



Friedrich Eye Associates, PLLC

David L. Friedrich, MD

Aaron G. Thompson, OD

Appointment Date: _____ Appointment Time: _____

Dear New Patient:

We are honored that you have chosen Friedrich Eye Associates, PLLC to provide you your medical and/or surgical eye care needs. To help prepare you for your upcoming visit, please read the enclosed information.

1. To make your visit as efficient as possible, please complete the attached **Patient Registration Form** and **Medical History Questionnaire** and bring them with you to your appointment. We will also need a copy of your **driver's license** and **insurance card(s)**.

If your insurance requires a referral from your primary physician, please call them ASAP to get your referral. We cannot see you without a referral in place at the time of your visit.

2. It is common for both of your eyes to be dilated. We, therefore, highly recommend that you have someone accompany you here and drive you home. We also recommend this if you are scheduled for any in-office procedures or surgery.
3. Please bring a list of all medications that you use, their dosage and frequency, and the name of your doctor(s). Also bring any prescription glasses you may wear. We also suggest that you bring sunglasses; if your pupils are dilated, your eyes will be sensitive to light when you leave.
4. Our collection policy: The physicians at Friedrich Eye Associates participate in a variety of insurance plans. As a courtesy to our patients, we file all claims. You will be expected to pay your co-payment and/or deductibles at each visit. If you have any questions about your insurance or account, please feel free to contact us.

We hope this letter of introduction will help make your visit with us as pleasant and efficient as possible. If you have any questions, please do not hesitate to contact us. Again, thank you for allowing us to participate in the care of your eyes.

Sincerely,

Friedrich Eye Associates Physicians and Staff



PATIENT REGISTRATION

Patient Name			Salutation	
Birth Date		Age	Birth State	
Sex			SS #	
CURRENT ADDRESS				
Address				
ADDRESS YOUR INSURANCE COMPANY HAS ON FILE <input type="checkbox"/> Same As Above				
Address				

COMMUNICATION				
Home Phone #		Work Phone #		Extension
Cell Phone #		Carrier		
Email				

REFERRAL SOURCE				
Referring MD		Phone #		Fax #
Address		City and Zip		
Primary MD		Phone #		
Address		City and Zip		

GOVERNMENT REQUIRED INFORMATION Check One in EACH Section				
Primary Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> Other: _____			
Race	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other Race <input type="checkbox"/> Decline to Answer	Ethnicity	<input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Decline to Answer	

INFORMATION			
Marital Status		Special Needs	
Occupation		Employer	
Employer Address		Employer Phone #	

ACCOUNT RESPONSIBLE					<input type="checkbox"/> Same As Above
Responsible			Birth date		
Pt. Relationship			SS #		
Address					
Home Phone #		Work Phone #		Extension	
Email					

PRIMARY INSURANCE			
Name		Group Name	
ID #		Group #	
Address			
Phone			
Insured		Date of Birth	

SECONDARY INSURANCE			
Name		Name	
ID #		Group #	
Address			
Phone			
Insured		Date of Birth	

EMERGENCY CONTACT		
Name	Relationship	Phone #

FRIEDRICH EYE ASSOCIATES, PLLC
 PATIENT PERSONAL HISTORY AND PHYSICAL

HISTORY AND PHYSICAL

NAME: _____ DOB: _____ DATE: _____

REASON FOR VISIT: _____

DRUG ALLERGIES	EYE HISTORY		
	Do you wear glasses? Y N Fulltime reading only? Y N		
	Do you wear contact lenses? Y N Brand: _____		
	Please check all items which pertain to you:		
	BLOOD SHOT EYES		EYE STRAIN
	BLURRED VISION		FLOATERS/FLASHES
CURRENT MEDICATIONS	BURNING EYES		GLAUCOMA
	CATARACTS		HEADACHES
	COLOR VISION, POOR		ITCHING EYES
	CROSS EYES		LIGHT SENSITIVITY
	DISCHARGE FROM EYE		LOSS OF VISION
	DIZZY/FAINTING		NIGHT VISION, POOR
	DOUBLE VISION		RED EYES
	DRY EYES		SEEING HALOS
PHARMACY NAME/PHONE	EYE INFECTION		TWITCHING EYELID
	EYE INJURY		WATERING EYES

HOSPITALIZATIONS AND SURGERIES

REASON	DATE	REASON	DATE

MEDICAL HISTORY

PLEASE MARK S FOR SELF OR F FOR FAMILY WHERE APPLICABLE:

ALLERGIES	EPILEPSY/CONVULSIONS	MENTAL ILLNESS	
ANEMIA	GALLBLADDER	MIGRAINES	
ARTHRITIS	GI DISORDER	OSTEOPOROSIS	
ASTHMA	GLAUCOMA	OTHER:	
BLEEDING	GOUT	PERIPHERAL VASCULAR	
BLINDNESS	HEADACHE	PNEUMONIA	
BOWEL PROBLEMS	HEART MURMUR	PROSTATE DISEASE	
BRONCHITIS	HEART PALPITATIONS	RHEUMATIC FEVER	
CANCER	HEPATITIS	MENSES DYSFUNCTION	
CATARACTS	HIGH BLOOD PRESSURE	SHORTNESS OF BREATH	
CHEST PAIN	INCONTINENCE	STROKE	
DEPRESSION	KIDNEY DISEASE	THYROID DISEASE	
DIABETES	LACTOSE INTOLERANCE	ULCERS	
DIZZINESS/FAINTING	MACULAR DEGENERATION	VENEREAL DISEASE	

HABITS

TOBACCO:	ALCOHOL:	DIABETIC:
PACKS DAILY:	TYPE:	INSULIN DEPENDENT: Y N
HOW LONG:	AMOUNT:	NON-INSULIN: Y N
WHEN STOPPED:		LAST BLOOD SUGAR:

FINANCIAL AGREEMENT

The financial policy has been fully explained to me and I acknowledge full responsibility for all charges incurred, including any additional charges incurred in the collection of this account, if my insurance later determines my services to be non-covered or not a benefit. I also understand that refractions are a non-covered service, but necessary for my medical care. I agree to pay the refraction fee at the time of service.

PATIENT SIGNATURE: X _____ **DATE:** _____

PRIVACY POLICY

I understand that HIPAA has implemented procedures that require specific authorization for release of my information. I agree to the following statements and understand that I can revoke these at any time by informing the Privacy Officer in writing.

Home telephone: We may leave a message with a callback number or appointment reminder on voice mail.

Written Communication: We may mail postcards to your home address or send you an e-mail.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. I understand that the last four digits of my social security number will be used as a password to identify persons seeking information regarding my healthcare, test results, prescription refills, billing information. If I would like a different code assigned, I will list it here: _____. I will give this code to my family members or friends who may need to call the practice on my behalf. Without this code, the physicians or staff members will not be able to speak to anyone except myself.

PATIENT SIGNATURE: X _____ **DATE:** _____

LIFETIME INSURANCE AUTHORIZATION

I authorize and request that payments under my medical insurance plan(s) be made directly to pay the provider for any services furnished to me. I also authorize the provider to release any information needed for payment of claims. I further permit copies of this authorization to be used in place of the original.

PATIENT SIGNATURE: X _____ **DATE:** _____

FRIEDRICH EYE ASSOCIATES, PLLC

Notice of Privacy Practices

Effective Date: December 17, 2012

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.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires 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, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

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

A. How the Practice May Use or Disclose Your Health Information

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

– **TREATMENT** means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include performing diagnostic tests in our office.

– **PAYMENT** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

– **HEALTH CARE OPERATIONS** include the business aspects of running the Practice, such as conducting quality assessment and improvement activities, auditing functions, cost- management analysis and customer service. An example would be an internal quality assessment review.

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

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

There are times we may be required by law to disclose information for law enforcement or public health reasons without additional authorization from the patient.

B. When the Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, the Practice will not use or disclose health information that identifies you without your written authorization. If you do authorize the Practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. 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.

C. Your Health Information Rights

You have the following rights with respect to your protected health information ("PHI"), which you can exercise by presenting a written request to the Privacy Officer using Practice forms:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of PHI from us by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to obtain a paper copy of this Notice from us upon request. We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI.

D. Changes to this Notice of Privacy Practices

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PHI that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from the Practice.

E. Complaints

If you believe there has been a problem with our collection, use or disclosure of your PHI, you have the right to file a complaint with our Privacy Officer. Our Privacy Officer's name is Debbie Grayson. Here phone number is (423) 702-2020. If we do not respond to your complaint in a satisfactory manner, you may file a complaint with the U.S. Office of Civil Rights. We will not retaliate against you for filing a complaint. For more information about HIPAA or to file a complaint contact: The U. S. Department of Health & Human Services Office of Civil Rights 61 Forsyth Street, SW, Suite 3B70 Atlanta, GA 30303-8909 Telephone (404)562-7886; (404) 331-2867 (TDD) FAX: (404) 562-7881 www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint

FRIEDRICH EYE ASSOCIATES, PLLC

Patient Acknowledgement Form

Patient Name: _____ (Please Print)

When you visit the Practice, it is very important that you feel safe in telling your physician personal information that may be required to fully diagnose or treat a problem. The Practice has strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. The Health Insurance Portability and Accountability Act ("HIPAA") rules require that the Practice provide all of our patients with the attached Notice of Privacy Practices on their first visit. The Notice describes how the medical information we receive from you may be used or disclosed by the Practice and your rights related to your access to this information.

Please sign below that we have provided you with a copy of our Notice to review. If you have any questions about our Privacy Practices, please feel free to contact our Privacy Officer. Thank you for your cooperation.

Please Tell Us How to Contact You to Discuss Your Medical Care

It is our policy to not release a patient's confidential and/or unauthorized information by telephone or voice mail except for appointment confirmation. Whenever returning phone calls, we do not leave a message in voice mail if the name or telephone number is not on the recorded message to identify the residence. Information will not be left with an unauthorized person who may answer the telephone. If you would like to have information released to someone other than yourself, please complete the following:

I authorize the Friedrich Eye Associates, PLLC to leave medical information pertaining to my care by the following methods and will assume responsibility to notify the Practice, in writing, whenever this information changes.

Home telephone: yes _____ no _____

Cell phone: yes _____ no _____

Voice Mail/Answering machine: yes _____ no _____

Work phone: yes _____ no _____

May we fax medical records for referrals? yes _____ no _____

Please list names of people with whom we can discuss your medical care:

Spouse Name _____

Parent Name _____

Other Name (s) & Relationship: _____

Please list a "unique identifier" as a way to confirm your identity when calling the office. This "unique identifier" must be given before any information can be disclosed.

Unique Identifier: _____

(last four digits of your social security number or mother's maiden last name)

I also acknowledge that I have received a copy of the Practice's Notice of Privacy Practices and have been given an opportunity to ask questions.

Signature of Patient or Personal Representative:

X _____ **Date:** _____

If personal Representative, give relationship to patient: _____