My staff and I would like to welcome you to

6029 Walnut Grove Road • Medical Plaza 3, Suite 101 • Memphis, TN 38120 • 901-747-3900

Dear Patient,

We thank you for trusting us with your medical needs and look forward to meeting you at your upcoming appointment! I have been providing ophthalmic care to patients in the Mid-South since 2003 and will do my absolute best to ensure that you receive the proper care and attention that your condition requires. We will also strive to offer a friendly and welcoming environment during your visit with us.

This packet of information contains your registration form, a medical history questionnaire, an information disclosure form, as well as some information on our insurance policy and privacy practices. Please bring these completed forms with you for your upcoming appointment. Directions to our office can be found at our website, www.MemphisEyeClinic.com.

In addition to your completed forms, please bring your health insurance card and information on all medications you are currently taking. Note that a referral from your Primary Care Physician may be required by your insurance company before we are able to treat you. It is your responsibility to bring this referral with you.

If this is your first visit with us, I would ask that you plan on spending some extra time with me so that I may properly diagnose your condition. Our staff will kindly assist you with any questions or concerns before your appointment (901-747-3900). We look forward to meeting you!

Ana Lucía Flores, M.D.

Patient Registration Form

(PLEASE PRINT)

6029 Walnut Grove Road, Suite 101 • Memphis, TN 38120 • TEL: 901.747.3900 • FAX: 901.747.0756

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ Middle Initial: ____

Date of Birth: ______ / ______ / _______ SSN: ______ - ______ - ________ Gender: M F

Address: ____ Single / Married

City: ____________________________ State: ______ Zip: __________ Widowed / Divorced

Home Phone: (______) - ______ - _______ Race: Caucasian / African American / Asian / Hispanic / Other

Mobile Phone: (______) - ______ - _______ (Note: we may send text messages for appointment confirmations)

Work Phone: (______) - ______ - _______ Occupation: ________________________________

Employer: __________________________ Status: Full-Time / Part-Time / Retired / Not Employed

Email Address: ______________________________________ (used for initial set up of patient portal*)

*To comply with the Federal Government's *Health Information Technology for Economic and Clinical Health Act* (HITECH / ARRA, 2009), we are required to engage our patients through an online portal that allows patient access to medical records, appointment requests and other useful tools.

INSURED PARTY or PARTY RESPONSIBLE FOR BILL (IF DIFFERENT THAN ABOVE)

Last Name: ______________________ First Name: ______________________ Middle Initial: ____

Date of Birth: ______ / ______ / _______ SSN: ______ - ______ - ________ Gender: M F

Address: ____

City: ____________________________ State: ______ Zip: __________

Relationship to Patient: ____

Home Phone: (______) - ______ - _______ Mobile Phone: (______) - ______ - _______

INSURANCE INFORMATION (PLEASE GIVE INSURANCE CARD TO RECEPTIONIST)

PRIMARY INSURANCE	Policy Holder Name:	
Plan Name:		Member ID:
SECONDARY INSURANCE	Policy Holder Name:	
Plan Name:		Member ID:

PRIMARY CARE PHYSICIAN / REFERRING PHYSICIAN INFORMATION

Primary Care Physician: ____

Practice Name: ____________________________ Phone Number: ________________________

Referred from a Specialist? Name: ____

Practice Name: ____________________________ Phone Number: ________________________

EMERGENCY CONTACT	Name:	Phone Number:

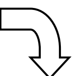
YOU MUST NOTIFY THE RECEPTIONIST IF THIS VISIT IS RELATED TO AN ACCIDENT

____ ____________________

Signature of Patient or Legal Representative *Date*

PRF-F-r1.2

PLEASE SEE BACK OF THIS FORM



Patient Registration Form
Disclosures and Consents

6029 Walnut Grove Road, Suite 101 • Memphis, TN 38120 • TEL: 901.747.3900 • FAX: 901.747.0756

Patient Full Name: ______________________________ Date of Birth: ______________

ASSIGMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of my insurance benefit otherwise due to me to be made directly to Memphis Eye Clinic (hereinafter referred to as MEC) or to the individual physician for services rendered to me or my dependents under the physician's supervision. I understand all of the following: it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit; it is my responsibility to notify MEC of any changes to my insurance benefits, and that failure to do so may delay or prevent payment from my insurance company to MEC; it is my responsibility to know if my insurance company requires a referral, and to secure this referral before my appointment with MEC; my insurance company may require my Social Security Number for processing claims, and if I refuse to give MEC my Social Security Number, I may be asked to pay up front for services rendered.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS

I certify that the information provided by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I further authorize payment of my or my dependent's benefits be made directly to MEC or the physician on my behalf.

FINANCIAL AGREEMENT

I understand and agree that I will be financially responsible for any co-pay or amount due for services rendered, including diagnostic services that MEC is unable to collect from my insurance company for any reason. Should my bank refuse to honor my check, or should my credit card be denied, I will be responsible for any amount due to MEC including returned check fees. Should any portion of my balance become delinquent, I understand that MEC may employ the service of third-party collection agencies and that I will be responsible for any costs, legal or otherwise, involved with the collection process.

RECEIPT OF PRIVACY PRACTICES

I certify that I have received and read a copy of the MEC Notice of Privacy Practices.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION

I hereby authorize MEC or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance claims.

AUTHORIZATION TO CONTACT PATIENT

I hereby authorize MEC staff or the physician individually to contact me, through usual and customary mediums (telephone, mail, etc.), regarding my healthcare, including but not limited to such items as appointment reminders, referral arrangements, billing inquiries, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying MEC to that effect in writing.

CONSENT TO TREATMENT

I hereby consent to evaluation, testing, and treatment as directed by the physician or his/her designee.

APPOINTMENT CANCELLATIONS AND NO-SHOW POLICY

As a courtesy, MEC or a third-party representing MEC will attempt to contact me by telephone, text message, or similar method to remind me of my upcoming scheduled appointments. I fully understand that MEC reserves the right to charge a reasonable fee if I no-show, cancel or reschedule my appointment without 24-hour advance notice. Repeat no shows may result in my release from MEC's care.

I HAVE READ AND UNDERSTAND THE ABOVEMENTIONED DISCLOSURES AND CONSENTS

____ ____________________

Signature of Patient or Legal Representative *Date*

Notice of Privacy Practices

(PLEASE RETAIN FOR YOUR RECORDS)

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.

About This Notice

We are required by law to maintain the privacy of your Protected Health Information (PHI) and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your PHI. This notice explains your rights and our obligations. We are required to abide by the terms of the current version of this notice.

What is "Protected Health Information"?

Protected Health Information ("PHI") is demographic and individually identifiable health information that will or may identify a patient and relates to the patient's past, present or future physical or mental health. PHI includes information about a patient's symptoms, test results, diagnosis, treatment, and related medical information. PHI also includes payment, billing and insurance information.

How is My Protected Health Information Used or Disclosed?

Memphis Eye Clinic uses medical records as a way of recording health information, planning care and treatment and as a tool for routine health care operations. Your insurance company may request information, such as procedure and diagnosis information, that we are required to submit in order to bill for treatment we provide to you. Other health care providers or health plans reviewing your records must follow the same confidentiality laws and rules. We may also use your information to contact you about upcoming appointments and to discuss treatment alternatives or other health related benefits that may be of interest.

When you, as the patient or the parent or guardian of a patient, sign an authorization release form, you are giving Memphis Eye Clinic permission to use and disclose protected health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

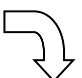
Memphis Eye Clinic may also use or disclose your information, even without your consent, for the following reasons:

- *Required by Law:* We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
- *Public Health Activities:* As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
- *Health Oversight:* We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
- *Judicial and Administrative Proceedings:* We may disclose information in response to an appropriate subpoena or court order.
- *Law Enforcement Purposes:* Subject to certain restrictions, we may disclose information required by law enforcement officials.
- *Deaths:* We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
- *Serious Threat to Health or Safety:* We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- *Military and Special Government Functions:* If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
- *Research:* We may use or disclose information for approved medical research.
- *Workers Compensation:* We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

What Are My Individual Rights Regarding Protected Health Information?

You have the following rights, subject to certain limitations, regarding your PHI.

1) Right to Inspect and Copy. You have the right to inspect and/or receive a copy of PHI that may be used to make decisions about your care or payment for your care. But you do not have a right to inspect or copy psychotherapy notes. We may charge you a fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim of benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your requests in certain limited circumstances. If we deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved with the denial of your request, and we will comply with the outcome of the review.

PLEASE SEE BACK OF THIS FORM 

Notice of Privacy Practices, Continued

2) Right to an Electronic Copy of Electronic Medical Records. If your PHI is maintained in one or more designated record sets (for example, an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We may charge you a reasonable, cost-based fee for the labor associated with copying or transmitting the electronic PHI. If you choose to have your PHI transmitted electronically, you will need to provide a written request to this office listing the contact information of the individual or entity who should receive your electronic PHI.

3) Right to Receive Notice of a Breach. We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by email), of any breach of your unsecured PHI.

4) Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment or healthcare operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved with your care or the payment for you care, like a family member or friend. We are not required to agree to your request. If we agree, we will comply with your request unless we terminate our agreement or the information is needed to provide you with emergency treatment.

5) Right to Request Certain Disclosures to Your Health Plan. You have the right to restrict certain disclosures of PHI to a health plan if the disclosure is for payment or health care operations and pertains to a health care item or service for which you have paid out of pocket in full. We will honor this request unless we are otherwise required by law to disclose this information. This request must be made at the time of service.

6) Right to Request Confidential Communications. You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a special address or call you only at your work number. You must make such requests in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

7) Right to Request Amendments. You have the right to request an amendment of PHI about you in a designated record set for as long as we maintain this information. Requests for amendment must be in writing, and must include a reason for the request. We may deny your request if you ask us to amend information that (1) was not created by us, (2) is not part of the medical information kept by or for us, (3) is not information that you would be permitted to inspect and copy, or (4) is accurate and complete. If we deny your request, you may submit a written statement of disagreement. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement.

8) Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures we made of your PHI. We are not required to list certain disclosures, including disclosures (1) made for treatment, payment, and healthcare operation purposes, (2) made with your authorization, (3) made to create a limited data set, and (4) made directly to you. The request for an accounting must be made in writing and include how you prefer to receive it. The request should specify a time period not longer than 6 years before your request. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same time period, we may charge you the reasonable costs of providing the information. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

9) Right to a Paper Copy of this Notice. You have the right to obtain a paper copy of this Notice of Privacy Practices at any time upon request, even if you have agreed to receive this notice electronically. A copy of this notice is at our website as part of the new patient packet (www.memphiseyeclinic.com).

How to Exercise Your Rights

To exercise your rights described in this notice, send you request, in writing, to our Privacy Officer at the address listed below. We may ask you to fill out a form that we will supply. To get a paper copy of this notice, conact our Privacy Officer by phone or mail.

Changes to This Notice

The effective date of this notice is listed below. We reserve the right to change this notice. We reserve the right to make the changed notice effective for PHI we already have as well as for any PHI we create or receive in the future.

If you believe your rights have been violated, you may file a complaint by contacting the address below. You may also file a complaint with Secretary of the Department of Health and Human Services. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. You will not be penalized for filing a complaint.

Memphis Eye Clinic
ATTN: Privacy Officer
6029 Walnut Grove Road, Ste. 101
Memphis, TN 38120
PH: 901.747.3900
FAX: 901.747.0756

The effective date for this Notice of Privacy Practices is 09-01-2013.

Please retain this Privacy Practice Notice for your records. After you have read this notice, please sign the corresponding Acknowledgement of Receipt *form and return it to the front desk.*

Patient Health / Medical / Social History

(PLEASE PRINT)

Patient Name: ______________________________ Today's Date: ______________

HEALTH HISTORY

Please Check YES or NO to the Following Questions, and Indicate Family History (Where Asked):

❑ Yes ❑ No Asthma, Bronchitis, Emphysema
❑ Yes ❑ No Kidney Disease
❑ Yes ❑ No Tuberculosis
❑ Yes ❑ No Diabetes (number of years______)
❑ Yes ❑ No Insulin (number of years______)
❑ Yes ❑ No Migraines
❑ Yes ❑ No Psychiatric Disorder
❑ Yes ❑ No Any Nervous Disorder
❑ Yes ❑ No Chest Pain
❑ Yes ❑ No Congestive Heart Failure
❑ Yes ❑ No Ulcer, Heartburn
❑ Yes ❑ No Carotid Artery Disease
❑ Yes ❑ No Rheumatoid Arthritis
❑ Yes ❑ No Sickle Cell Anemia
❑ Yes ❑ No Head or Spinal Injuries

❑ Yes ❑ No Seizures, Convulsions or Fainting
❑ Yes ❑ No Temporal Arteritis
❑ Yes ❑ No Permanent Defect from Illness, Disease or Injury
❑ Yes ❑ No Extensive Confinement by Illness or Injury
❑ Yes ❑ No (Women) Are You Pregnant?
❑ Yes ❑ No High Blood Pressure
❑ Yes ❑ No HIV
❑ Yes ❑ No Suffering from Any Other Disease___________
❑ Yes ❑ No Other Diagnosed Health Problem___________
❑ Yes ❑ No Iritis
❑ Yes ❑ No Retina Disease
❑ Yes ❑ No Crossed Eyes
❑ Yes ❑ No Lens Implant (in which eye ____________)
❑ Yes ❑ No Eye Injury ____________________________

❑ Yes ❑ Fam His? ❑ No Glaucoma
❑ Yes ❑ Fam His? ❑ No Cataracts
❑ Yes ❑ Fam His? ❑ No Cornea Disease
❑ Yes ❑ Fam His? ❑ No Retinitis Pigmentosa
❑ Yes ❑ Fam His? ❑ No Retinal Detachment
❑ Yes ❑ Fam His? ❑ No Other Eye Disorder __________
____

❑ Yes ❑ Fam His? ❑ No Macular Degeneration
❑ Yes ❑ Fam His? ❑ No Diabetes Type I / Type II
❑ Yes ❑ Fam His? ❑ No Diabetic Retinopathy
❑ Yes ❑ Fam His? ❑ No Heart Attack
❑ Yes ❑ Fam His? ❑ No Stroke
❑ Yes ❑ Fam His? ❑ No Other Health Problems________
____

Please List All Medications You Currently Take:		Please List All Medications You Are Allergic To:	
______________________	Dosage:__________	______________________	Reaction:__________
______________________	Dosage:__________	______________________	Reaction:__________
______________________	Dosage:__________	______________________	Reaction:__________
______________________	Dosage:__________	______________________	Reaction:__________
______________________	Dosage:__________	______________________	Reaction:__________
______________________	Dosage:__________	______________________	Reaction:__________

SOCIAL HISTORY

❑ Yes ❑ No Do You Drive? If YES, Do You Have Visual Difficulty Driving? ❑ Yes ❑ No
❑ Yes ❑ No Do You Exercise Regularly?
❑ Yes ❑ No Do You Drink Alcohol? If YES, for How Many Years? _____ If NO, How Many Years Since Last Use? _____
❑ Yes ❑ No Do You Smoke? If YES, for How Many Years? _____ If NO, How Many Years Since Last Use? _____
❑ Yes ❑ No Do You Use Drugs? If YES, for How Many Years? _____ If NO, How Many Years Since Last Use? _____
❑ Yes ❑ No Do You Have an Advance Directive / Living Will?
EDUCATION: ❑ High School Graduate ❑ College Graduate ❑ Post-Graduate Degree ❑ Other____________________

SURGICAL HISTORY

Please List All Surgery You Have Undergone and the Date, Including All Cataract and Retina Surgery:

______________________	Date:__________	______________________	Date:__________
______________________	Date:__________	______________________	Date:__________
______________________	Date:__________	______________________	Date:__________
______________________	Date:__________	______________________	Date:__________
______________________	Date:__________	______________________	Date:__________