LINCOLN CITY
EYE CLINIC

LINCOLN CITY EYE CLINIC
PHYSICIANS'OPTICAL
4079 NW Logan Road, Ste. B
Lincoln City, OR 97367
Phone (541) 994-7652 (800) 422-6024
Fax (541) 994-8578
Monday through Friday 8:00am-5:00pm Saturday 8:00am-noon

PREPARING FOR YOUR VISIT

If you will be visiting our office for the first time, please take the time to complete the information in your new patient packet before your appointment. Please arrive 15 minutes early for your new patient appointment. Your first appointment at our office will last about 90 minutes. Please bring the following items to your exam.

- All glasses that you currently use
- If you wear contact lenses, wear them to your appointment and bring original packaging
- A list of medications that you are currently taking

Kindly provide 24 hours' notice if you are unable to keep your appointment.

FEES AND INSURANCE

We contract with a broad variety of medical insurance companies, HMO's, PPO's, medical groups and vision insurance plans. We are happy to bill your insurance. Due to the complexity of the ever changing insurance industry, ultimately, it is your responsibility to understand your insurance coverage (deductible, exclusions, co-payment and co-insurance). Personal balances are due at the time that the service is rendered.

REFERRALS FOR SPECIALTY CARE

Some insurance plans require that you have the approval of your primary care physician prior to a visit to a specialist. If you belong to a managed care plan, please talk to your primary care doctor prior to planning a specialist visit. If you do not have a referral, the insurance plan may not cover your expenses.

REFRACTION

The portion of the eye exam that determines your eyeglass or contact lens prescription is called refraction. Refraction is done under some circumstances for diagnostic purposes. Refraction is not covered by Medicare or most medical insurance plans, even if the doctor feels that it is necessary for medical purposes. The refraction fee is $25.00, we will ask that this be paid at the time of service.

PRESCRIPTIONS AND REFILLS

Call your pharmacy during normal business hours for prescription refills. If necessary, the pharmacy will call the clinic directly for prescription approval.

MICHAEL S.PASSO, M.D.—Dr. Passo graduated with honors from Indiana University Medical School and completed two years of internal medicine residency there. He completed his Ophthalmology residency and glaucoma fellowships at OHSU, serving as chief of Ophthalmology at the Portland VA Medical Center. Dr. Passo practices comprehensive eye care.

DAVID J.C. HAYES, M.D.—Dr. Hayes earned his medical degree at University of California, San Francisco. He completed his Ophthalmology residency at the Medical University of South Carolina in Charleston. Dr. Hayes practices comprehensive eye care including cataract lens implant surgery and cosmetic services such as Botox and dermal fillers.

G. RYAN BERGER, M.D.—Dr. Berger graduated from Georgetown University School of Medicine and completed an internal medicine residency at Dartmouth-Hitchcock Medical Center. He completed his Ophthalmology residency at the University of Colorado. He practices comprehensive eye care including cataract lens implant surgery.

STEVEN D. MAXFIELD, M.D.—Dr. Maxfield completed his Ophthalmology residency at Mayo Clinic. He completed his internship in medicine/pediatrics at MetroWest Medical Center. He attended medical school at Dartmouth. Dr. Maxfield practices comprehensive ophthalmology, including cataract lens implant surgery.

LAURA C. BURKE, M.D. — Dr. Burke was awarded her medical degree from Creighton University School of Medicine and completed her Ophthalmology residency at Loyola University Medical Center. She practices general ophthalmology including cataract lens implant surgery.

AMY R. VAN HEEL, O.D. — Dr. Amy Van Heel received her Optometry degree from Pacific University in Forest Grove, Oregon. She also completed her Master of Science in Vision Science while at Pacific University. Dr. Van Heel is a member of Oregon Optometric Physicians Association and the American Optometric Association. She has an interest in primary care optometry, as well as contact lenses.

Our optical department offers an extensive line of the latest frames including sun, safety, golf, and sport and driving goggles. Physicians' Optical can fit glasses for all age groups, from infants to senior citizens. We provide top-of –the-line education on all eyewear products to assure that patients are totally satisfied.

Physicians' Optical is conveniently located inside Lincoln Eye Clinic.

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Michael Passo, M.D. Nicholas Grinich, M.D. David Hayes, M.D. G. Ryan Berger, M.D.
Steven Maxfield, M.D. Laura Burke, M.D. Amy Van Heel, O.D.

Welcome to Lincoln City Eye Clinic,

If your insurance carrier requires a referral, please contact your Primary Care Physician to request the referral. If you have a co-payment or insurance deductible, we will ask you to pay these amounts on the day of your visit.

Here is a list of item that we would like for you to bring to your appointment:

- ✓ Patient Demographic Sheet (please complete prior to appointment)
- ✓ Medical History Sheet (please complete prior to appointment)
- ✓ Financial Policy (please read and sign prior to appointment)
- ✓ All insurance cards (Medical and Vision)
- ✓ List of all current medications that you are using
- ✓ List of all medication allergies
- ✓ All glasses that you are currently using

IF YOU ARE A CONTACT LENS WEARER

- ✓ Please wear your contact lenses to the appointment. If you cannot wear the contact lenses, please bring packaging for most recently used contact lenses.
- ✓ Please read and sign the enclosed Contact Lens Service Agreement

Physician's Optical is located adjacent to our medical offices, and is available to serve all of your eyewear needs.

We look forward to seeing you! If you will be unable to keep your scheduled appointment, kindly provide us with a minimum of 48 hours' notice so that we might offer the appointment time to another patient. We appreciated the opportunity to provide you with complete eye care. If you have any questions regarding your visit, please call our office at (503) 472-4688.

The Physicians and Staff at Lincoln City Eye Clinic

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PATIENT INFORMATION		How did you hear about our office?		
NAME (Last, First Middle):		SSN:	DOB:	SEX: MALE FEMALE
ADDRESS:	CITY/STATE/ZIP:		ETHNICITY:	LANGUAGE:
HOME PHONE:	DAY PHONE:		E-MAIL:	
EMPLOYER:	EMPLOYER ADDRESS:		EMPLOYER PHONE:	
PRIMARY CARE PHYSICIAN:		REFERRING PHYSICIAN:		
EMERGENCY CONTACT NAME:		EMERGENCY CONTACT PHONE:		

RESPONSIBLE PARTY INFORMATION (if different than above)				
NAME (Last, First Middle):		SSN:	DOB:	SEX: MALE FEMALE
ADDRESS:	CITY/STATE/ZIP:		RELATIONSHIP TO PATIENT:	
HOME PHONE:	DAY PHONE:		E-MAIL:	
EMPLOYER:	EMPLOYER ADDRESS:		EMPLOYER PHONE:	

PRIMARY INSURANCE – if applicable		
NAME OF INSURANCE COMPANY (please provide insurance card):		DOB OF SUBSCRIBER:
SUBSCRIBER POLICY AND GROUP #:		
NAME OF INSURANCE SUBSCRIBER:	EMPLOYER OF SUSCRIBER:	

SECONDARY INSURANCE – if applicable		
NAME OF INSURANCE COMPANY: (please provide insurance card):		DOB OF SUBSCRIBER:
NAME OF INSURANCE SUBSCRIBER:	EMPLOYER OF SUBSCRIBER:	

VISION INSURANCE – if applicable		
NAME OF INSURANCE COMPANY: (please provide insurance card):		DOB OF SUBSCRIBER:
NAME OF INSURANCE SUBSCRIBER:	EMPLOYER OF SUBSCRIBER:	

IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR THE PAYMENT, PLEASE COMPLETE THIS SECTION		
RESPONSIBLE PARTY NAME:		DOB:
ADDRESS:		RELATIONSHIP TO PATIENT:
EMPLOYED BY:	WORK PHONE:	

ASSIGNMENT AND RELEASE: I hereby authorize that my insurance benefits be paid directly to Lincoln City Eye Clinic. I understand that it is my responsibility to pay deductible amount, coinsurance amount, co-payment amount, or any other balance not paid to the physician by my insurance company. It is our policy to collect at the time of service for all services that are not covered by your insurance carrier.

_____ _____

PATIENT OR RESPONSIBLE PARTY SIGNATURE DATE

LINCOLN CITY EYE CLINIC
PHYSICIAN'S OPTICAL

FINANCIAL POLICY

Medicare Insurance Billing – You are financially responsible for any non-covered services under Medicare guidelines, as well as your 20% co-pay and any amounts applied to your yearly Medicare deductible.

Health Insurance Billing: Co-pay, Deductible and co-insurance – If you have a co-pay, deductible and/or co-insurance that have not been met, we ask that you pay this on the day of service. We will submit the claim to your insurance company. If payment is not received from your insurance company within 60 days, we will then ask that you contact your insurance carrier to assist us in getting your claim paid.

No Insurance – If you are an uninsured patient to the office you will be required **to pay in full at the time of service.** We gladly give estimates upon request. Our office offers Care Credit (a financing plan for patients). Care Credit is available at www.carecredit.com.

Auto Insurance/PIP/Home Owners Insurance – Our office does not bill Auto/Home/PIP insurance. You will be required to **pay in full at the time of service**. We will provide you with a copy of our bill for you to submit to your carrier for reimbursement directly to you.

Refraction – The part of the examination that determines your eyeglass or contact lens prescription is called refraction. Refraction is done under certain circumstances for diagnostic purposes. Refraction is not covered by Medicare or most insurance plans, even when your doctor feels that it is necessary for diagnostics purposes. The fee for the refraction is $25.00. You will be asked to pay the fee for the refraction on the day of your visit.

Hardware (glasses) – Frames generally come with a 1- year manufacturer's warranty for manufacturer's defects. If your frame breaks under normal wear and tear with no apparent abuse, it will be replaced under the warranty. Lenses purchased with scratch resistant coatings are covered for a 2-year scratch resistant warranty, as long as the lens has no apparent abuse, it will be replaced under the warranty.

Progressive lenses are covered under a 60-day non-adaption guarantee. If you are unable to adapt to progressive lenses within 60 days, we will remake your lenses into single vision, lined bifocal or lined trifocal lenses at no additional cost to you. No refund can be given for the difference in the price of these lenses.

If you feel that there has been an error in your prescription, we will ask you to see the optician in our optical department who will verify that your lenses have been manufactured per the specifications of the written order. After this, you may be scheduled to see a doctor to verify the prescription. If the doctor makes a change to the prescription, that requires that the lenses be remade, the lenses will be remade at no charge. After 60 days, however, you will be charged for office visits/lens changes.

Your prescription glasses are custom made, and therefore not returnable. No refunds or insurance reversals will be given for any order. If you cancel your order before the lenses are processed, you will receive a 90% refund and a 10 % processing fee will be charged.

_____ _____

Patient Name | Guarantor Name (if patient is under 18 years of age)

_____ _____

Patient / Guarantor Signature | Date

MEDICAL HISTORY

Name_____ Date_____ Acct. #_____

DOB_____Primary Care Physician_____

Have you ever had an eye surgery or an eye injury? □ Yes □ No

If yes, please describe:_____

List all non-eye related surgeries:_____

Medications and Allergies

Do you take any medications? □ Yes □ No If YES, please list:_____

_____

_____

_____

Do you use any EYE medications? □ Yes □ No If YES, please list:_____

Do you have any drug allergies? □ Yes □ No If YES, please list:_____

Personal History (conditions you have)

Do you currently have any of the following problems:	YES	NO	If YES, please explain:
Chronic fever, unexplained weight loss/gain, fatigue	□	□	_____
Ear/nose throat problems (hearing loss, sinus issues, sore throat)	□	□	_____
Heart problems (chest pain, irregular heart beat)	□	□	_____
Respiratory problems (shortness of breath, coughing, wheezing)	□	□	_____
Gastrointestinal problems (heartburn, abdominal pain, diarrhea)	□	□	_____
Urinary problems (pain or discomfort, blood in urine)	□	□	_____
Musculoskeletal problems (muscle aches, joint pain, swollen joints)	□	□	_____
Skin problems (rashes, excessive dryness)	□	□	_____
Neurological problems (numbness, weakness, headaches, paralysis)	□	□	_____
Psychiatric problems (depression, anxiety)	□	□	_____
Diabetes Mellitus	□	□	_____
Circulatory problems (high blood pressure, stroke)	□	□	_____
Cancer	□	□	_____

Social History

Current occupation_____

Do you drive? □ Yes □ No Do you smoke? □ Yes □ No Do you drink alcohol? □ Yes □ No

Leisure Activities

□ Computer □ Golf □ Piano □ Playing Cards □ Other_____

Family History (conditions in your blood relatives)

SYSTEMIC CONDITIONS		EYE CONDITIONS	
□ arthritis	□ high blood pressure	□ blindness	□ "lazy eye"
□ diabetes	□ high cholesterol	□ cataracts	□ macular degeneration
□ cancer	□ stroke	□ color blindness	□ night blindness
□ heart disease	□ thyroid disease	□ glaucoma	□ retinal

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 READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alterative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of September 23, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with our office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Privacy Officer at 503-472-4688 for more information, in person or in writing.

PATIENT COMMUNICATION/WRITTEN ACKNOWLEDGEMENT

A. Family and Friends. It is the office policy of Lincoln City Eye Clinic not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check (√) the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse: _____ _____ yes _____ no

Parent: _____ _____ yes _____ no

Other: _____ _____ yes _____ no

B. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only: _____

_____

I hereby acknowledge receipt of Lincoln City Eye Clinic's Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

DOB:_____ Date: _____

I am a parent/legal guardian of _____ [patient name]. I hereby acknowledge receipt of Lincoln City Eye Clinic's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Patient DOB:_____ Date: _____

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Permission to Release Medical Records and Medical Information

Please fill out this form carefully and completely. Federal and State law require this information in order for our facility to comply with your request.

Patient Name _____ Date of Birth _____
Last First MI

Current Address _____
Street City State Zip

Daytime Phone _____ Home Phone _____ SSN _____

Purpose of Release Request:

- ☐ Change Doctors
- ☐ Moving/Relocating
- ☐ Self-Use
- ☐ Other, please specify:_____

I authorize information to be released to:

Name of Physician or Facility: _____

Street Address _____
Street City State Zip

Phone _____ Fax _____

I authorize information to be released from the facility listed below, to Lincoln City Eye Clinic:

Name of Physician or Facility: _____

Street Address _____
Street City State Zip

Phone _____ Fax _____

Type of information to be released:

(It is the policy of Lincoln City Eye Clinic to release only our own records, we will no re-release other physician's records)

- ☐ Physician notes and records (Limited to two (2) years of information
- ☐ Diagnostic Testing
- ☐ Operative Reports
- ☐ Other, please specify_____

I have reviewed and understand this authorization to release medical records. I also understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under federal law.

This authorization will expire 90 days from the date of signing and may be revoked at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on the authorization. If you wish to revoke this authorization, please send you written request to: McMinnville Eye Clinic, 235 SE Norton Lane, Suite A, McMinnville, OR 97128 and Attention: HIPPA Privacy Officer.

I authorize Lincoln City Eye Clinic to fax my medical information. I understand the risk involved in faxing records and that the recipient cannot guarantee the confidentiality. All faxed information will contain a confidentiality statement and instruction for returning misdirected information.

_____ _____
Signature of Patient **Date**

_____ _____
Signature of Legal Guardian **Relationship** **Date**