patient Registration Information
- b) Medical Questionnaire
- c) Patient Responsibility Payment Policy
- d) Contact Lens Fitting, Evaluation & Management Policy

To help avoid delays, please arrive ten minutes prior to your scheduled appointment and please bring the following information with you to your appointment:

1. The completed enclosed forms
2. Your MOST current insurance card(s)
3. Any required physician, insurance or employer referral authorizations
4. All of your current medication and pertinent medical information
5. **Note:** Eyes may be dilated and sensitive to light – may require a driver

In addition to quality eye care, Southern Eye provides full optical centers in which we offer the latest in frame designs, a wide range of lens options and sunglasses. We are a retailer for Oakley, Maui Jim and Costa Del Mar sunglasses. We offer complete contact lens service with contact lens fitting and products at competitive prices. If you are interested in contact lenses, please let our technicians know at the time of your visit.

Our office location directions are enclosed and available on our website. Take a moment to confirm the address of your appointment as we may be unable to accommodate your visit if you arrive at the incorrect location for your scheduled appointment.

We are looking forward to meeting you in the near future. If you have any questions pertaining to your upcoming visit please do not hesitate to give us a call at (864) 269-3333 for the Greenville office or (864) 801-8053 for the Greer office or toll-free at 800-959-5593. For more information regarding Southern Eye, please visit our website at www.southern-eye.com.

Sincerely yours,

The Physicians and Staff of Southern Eye Associates, P.A.

SOUTHERN EYE ASSOCIATES, P.A.

Patient Responsibility Payment Policy

Thank you for choosing our practice for your eye care needs. We are committed to providing the best possible care. The following information is provided to avoid any confusion regarding payment for our professional services. Please sign below that you have read and agree to this Policy.

Please present current insurance cards and photo ID at the time of your visit.

Payment Policy:

- We accept cash, check, debit card, Visa, Master Card, Discover and American Express.
- At the time of your visit, you are responsible for paying your co-pay, any deductible not met and non-covered services, such as, Refractions. Your insurance company requires us to collect your co-pay and deductible.
- Payment is expected at the time of Check-out. If you are not prepared to pay your exam, then we can offer payment arrangements through our billing department. Note: We can not make payment arrangements on co-pays.
- Non-covered services may be essential for the physician to properly evaluate and treat you during your eye exam, such as, Refraction, Contact Lens Fittings (separate from eye exam fee), etc. Medicare and most insurance plans do not cover these fees which will be payable upon Check-out. You may choose to defer these or any services prior to receiving them – please discuss with the technician and doctor.
- Payment for any contact lens fitting (separate fee form the eye exam) is due at the time of service. We will file your contact lens fitting fee if we are contracted with your vision plan.
- For High-Deductible policies (including patients with Health Savings Accounts), payment will be collected at the time of service (except in rare circumstances where benefit requires filing claim for contracted discount fee to apply).
- Other information: We will be happy to complete a Driver's License form for you for a nominal fee. Fees apply for copies of medical records (separate authorization required), to complete disability or other forms and are payable at the time forms are picked up.
- If the patient is a minor (18 years old and younger), the parent or guardian is responsible for payment of the account in accordance with the policies outlined above. If parents are divorced, the adult who brings the child to the appointment is responsible for applicable fees.

Insurance:

Private & Managed Care Insurance and Vision Plans: If you participate in a plan that we accept as a contracted provider we will be happy to file your insurance claims for you. Otherwise payment in full is your responsibility. Please note that you are ultimately responsible for payment if your private insurance company denies payment. It is your responsibility to know your benefits, to notify this office of any changes to your insurance coverage, and to pay any amount that is determined to be your responsibility. You must provide the office with the correct insurance card at the time of service. You must obtain referrals from your insurance or primary care physician prior to your appointment if required. **You must notify us if you will be using your Vision Plan (must be a contracted plan) at the time of Check-In. We can not change diagnoses or types of insurance during or after the doctor's exam.**

Medicare: Your current copy of the Medicare card or your Medicare Advantage card is required. Deductibles, co-pays and non-covered fees will be your responsibility.

Medicaid: A current copy of the Medicaid card is required prior to treatment at every visit or the patient will be rescheduled. Southern Eye is NOT contracted with every Medicaid plan.

Acknowledgement and Authorization:

I have read, understand and agree to the above Payment Policy. I understand that any charges not covered by my insurance company are my responsibility. I authorize my insurance benefits to be paid directly to Southern Eye Associates, P.A. I authorize Southern Eye Associates, P.A. to release any medical or other information to my insurance company when requested.

Patient/Guardian Printed Name

Signature of Patient/Guardian

Date


PEDIATRIC PATIENT MEDICAL FORM

PATIENT'S NAME: _____ ACCOUNT #: _____

REASON FOR VISIT (please be specific; insurance companies will not pay for routine exams): _____

EYE AND MEDICAL HISTORY – REVIEW OF SYSTEMS

**Please check if you/your child (i.e. the patient) has problems with any of the following.
If yes, how long and what type?**

NAME	 IF APPLICABLE	HOW LONG?	WHAT TYPE?
Glasses/contact lens wear			
Amblyopia/"lazy" eye			
Strabismus/misaligned eyes			
Ptosis/droopy lid			
Retinopathy of Prematurity/ROP			
Eye injury			
Cataract			
Glaucoma			
Malformation			
Retinal dystrophy			
Retinal detachment			
Macular degeneration			
Other			
Prematurity (How much, birth weight)			
Growth			
Development			
Immunizations			
Ear/Nose/Throat (eg ear infections)			
Respiratory (eg asthma)			
Cardiac (eg malformation)			
GI (eg reflux)			
GU (eg reflux)			
Musculoskeletal (eg arthritis)			
Neurological (eg seizures, hydrocephalus)			
Skin (eg eczema)			
Psychiatric (eg ADD/ADHD, tics, behavioral issues)			
Endocrine (eg Diabetes, Growth Hormone)			
Blood (eg anemia, sickle cell)			
Allergies (eg latex, environmental)			
Adopted (from where):			
Other			

Does anyone in your **family** have any of the above problems or diseases? If so, which ones?

Have you/your child had any eye surgery? If yes, what type, when and by whom? _____

(OVER)

If you/your child wears glasses or contact lenses, when was his/her last prescription change? _____

When was his/her last eye exam? _____ By whom? _____

Name of his/her primary care physician: _____ Telephone: _____

SOCIAL HISTORY – IF APPLICABLE

Any alcohol use? _____ If yes, how much? _____ Any tobacco use? _____ If yes, how much? _____

Hobbies: _____

Occupation: _____ Single Separated Married Divorced Widowed

LIST ALLERGIES TO ANY MEDICATIONS AND YOU/YOUR CHILD’S REACTION

CURRENT MEDICATIONS (including eye medications)

Name of Medication	Reason

Southern Eye Associates, P.A.

NOTICE OF PRIVACY PRACTICES

**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.**

Under the HIPAA privacy regulations, we are required by federal law to maintain the privacy of your protected health information (“PHI”). PHI is information about you that may identify you and that relates to your past, present, or future physical or mental health condition and related healthcare services. Federal law also requires us to provide you with notice of our legal duties and privacy practices with respect to PHI, and we are required to abide by the terms of the notice currently in effect. We reserve the right to change our notice of privacy policies and this change will effect all PHI that we maintain. Before we make a material change in our policies, we will change our notice and post the new notice in the waiting area, and on our website. You may request a copy of the notice at anytime.

Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you. Your PHI may also be used and disclosed to pay your healthcare bills and to support the operation of our office. The following is a list of examples of the types of uses that our office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We may use your PHI in rendering treatment to you. For example, we are permitted to use your PHI in providing you medical care when you visit our office. This includes the coordination or management of your healthcare – for instance, we can disclose your PHI to third parties for treatment, such as, a specialist we may refer you to. We may disclose your PHI when we contact you about appointment reminders, no-show appointments, or treatment alternatives. We may disclose your PHI information to your family or friends that are in the examination room with you. We may also disclose your PHI with your family or friends that are assisting you with appointments, surgical procedures, diagnostic testing or your care. We may also disclose your PHI to optical or contact lens vendors or companies for the processing of your eyeglass or contact lens order. We may disclose your PHI to, but are not limited to, healthcare facilities, and laboratories for the continuing of your healthcare.

Payment: We may disclose your PHI for payment purposes. For example, PHI may be disclosed to your insurance provider so we may be reimbursed for services rendered to you. If someone else is responsible for your payment, we may contact that person. We may disclose PHI to an outside collection agency as deemed necessary. Or, we may need to disclose your PHI to your health plan when obtaining pre-approval for diagnostics, surgical procedures or hospital stays.

Healthcare Operations: We may disclose or use your PHI to support the business activities of this office. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical professionals, licensing, and conducting or arranging other business activities. For instance, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician or we may call you by name from the lobby or other area in the building. For example, medical record storage may provide some related services for business operations and will have a written contract that requires them to protect your PHI in the course of performing their job.

In addition, the practice may use or disclose your PHI in accordance with the specific requirements of HIPAA regulations without us needing to obtain an authorization or giving you an opportunity to agree or object if any of the following instances occur:

- Required by law. For example, we must provide your PHI to the Secretary of the Department of Health and Human Services if the Secretary so requests.
- Required for public health purposes. For example, we may disclose PHI for the maintenance of vital records such as the number of births and deaths.
- Required disclosures about victims of abuse, neglect, or domestic violence. For example, we may disclose PHI for the reporting of spousal, adult or child abuse.
- Required by a health oversight agency for oversight activities authorized by law. For example, we may disclose PHI to government health oversight agencies for such purposes as investigations, inspections, audits, surveys, and licensure.
- Required in the course of any judicial or administrative proceeding. For example, we may disclose PHI in response to a court or administration order if you are involved in a lawsuit or similar proceeding.
- Required for law enforcement purposes. For example, we may disclose PHI for the purpose of identifying a fugitive from justice.
- Required by a coroner or medical examiner. For example, we may disclose PHI to a medical examiner to identify a deceased individual or to identify the cause of death.
- Required for organ or tissue donation purposes. For example, we may disclose PHI to an organ donation bank to facilitate the donation if you are an organ donor.
- Required for research purposes. For example, we may disclose PHI to a medical university to aid their research activities.
- Required to prevent or lessen a serious and imminent threat to the health or safety to the person or the public. For example, we may disclose PHI to prevent the spread of a communicable disease.
- Required for military purposes. For example, we may disclose the PHI of individuals who are in the armed forces for activities deemed necessary by appropriate military command authorities to ensure the proper execution of the military mission.
- Required for national security purposes. For example, we may disclose a patient’s PHI to the appropriate government agencies for counter-intelligence purposes.
- Required for penal purposes. For example, we may disclose a patient’s PHI to a correctional facility if the patient is an inmate in the facility.

- Required for workers' compensation programs. For example, we may disclose a patient's PHI for workers' compensation and other similar programs.

You have the following rights regarding your PHI.

Confidential Communications. You have the right to request that you receive communications of PHI by alternative means or at alternative locations. For example, you may request that your health information be communicated to you in a confidential manner such as sending mail to an address other than your home. You do not need to give a reason for your request, and we must accommodate reasonable requests.

Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or healthcare operations. In addition, you have the right to request that we restrict disclosure of your PHI to certain individuals involved in your care or the payment of your care, such as family members or friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, emergencies, or when the information is necessary to treat you. We may terminate the restriction by informing you of the termination, except that such termination is only effective with respect to PHI created or received after we have informed you of the restriction termination.

Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, except for psychotherapy notes, information compiled in anticipation of litigation, or that we are otherwise forbidden by law to disclose. You must submit your request in writing to the office designated at the bottom of this notice. We may charge a fee for the costs of copying, mailing, labor, and supplies associated with the request. We may deny your request in certain cases; however, you may request a review of our denial. Another licensed healthcare professional chosen by us will conduct reviews.

Amendment. If you believe the information we have about you is incorrect or incomplete, you may ask that we modify or add to the information. To do so, please submit your request in writing to the office designated at the bottom of this notice. We may deny your request if it is not in writing or does not include a reason to support the request. We may also deny a request for amendment in the following cases: (1) the current information is accurate and complete; (2) it is not part of the medical information we keep; (3) it is not part of what you would be allowed to view and copy; and (4) it was not created by us. If we deny the request, you have the right to file a statement of disagreement. We may then prepare a rebuttal and we will give you a copy of the rebuttal.

Accounting of Disclosures. You have the right to receive an accounting of disclosures of PHI made by us in the six years prior to the date on which the accounting is requested. We are not required to include in the list we provide you the following types of disclosures: (1) to carry out treatment, payment, and healthcare operations; (2) to you; (3) for our directory; (4) for national security or intelligence purposes; (5) to correction institutions or law enforcement officials; or (6) that occurred prior to April 14, 2003. Your request must be in writing and be sent to the office designated at the bottom of this notice. The first accounting you request within a 12-month period will be free. Additional accountings may involve a charge, and you may cancel or adjust your request before any fees are incurred.

Right to Provide an Authorization. We will obtain your written authorization for uses and disclosures that are not identified in this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the purposes described in the authorization.

Paper Copy of Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a copy, simply inform the office designated on the bottom of this notice.

Filing Complaints. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact the office designated at the bottom of this notice. All complaints must be in writing and we will not penalize you for filing a complaint.

The Effective Date for this notice is April 14, 2003.

Contact information regarding this notice or the privacy policies described above:

Attn: Privacy Officer
Southern Eye Associates, P.A.
104 Simpson Street
Greenville, SC 29605

Southern Eye Associates, P.A. is committed to maintaining the privacy of your protected health information. If you feel that we are upholding the privacy regulations as established by HIPAA, you do not need to do anything further with this notice.