



Date: _____

Dear: _____

**Your appointment has been scheduled for _____ at _____
at our _____ office.**

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 certain documents that must be completed and signed by you. **Please complete, sign and mail us the following enclosed forms: a) Patient Registration Form; b) Medical Questionnaire; and c) the Acknowledgement of Receipt of Notice of Privacy Practices.** A self addressed envelope is enclosed for your convenience. If sufficient time does not exist for us to receive them by mail, please bring the completed forms with you to your appointment and arrive ten minutes early.

To help avoid delays or problems, please bring the following information with you to your appointment:

1. If not mailed prior to your appointment, the completed Patient Registration Form, Medical Questionnaire, and Acknowledgement of Receipt of Notice of Privacy Practices.
2. Your most current insurance card(s).
3. Any required physician, insurance, or employer referral authorizations.
4. All of your current medications and pertinent medical information.

In addition to quality eye care, Southern Eye provides a full optical dispensing area at both of our offices in which we offer the latest in frame designs, a wide range of lens options and sunglasses. We also have a complete contact lens service with contact lens fitting and products at competitive prices.

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.

Please note above as to which office your appointment is scheduled. Our office location directions are enclosed.

Sincerely yours,

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

PATIENT REGISTRATION FORM

Today's Date: _____

Account # _____

Primary Care Physician: _____ Consulting or Referring Physician: _____

Other Physicians involved in the PATIENT'S care: _____

SECTION A: PATIENT'S INFORMATION

Patient's Legal Name: First _____ Middle _____ Last _____

Patient Goes by: _____ Patient's Date of Birth _____ Sex (circle): M or F

Patient's Social Security Number _____ Email address _____

Patient's Marital Status: Single Separated Married Divorced Widowed Spouse's Name (if applicable) _____

Home Address _____ City _____ State _____ Zip Code _____

Mailing Address, if different _____ City _____ State _____ Zip Code _____

Patient's Home Telephone (_____) _____ Cell (_____) _____

In case of EMERGENCY, notify (name) _____ Relationship _____ Phone (____) _____
Other Emergency Contact: (name) _____ Relationship _____ Phone (____) _____

Is patient employed? Y or N If yes, circle one: Full Time Part Time

Patient's Employer _____ Occupation _____ Work Phone (____) _____

Employer's Address _____ City _____ State _____ Zip _____

Is patient a student? Yes or No If yes, school attended & grade: _____

Please tell us who consulted or referred patient to our office: _____

Other family members who have been seen in our practice and their relationship to patient: _____

SECTION B: RESPONSIBLE PARTY INFORMATION: Statements will be mailed to this person at this address. If any information is the same as above, please indicate by writing "Same" in appropriate section.

Relationship to Patient: Self Spouse Parent Other _____

Legal Name: First _____ M.I. _____ Last _____

Home Address _____ City _____ State _____ Zip _____

Mailing Address, if different _____ City _____ State _____ Zip _____

Home Telephone (_____) _____ Cell (_____) _____

Social Security Number _____ Date of Birth _____

Responsible Party's Drivers License _____ State _____

Employer _____ Work Phone (____) _____

Employer's Address _____ City _____ State _____ Zip _____

THE INSURANCE INFORMATION IS NOT REQUIRED TO BE COMPLETED IF YOU ARE ABLE TO BRING YOUR MOST CURRENT INSURANCE CARD WITH YOU TO YOUR APPOINTMENT OR IF YOU MAIL A COPY (FRONT AND BACK) OF THE INSURANCE CARD(S) WITH THIS FORM TO US.

SECTION C: PRIMARY INSURANCE INFORMATION – Please present insurance card with the completed form.

Name of Insurance Company _____

Insurance Company Address _____ City _____ State _____ Zip _____

Group Number _____ Policy/Certificate Number _____

Name of INSURED _____ Relationship to Patient _____

Insured's Home Address _____ City _____ State _____ Zip _____

Insured's Social Security Number _____ Date of Birth _____ Sex: Male or Female

Insured's Home Phone (____) _____ Work Phone (____) _____

Insured's Employer _____ City _____ State _____ Zip _____

SECTION D: SECONDARY INSURANCE INFORMATION – Please present insurance card with completed form.

Name of Insurance Company _____

Insurance Company Address _____ City _____ State _____ Zip _____

Group Number _____ Policy/Certificate Number _____

Name of INSURED _____ Relationship to Patient _____

Insured's Home Address _____ City _____ State _____ Zip _____

Insured's Social Security Number _____ Date of Birth _____ Sex: Male or Female

Insured's Home Phone (____) _____ Work Phone (____) _____

Insured's Employer _____ City _____ State _____ Zip _____

ASSIGNMENT OF INSURANCE/RELEASE & ASSIGNMENT

Southern Eye may file an insurance claim on your behalf, but it is the patient's ultimate responsibility to pay any deductible amount, co-insurance, or any other balance not paid by Medicare or your insurance company. You will be required to pay any applicable co-pays, deductibles or non-covered charges at the time of service. After a reasonable amount of time for the insurance company to process/pay covered charges/claims, you will be billed for any unpaid amounts which are due upon receipt. Billing is only done as a courtesy to the patient and is not to be done as to dismiss patient or legal guardian's responsibility. I certify that I have read and understand fully the provider's billing policy and agree to make payment in full and/or satisfactory arrangements when asked to so as specified above.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including MEDICARE, MEDICAID, PRIVATE INSURANCE, WORKER'S COMPENSATION, and other health plans to Southern Eye Associates, P.A. This assignment applies to all charges outstanding as of the date of signature and will remain in effect for all current and future charges until revoked in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by the insurance carrier. I hereby authorize said assignee to release all information necessary to secure payment. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense.

I understand that while I am a patient of Southern Eye Associates, P.A., I may be referred to a non-Southern Eye physician or health care facility for treatment, consultation or diagnosis which my physician believes is a necessary part of my medical care. I hereby authorize Southern Eye Associates, P.A. to release any and all medical records and information which may be required for the continuation of my medical care during the course of the referral. A photocopy of this release shall have the same effect as the original. This release shall remain in effect until revoked by me or my legal representation in writing.

EXCEPTIONS (CHECK ONE): _____ None _____ Yes, please describe: _____

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE _____ **Date** _____
Relationship to Patient _____

MEDICAL QUESTIONNAIRE

Patient's Name: _____

Chart#: _____

Reason for Visit (Please be specific): _____

MEDICAL, EYE AND FAMILY HISTORY

Please check if you have any of the following. If YES, how long or what type?

Macular Degeneration _____	High Blood Pressure _____
Cataracts _____	Diabetes _____
Retinal Detachment _____	Asthma _____
Glaucoma _____	Emphysema _____
Lazy Eye _____	Heart Disease _____
Eye Injury _____	Cancer _____
Other Eye Problems _____	Other Problems _____

Does anyone in your IMMEDIATE family have any of the above problems or diseases? If so, which ones and their relationship to you? _____

Have you ever had EYE surgery? If yes, what type, when and by whom? _____

If you wear glasses or contacts, when was your last prescription change? _____

When was your last eye examination? _____ By whom? _____

Name of your family physician: _____

SOCIAL HISTORY

Any alcohol use? _____ If yes, # drinks week? _____ Any tobacco use? _____ If yes, # packs week? _____

Hobbies: _____ Occupation: _____

Married _____ Single _____ Divorced _____ Widowed _____

SYSTEMIC REVIEW OF SYMPTOMS

Please check any that apply to you.

_____ Weight loss or gain	_____ Mental health problems	_____ Frequent urination
_____ Loss of Smell	_____ Double vision	_____ Painful joints
_____ Shortness of breath	_____ Chest pain	_____ Skin rashes
_____ Numbness/Headaches	_____ Intestinal problems	_____ Diabetes
_____ Easily Bleeding	_____ Allergies	_____ Thyroid problems

LIST ALLERGIES TO ANY MEDICATIONS AND YOUR REACTION

CURRENT MEDICATIONS (Including Aspirin, Blood Thinners and Eye Medications)

Name of Medication	Dosage	Times Per Day		Name of Medication	Dosage	Times Per Day



GREER OFFICE DIRECTIONS (864) 801-8053

Traveling from Interstate 85

Take exit 56 (Highway 14 – Pelham/Greer). Proceed west on Highway 14 toward Greer (if traveling North on 85 you will turn left after taking the exit; if traveling South on 85 you will turn right after taking the exit). Travel approximately 3 miles on Highway 14 and turn/veer left onto South Buncombe Rd (Pleasant Grove Baptist Church will be on your right). Travel approximately .7 mile on S Buncombe Rd and then turn left into the entrance for The Cottages at Brushy Creek. Go around the traffic circle and turn right on Village Green Drive (this road will be taking you behind/parallel to the hospital). You will then turn right on Physicians Drive (you will see the office on the right from here). Southern Eye Associates - **GREER OFFICE** is the first building on the right.

Traveling North on Hwy 29 from Greenville toward Greer

At the intersection of Hwy 29 and South Buncombe Road, turn right onto South Buncombe Road. (Taco Bell will be on your right at this intersection. Walgreens, Sunoco, and BP are also at this intersection.) Travel approximately 1.6 miles on South Buncombe Rd and then turn right at the entrance to The Cottages at Brushy Creek. Go around the traffic circle and turn right on Village Green Drive (this road will be taking you behind/parallel to the hospital). You will then turn right on Physicians Drive (you will see the office on the right from here). Southern Eye Associates - **GREER OFFICE** is the first building on the right.

GREENVILLE OFFICE DIRECTIONS (864)269-3333

Traveling from Interstate 85

Take exit 42 toward downtown Greenville which will be I-185. Stay on I-185 until the first traffic light (you will see a Wendy's at this intersection). Turn right at the stoplight and then immediately take your first right (Cannon Rd). At the end of Cannon Rd, turn right on West Faris Rd. Within 100 yards, you will pass Burger King and a Mexican restaurant. Turn left past the Mexican restaurant. Southern Eye Associates – **GREENVILLE OFFICE** is the second building on the right.

Traveling from I-385 or downtown Greenville

Stay on I-385 to downtown Greenville and turn left onto Church Street (Church Street will be approximately 75 yards after the BiLo Center which will be on your left). Stay on Church Street which will become Mills Avenue. Turn left at the stoplight intersection with a Wendy's on your left and a CVS on your right (this will be Henrydale Av). After turning left, immediately take your first right (Cannon Rd). At the end of Cannon Rd, turn right on West Faris Rd. Within 100 yards, you will pass Burger King and a Mexican restaurant. Turn left past the Mexican restaurant. Southern Eye Associates – **GREENVILLE OFFICE** is the second building on the right.

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.

Southern Eye Associates, P.A.

Acknowledgement of Receipt of Notice of Privacy Practices

Southern Eye Associates's Notice of Privacy Practices describes how Protected Health Information about you may be used or released. It also explains your rights regarding your medical information. **Southern Eye Associates is required by federal law to obtain your acknowledgement that you have received this Notice.**

I acknowledge that I have received Southern Eye Associates's Notice of Privacy Practices.

Patient Name Printed

Chart Number

Patient or Legal Representative Signature

Date