Patient Information Form

Last Name	First Name	MI	DOB	Today's Date

Mailing Address	City County	State	ZIP Code

Home phone # Cell phone #	Work Phone (Ext)	Preferred method for your next appointment reminder ☐Text ☐E-mail ☐Phone Call	Social Security # Marital Status ☐Single ☐Married ☐Divorced

Email:

Secondary Address & Phone Number (if applicable)

Emergency Contact: _____

Phone # _____

Race ☐Black/African American ☐American Indian/Alaska Native ☐Asian ☐White ☐Native Hawaiian or Pacific Islands ☐Patient Declined

Ethnicity ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Chinese ☐Filipino ☐Japanese ☐Multi-Racial ☐Other

How did you hear about our practice?

☐Facebook ☐Website ☐Newspaper ☐Radio ☐Patient of Eye Care ☐School ☐Prior Patient ☐Physician:

Insurance information

Primary Insurance Name		Secondary Insurance Name	
Subscriber's Name	**Subscriber DOB**	**Subscriber's Name**	**Subscriber DOB**
Subscriber's ID No.	**Group No.**	**Subscriber's ID No.**	**Group No.**
Patient's Relation to Subscriber ☐Self ☐Spouse ☐Child ☐Other		**Patient's Relation to Subscriber** ☐Self ☐Spouse ☐Child ☐Other	

Please provide the following information so we may improve patient care

Primary Care Physician:
Address:
Phone Number:

Drug Store/Pharmacy:
Address:
Phone Number:

Patient Employment: ☐Employed ☐Retired ☐Unemployed ☐Other **Occupation:** _____
Employer Name: **Address:** **Phone:**

Patient Guarantor

Guarantor: ☐Self **Name:** **SSN:** **Date of Birth**
Phone # **Address:** **City/State/Zip**

Release of Information From Eye Care for the Adirondacks & Authorization for Payment of Insurance

I give permission for Eye care for the Adirondacks to communicate any, all or summary of findings pertinent to the overall management of my health to my Primary Care Physician. Additionally these Secondary Providers, Specialty, School or other:
Names: _____

I request that payment of authorized Medicare and/or my insurance benefits be made on my behalf of Eye Care for the Adirondacks for any services furnished to me by any physician or provider of that organization. I authorize Eye Care for the Adirondacks to release medical information about me as necessary to the Health Financing Administration and/or my insurance carrier in order to determine these benefits payable for related services.

I understand that I am finacially responsible for any balances my insurance carrier doesn't pay. If insurance is not involved, I agree to pay at the time of service unless other arrangements have been made.

Signature of Patient/Parent/Guardian: _____ **Date:** _____

Eye Care for the Adirondacks
450 Margaret Street Plattsburgh, NY 12901 Phone (518) 566-2020 Fax (518) 566-8211

Consent To The Use and Disclosure Of Health Information For Treatment, Payment Or Healthcare Operations

(The Practice provides this form to comply with the federal government's Health Insurance Portability and Accountability Act of 1996.)

I understand that as part of my healthcare, Eye Care for the Adirondacks creates and maintains health records describing my health history. I understand that Eye Care for the Adirondacks may use this information as:

1. a basis for planning my care and treatment;
2. a means of communication among many health professionals who contribute to my care;
3. a means by which third-party payers can verify that services billed were actually provided; and
4. a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I hereby consent to Eye Care *for the* Adirondacks' use and disclosure of my individually identifiable health information for the purposes listed above and other purposes relating to my treatment, the payment of my health care, and other health care operations of the practice. In addition, I acknowledge that I received on the date indicated below a copy of Eye Care *for the* Adirondacks' Notice of Privacy Practices, which describes the obligations of Eye Care *for the* Adirondacks regarding its use and disclosure of my individually identifiable health information and my rights regarding this information. I also understand the Eye Care *for the* Adirondacks reserves the right to change its notice and practices. If Eye Care *for the* Adirondacks changes the notice, I can obtain a revised copy by asking the administrator of the practice. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or other healthcare operations and that Eye Care *for the* Adirondacks is not required to agree to the restrictions requested. If Eye Care *for the* Adirondacks does agree to such restrictions, however, it will comply with such restrictions.

I request the following restrictions to the use of disclosure of my health information:

_____

Effective Date of Notice: April 14, 2003

_____Date: _____ _____

Signature of patient or patient's representative — Witnessed by: ECFTA representative

Printed name of patient's representative: _____

Relationship to patient: _____

HIXNY ELECTRONIC DATA ACCESS CONSENT FORM
Eye Care of the Adirondacks Associates in Ophthalmology, P.C.

In this Consent Form, you can choose whether to allow Eye Care for the Adirondacks Associates in Ophthalmology, P.C. to obtain access to your medical records through a computer network operated by the Healthcare Information Xchange of New York (HIXNY), which is part of a statewide computer network. This can help collect the medical records you have in different places where you get health care, and make them available electronically to our office.

You may use this Consent Form to decide whether or not to allow Eye Care for the Adirondacks Associates in Ophthalmology, P.C. to see and obtain access to your electronic health records in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, Eye Care for the Adirondacks Associates in Ophthalmology, P.C.'S staff involved in my care may see and get access to all of my medical records through HIXNY."

If you check the **"I DENY CONSENT"** box below, you are saying "No, Eye Care for the Adirondacks Associates in Ophthalmology, P.C. may not be given access to my medical records through HIXNY for any purpose."

HIXNY is a not-for-profit organization. It shares information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about HIXNY and ehealth in New York State, read the brochure, "Your Health Information – Always at Your Doctor's Fingertips." You can ask Eye Care for the Adirondacks Associates in Ophthalmology, P.C. for it, or go to the website www.hixny.org.

Please carefully read the information on the back of this form before making your decision.

Your Consent Choices. You can fill out this form now or in the future. You have two choices.

- ☐ **I GIVE CONSENT for Eye Care for the Adirondacks Associates in Ophthalmology, P.C. to access ALL of** my electronic health information through HIXNY in connection with providing me any health care services, including emergency care**.**

- ☐ **I DENY CONSENT for Eye Care for the Adirondacks Associates in Ophthalmology, P.C. to access** my electronic health information through HIXNY for any purpose, *even in a medical emergency*.

NOTE: UNLESS YOU CHECK THIS BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through HIXNY.

_____	_____
Print Name of Patient	Patient Date of Birth
_____	_____
Signature of Patient or Patient's Legal Representative	Date
_____	_____
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about patient information in HIXNY and the consent process:

1. **How Your Information will be used**. Your electronic health information will be used by Eye Care for the Adirondacks Associates in Ophthalmology, P.C. **only** to:

   - Provide you with medical treatment and related services
   - Check whether you have health insurance and what it covers
   - Evaluate and improve the quality of medical care provided to all patients.

   NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. **What Types of Information about You Are Included**. If you give consent, Eye Care for the Adirondacks Associates in Ophthalmology, P.C. may access ALL of your electronic health information available through HIXNY. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

   - Alcohol or drug use problems
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current Information Sources is available from Eye Care for the Adirondacks Associates in Ophthalmology, P.C. You can obtain an updated list of Information Sources at any time by checking the HIXNY website: www.hixny.org.

4. **Who May Access Information About You, If You Give Consent.** Only these people may access information about you: doctors and other health care providers who serve on Eye Care for the Adirondacks Associates in Ophthalmology, P.C.'s medical staff who are involved in your medical care; health care providers who are covering or on call for Eye Care for the Adirondacks Associates in Ophthalmology, P.C.'s doctors; and staff members who carry out activities permitted by this Consent Form as described above in paragraph one.

5. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call Eye Care for the Adirondacks Associates in Ophthalmology, P.C. at: (518) 566-2020; or call HIXNY at (518) 783-0518; or call the NYS Department of Health at (877) 690-2211.

6. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by Eye Care for the Adirondacks Associates in Ophthalmology, P.C. to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. Some state and federal laws provide special protections for some kinds of sensitive health information, including HIV/AIDS and drug and alcohol treatment. Their special requirements must be followed whenever people receive these kinds of sensitive health information. HIXNY and persons who access this information through the HIXNY must comply with these requirements.

7. **Effective Period**. This Consent Form will remain in effect until the day you withdraw your consent or until such time HIXNY ceases operation.

8. **Withdrawing Your Consent**. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to Eye Care for the Adirondacks Associates in Ophthalmology, P.C. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms from any HIXNY provider, from the HIXNY website at www.hixny.org, or by calling (518) 783-0518. **Note: Organizations that access your health information through HIXNY while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.**

9. **Copy of Form**. You are entitled to get a copy of this Consent Form after you sign it**.**

Cancellation and No Show Policy

Your appointment is important to us and to your vision and eye health. If you miss an appointment, you may delay the treatment that you need.

We understand situations arise in which you may need to cancel your appointment. If you must change your appointment **please call us at least 24-hours in advance**. Advance notice will allow other patients waiting, in need of eye health and vision services, the opportunity to be seen in the allotted time that was originally set aside for you.

Patients who no show for their scheduled appointment or reschedule (2) two or more times within a one year period, without a 24-hour advance notice, will be subject to a $50.00 charge for each appointment missed. The $50 fee is not covered under insurance and must be paid prior to being seen on your next office visit.

Three or more no-shows or cancellations in a one year period may be cause for dismissal from the practice.

We greatly appreciate your understanding and cooperation with this policy. Your signature below indicates that you understand and have read our cancellation and no-show policy.

_____ Date _____/_____/_____

Patient Signature (Parent or Guardian)