CASCADE OPHTHALMOLOGY, P.C. **791-A Kenmoor SE, Grand Rapids, MI 49546**
Elizabeth H. Henry, M.D., F.A.C.S. **Phone: 616-575-8200**
Amy S. Ranger, M.D. **Fax: 616-954-9622**
Sarah K. Hansen, O.D. www.cascadeeyes.com
James P. Patyi, O.D.

Today's Date:_____

Patient's Legal Name: _____ **Birth Date:** _____ **Age:**_____
LAST FIRST MI

Social Security Number:_____ - _____ -_____ **Email:**_____

Address: _____
STREET CITY STATE ZIP

Home Phone: (_____)_____-_____ **Cell Phone:** (_____)_____-_____ **Work Phone:** (_____)-_____-_____

Employer :_____**Preferred Contact Method:** *(Please Circle)* Home / Cell / Work

How did you hear about Cascade Ophthalmology: _____

PERSONAL INFORMATION- **Preferred Language:** English/ Other:_____

Please Circle: Married / Single / Divorced / Widowed **Please Circle:** Male / Female

Spouse/ Significant Other's Name: _____ **Phone:** (_____)_____-_____

Emergency Contact Person: _____ **Phone:** (_____)_____-_____

Relationship to Patient: _____

INSURANCE INFORMATION-

Who is responsible for this account? _____ **Relationship to Patient:**_____

Primary Insurance:_____ **Name of Cardholder:**_____

Secondary Insurance:_____ **Name of Cardholder:**_____

Card Holder's Social Security Number:_____-_____-_____ **Card Holder's Birthdate:**_____

Worker's Compensation: YES____ NO____ **Auto Accident: YES____ NO____**

PHYSICIAN INFORMATION-

Primary Care Physician: _____ (_____)_____- _____
NAME ADDRESS PHONE

Referring Physician: _____ (_____)_____- _____
NAME ADDRESS PHONE

Optometrist: _____ (_____)_____- _____
NAME ADDRESS PHONE

Pharmacy: _____ (_____)_____-_____
NAME ADDRESS PHONE

PLEASE SEE REVERSE SIDE:

COMPLETE IF PATIENT IS A MINOR OR PATIENT HAS A POWER OF ATTORNEY-

Name of Parent / Legal Guardian / P.O.A.: _____ (____)_____-_____
PHONE

Who is responsible for this account: _____ **Relationship to Patient:**_____

RELEASE OF INFORMATION AND FINANCIAL RESPONSIBILITY

I hereby authorize my insurance benefits to be paid directly to Cascade Ophthalmology, P.C., realizing that I am responsible to pay non-covered services. I hereby authorize the release of medical information to the insurance carrier and/or employer and their representatives. I also authorize Cascade Ophthalmology, P.C., to release any and all medical information contained within my medical records to referring physicians, consulting physicians, hospitals, laboratories, therapists, pain clinics, or a specifically named location in the course of treatment at Cascade Ophthalmology, P.C. This information may include my physical condition, diagnostic study results, diagnosis, prognosis and/or treatment plan I may also include drug abuse, alcohol abuse, HIV, AIDS, ARC and/or psychological information.

_____ _____
Patient/Legal Guardian Signature Date

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE FOR REFRACTIVE SERVICES (ABN)

Refraction is a service performed to evaluate whether or not someone is in need of a new eyeglass prescription. It is also needed in order to determine best corrected visual acuity. There are some medical complaints that require doing a refraction as well, such as blurred vision and cataract evaluation. This service is often NOT A COVERED BENEFIT with insurance companies and will generate an out of pocket charge to the patient. It is NEVER a covered benefit with Medicare. If your insurance does not cover refractions, you will be responsible for the refraction fee, which is $35.00. Please sign below to acknowledge that you have been notified and made aware of this issue. If you wish to not have this service provided please notify us at the start of your visit.

_____ _____
Patient/Legal Guardian Signature Date

MEDICARE PATIENTS ONLY

LIFETIME SIGNATURE ON FILE

Medicare Number:_____

I hereby authorize that payment of authorized Medicare benefits be made on my behalf, to Cascade Ophthalmology, P.C., for any services furnished to me by a physician of Cascade Ophthalmology, P.C. I authorize any holder of medical information about me, to release to the Center for Medicare and Medicaid Services (HCFA) and its' agents, any information needed to determine these benefits or the benefits payable for related services. I hereby authorize my insurance benefits to be paid directly to Cascade Ophthalmology, P.C., realizing that I am responsible to pay non-covered services. I hereby authorize the medical information to the insurance carrier and their representatives.

- This authorization is in effect until I revoke it.

_____ _____
Patient/Legal Guardian Signature Date

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Patient's Name:_____ **Today's Date:** _____

Birthdate: _____ **Age:**_____ **Height:** _____ **Weight:**_____

Present Problem: _____

How long have you had the problem:_____

Do you have any drug allergies? _____

Reactions:_____

What Are Your Current Medications?

_____ _____ _____

_____ _____ _____

_____ _____ _____

Past Ocular History **(Please circle any that apply to your eyes)**

Retinal detachment: R / L Eye | Glaucoma | Cataract: R / L Eye

Diabetic Retinopathy | Laser: R / L Eye-Treatment for:_____

Strabismus | Lazy eye: R / L Eye

Macular Degeneration | Other_____ | Contact Lens Wearer? Y / N

Eye Surgery: Y / N - What Kind? Which Eye?_____

Blindness: Y / N - From what? Which eye?_____

Past Medical History **(Please circle any of the following conditions you have)**

High Blood Pressure	Neurological problems (explain)	Asthma	Stomach problems (explain)
Emphysema	Heart Disease	Heart Attack	High Cholesterol
Thyroid Problems	Liver Problems	Kidney Problems	Dialysis
Stroke	Vascular Problems	Gastrointestinal	Rheumatoid arthritis

Diabetes Type: 1 2 Cancer-What kind?_____Did you Undergo: Chemotherapy / Radiation

Other: _____

Past Surgical History **(Please list all past surgeries you have had, including dates if possible)**

_____ _____ _____

_____ _____ _____

Family History **(Please complete as best as possible)**
HAS ANY FAMILY MEMBER HAD ANY OF THE FOLLOWING PROBLEMS?

Diabetes Who?_____ **Cancer** Who?_____

Problems with anesthesia Who?_____ **Bleeding** Who?_____

Eye Problems(see below ▼) Who?_____ **Heart** Who?_____
(ie: retinal detachment, glaucoma, cataract, lazy eye, macular degeneration, blindness)

PLEASE SEE REVERSE SIDE:

REVIEW OF SYSTEMS: Do you currently have:

Yes / No	Previous Eye Surgery	Yes / No	Jaundice/Hepatitis	**Social History**:
Yes / No	Contact Lens	Yes / No	Excess Hunger/Thirst	
Yes / No	Pain in Eye(s)	Yes / No	Unintentional Weight Gain	Do you drink alcohol? Yes / No
Yes / No	Double Vision	Yes / No	Pain/Difficulty Urinating	
Yes / No	Glaucoma	Yes / No	Blood in Urine	If yes, how much? _____
Yes / No	Cataracts	Yes / No	History of Kidney Stones	
Yes / No	Macular Degeneration	Yes / No	History of STD's	Do you currently or have you used tobacco products? Yes / No / Past
Yes / No	Dry Eyes	Yes / No	Anxiety/Depression	
Yes / No	Floaters	Yes / No	Sleep Disorder	
Yes / No	Burning Eyes	Yes / No	Mood Swings	If Yes, how many packs per day?
Yes / No	Watery Eyes	Yes / No	Difficulty Sleeping	
Yes / No	Itchy Eyes	Yes / No	Excess Fatigue	_____
Yes / No	Hard of Hearing	Yes / No	Easy Bruising	
Yes / No	Ringing in Ears	Yes / No	Gums Bleed Easily	Do/Did you use illicit substances? Yes / No
Yes / No	Vertigo	Yes / No	Prolonged Bleeding	
Yes / No	Sinus Problems	Yes / No	Heavy Aspirin Use	
Yes / No	Sore Throat/Mouth Ulcers	Yes / No	Anemia	If yes, what kind?
Yes / No	Chest Pain	Yes / No	Nose Bleeds	
Yes / No	Dizziness	Yes / No	Muscle Aches	_____
Yes / No	Fainting Spells	Yes / No	Arthritis	
Yes / No	Shortness of Breath	Yes / No	Joint Pain/Swelling	Marital Status:
Yes / No	Irregular Heart Beat	Yes / No	Skin Rash/Sores	Married
Yes / No	Difficulty Lying Flat	Yes / No	Skin Lesions	
Yes / No	Swollen Ankles	Yes / No	Hives/Eczema	Single
Yes / No	Nausea/Vomiting	Yes/No	Loss of Hair	
Yes / No	Congestion	Yes / No	Excess Dryness	Widowed
Yes / No	Wheezing	Yes / No	Seizures	
Yes / No	Coughing	Yes / No	Weakness/Paralysis	Divorced
Yes / No	Asthma	Yes / No	Numbness	
Yes / No	Seasonal Allergies	Yes / No	Tremors	Occupation:_____
Yes / No	Blood Disorders	Yes / No	Headaches	Present or Past
Yes / No	Heartburn	Yes / No	Tingling	

Have you ever or do you currently take **Flomax (**Prostate Medication**)**? Yes / No

Are there any other medical concerns you would like to discuss with the doctor? Yes / No
If yes? _____

The information provided is accurate to the best of my knowledge.

Signature:_____ Date: _____

Relationship to above patient: Self Parent Legal Guardian Power of Attorney

I, (The Doctor), have reviewed the above information with the patient or historian.

Signature: _____ Date: _____

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VSP and EYE MED PATIENTS

Vision Plan or Medical Insurance; who covers what?

Vision Care Plans are often an add on rider of your Medical Insurance intended to pre pay and provide a service and a durable good at a reduced fee. It is limited to a refractive diagnosis with the doctor performing a screening evaluation of the health of the eye. Vision plans such as VSP and Eye Med cover vision diagnosis known as nearsighted, farsighted, and some forms of astigmatism.

Medical care involves situations where during the course of the evaluation, a medical condition that requires a management decision related to your eyes is made. In these situations there is a need or indication for counseling, documentation, follow-up care, monitoring, and prescription of medications or referral to a surgeon.

What does my Vision Plan (VSP or Eye Med) cover?

Your vision plan is intended for "well eye" exams. This includes your eyeglass or contact lens prescription, and a screening for eye disease/disorders and no medical decision or management is done. Most vision plans are limited to one office visit and a partial coverage or discounts for eyeglasses, and / or for contact lenses.

What does my Vision Plan NOT cover?

Vision plans do not cover medical eye care (floaters, dry eyes, allergy, lazy eye, vision loss, red eyes, infections and such). Medical Insurance does not cover glasses or contacts or services related to prescribing eyeglasses and contact lenses.

What does my Medical Insurance cover?

If you are having a problem with your eyes or vision that is found to be caused by a medical condition or problem, then your exam is considered medical care. For example, if you are having difficulty seeing with your glasses, and the doctor finds that your blurry vision is caused by cataracts, then your exam is medical care. Likewise if there is a need to prescribe any medication to treat any condition.

If you have a pre-existing condition or any disease that can affect vision or cause blindness (cataracts, glaucoma, dry eye, diabetes, high blood pressure, cholesterol, etc) then your exam will be considered medical care. These services will be covered by your major medical insurance. We are providers for many Medical panels including Medicare, Medicaid, and other health plans. Vision plans do not cover medical eye care.

How do you decide whom to bill? Can you or I decide beforehand?

No, the patient does not have the medical knowledge and the doctor does not know beforehand. At the time of service, we require information for both entities (Vision Plans and Medical Insurance). Once the doctor has evaluated you, the billed entity is determined by the final diagnosis and treatment plan (what you have and what we are going to do).

Why is this so complicated?

We must follow rules that are set by our contract with your insurance company. The same applies to you, the patient.

Be mindful that until the doctor evaluates you, there is no way of determining which insurance coverage will apply.

☐ **I have no current vision plan to be billed, only Medical Insurance.**

Patient Name (Please Print): _____

Patient signature: _____

Date: _____

Witness: _____

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I_____ **acknowledge that either:**

(Print **Patient** Name)

☐ **I have received a copy of Cascade Ophthalmology, P.C.'s Notice of Privacy Practices;**

OR

☐ **I declined the offered copy of Cascade Ophthalmology, P.C.'s Notice of Privacy Practices. A copy of the Notice of Privacy Practices is available at** www.cascadeeyes.com

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This notice describes how Cascade Ophthalmology, P.C. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

BY CHECKING ANY OF THE BOXES BELOW, YOU CAN AUTHORIZE US TO DISCLOSE INFORMATION (OR RESTRICT ANY SUCH DISCLOSURES). YOU MAY:

☐ **Leave message on answering machine or voicemail**

☐ **Leave information with anyone who answers at my home**

☐ **My health information can be left/discussed with the following individuals:**

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

Name:_____ **Relationship:**_____

☐ **DO NOT give/leave information with anyone other than myself.**

X

_____

(Signature of Patient, or Personal Representative) ***(Date)***

_____

(Relationship to Patient)

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Cancellation/No Show Policy

1. Cancellation or No-Show Policy for a Doctor's appointment

We understand there are times when you must miss an appointment due to emergencies, illness, or inclement weather. However, when you do not call to cancel an appointment, you will be preventing another patient from getting a much-needed appointment.

***If an appointment is not cancelled at least 24 hours in advance, you will be charged a Twenty-Five ($25.00) fee, this will not be covered by your insurance.**

***If you do not show up for an appointment, established patient's will be charged a Fifty ($50.00) fee and New Patient's will be charged a Seventy-Five ($75.00) fee. This charge is not covered by insurance.**

2. Scheduled Appointments

We understand that delays can happen, however we do our best to keep the other patient's, and our doctors on time.

***If a patient arrives 10 minutes past their scheduled appointment time, we will have to reschedule the appointment.**

3. Cancellation/No Show Policy for Surgery

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office. Please note if you are not cleared for surgery due to health reasons there will not be a charge.

*** If surgery is not cancelled 10 days in advance you will be charged a seventy-five-dollar (75.00) fee; this will not be covered by your insurance company.**

Print Patient Name

Signature Patient/Guardian **Date**

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your protected health information and to provide you with information that describes our privacy practices. This Notice of Privacy Practices describes how Cascade Ophthalmology, P.C. will use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are required or permitted by federal, state, and local law. This notice also contains information about your rights to access and control your protected health information.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR THE TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS.

Federal privacy rules permit Cascade Ophthalmology, P.C. to use and disclose your protected health information without your written authorization for the purposes of treatment, payment, or healthcare operations.

TREATMENT: Your protected health information will be used and disclosed to provide, coordinate, or manage your health care and any related services. This includes the coordination and/or management of your health care with another health care provider for treatment purposes. Cascade Ophthalmology, P.C. participates in certain health information exchanges to facilitate the secure exchange of your health information electronically between health care providers and health care entities for your treatment, payment, or other healthcare operations purposes. This means that we may share information we obtain or created about you with outside entities (such as hospitals, doctor's offices and pharmacies) or we may receive information they create or obtain about you so that each of us can provide better treatment and coordinate your health care services.

PAYMENT: Your protected health information will be used and disclosed to obtain payment for the services we provide to you. This includes communicating with your insurance benefits.

HEALTH CARE OPERATIONS: Your protected health information will be used and disclosed in order to operate our practice. Health care operations include activities such as quality assessment and improvement; providing educational training programs for medical, nursing, and other allied health and no-health care professionals; accreditation, certification, and licensing activities; and general administrative, legal and auditing activities.

CERTAIN OTHER USES AND DISCLOSURES: Your protected health information may be used to remind you of appointments, medication, refills, treatment alternatives, and/or other health-related benefits and services that may be of interest to you. We may disclose limited protected health information to family member or close friend that you designate as being involved in your care.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION THAT ARE REQUIRED OR PERMITTED BY LAW

PUBLIC HEALTH ACTIVITIES: We will use and disclose your protected health information for the following public health activities and purposes as required or permitted by law:

- To prevent, control, or report disease, injury, or disability.
- To report suspected child abuse or neglect.
- To conduct public health surveillance, investigations, and interventions.
- To collect or report adverse events and product defects; enable product recalls, repairs, or replacement to FDA-regulated products or activities, and to track FDA-regulated products or conduct post-marketing surveillance.
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease.
- To report to an employer about an individual who is a member of the workforce if there is a work-related injury or illness or to conduct an evaluation relating to medical surveillance of the workplace.
- To report proof of immunizations to a school about an individual who is a student or prospective student of the school.

TO REPORT SUSPECTED ABUSE, NEGLECT, OR DOMESTIC VIOLENCE: We will use and disclose your protected health information to notify government authorities as required by law if we believe you are the victim of abuse, neglect, or domestic violence. If we make such a disclosure, we will inform you unless we believe that this will place you at risk of serious harm.

HEALTH OVERSIGHT ACTIVITIES: We will disclose your protected health information to a health oversight agency for activities authorized by law including audits; civil, administrative, or criminal investigations, proceedings or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS: We will use and disclose your protected health information in the course of a judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. We may disclose your protected health information in response to a subpoena to the extent authorized by law.

LAW ENFORCEMENT: We will disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting certain types of wounds or other physical injuries.
- Pursuant to a court order, court-ordered warrant, subpoena, summons, or similar process authorized under law.
- For the purposes of identifying or locating a suspect, fugitive, material witness, or missing person
- Under certain circumstances when there is a crime on our premises.
- In an emergency, to report a crime.

CORONERS, FUNERAL DIRECTORS, AND ORGAN DONATION: We may disclose you protected health information to a coroner or medical examiner for identification purposes, to determine cause of death, or to perform other duties authorized by law. We may disclose your protected health information to a funeral director in order for them to carry out their duties. We may disclose your protected health information if you are an organ donor for organ, eye, or tissue donation purposes.

RESEARCH: We may use and disclose your protected health information for research purposes when our institutional review board or privacy board waives the requirement to obtain an individual authorization.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY: We may disclose your protected health information when necessary to prevent or lessen a serious and imminent threat to your health or safety of the public.

SPECIALIZED GOVERNMENT FUNCTION: We may use and disclose your protected health information to facilitate specific government functions relating to military and veterans' activities, national security and intelligence activities, protective services to the President and other, medical suitability determinations, public benefit programs, correctional institutions and law enforcement custodial situations.

WORKERS' COMPENSATION: We may use and disclose your protected health information to comply with laws related to workers' compensation or similar programs established by law to provide benefits for work-related illnesses or injuries.

OTHER AS REQUIRED BY LAW: We will use and disclose your protected health information to the extent that such use or disclosure is required by laws not listed above.

Other than as stated in the previous paragraphs, we will not disclose your PHI without your written authorization. We are specifically required to obtain your written authorization for all treatment and health care communications (except face to face) if the office receives financial remuneration from a third party whose product or service is being marketed in exchange for making the communication. You may revoke your written authorization at anytime, except to the extent that action has been taken in reliance on the authorization.

YOUR RIGHTS UNDER THE PRIVACY RULE:

- **The right** to inspects and request a copy of your protected health, to the extent allowed by law. You may inspect and obtain a copy (paper or electronic) of the protected health information that is contained in your designated record set for as long as we maintain the protected health information. The designated record set contains both medical records and billing records. A fee may be charged to cover the copying, supplies, and postage costs incurred in complying with your request.
- **The right** to request communication of your protected health information by an alternative means or at an alternative location. You may request that we communicate with you in certain ways and we will accommodate reasonable requests. We will not require you to provide an explanation for your request.
- **The right** to request a restriction on the use and disclosure of your protected health information for treatment, payment, or health care operations purposes. With one exception, we are not required to agree to a restriction and will notify you if we deny the request. If we do agree, your protected health information will not be used or disclosed in violation of the restriction unless it is needed to provide you with emergency treatment. We are required to agree to the restriction if you pay 100% of your out of pocket for items or service and request that we do not disclose this to your health plan.
- **The right** to request amendments to your protected health information. This request must be in writing and you must provide a reason to support the requested amendment. In certain cases, we may deny your request. If we do, you have the right to file a statement of disagreement with us. If we prepare a rebuttal to your statement of disagreement, we will provide you with a copy.
- **The right** to receive an accounting of certain disclosures. You have the right to receive an accounting of certain disclosures of your protected health information by Cascade Ophthalmology, P.C. Your request for an accounting must be in writing and you are permitted one free accounting during any 12-month period but subsequent requests for an accounting will incur a fee.
- **The right** to be notified of a breach of you protected health information. Our office must notify you as soon as possible and no later than 60 day following discovery of the breach.
- **The right** to obtain a paper copy of this Notice. You may ask for a copy of this Notice at any time

If you are interested in pursuing any of these rights, please discuss them with your health care provider or contact the Cascade Ophthalmology, P.C. Privacy Officer at (616) 575-8200.

CHANGES TO THIS NOTICE: We reserve the right to revise, change, or amend out Notice of Privacy Practices. Any revision or amendments to this notice will be effective for of the protected health information that we already have as well as any protected health information that we may created, receive, or maintain in the future. We will post a copy of our current Notice in prominent locations within our clinics and you may request a current Notice during any visit to our organization or by calling the Cascade Ophthalmology, P.C. Privacy Officer at (616) 575-8200. In addition, you will find our current Notice on our website at www.cascadeeyees.com

COMPLAINTS: If you believe your privacy right have been violated, you may file a complaint with the Cascade Ophthalmology, P.C. Privacy Officer or with the Secretary of the Department of Health and Human Services. Complaints must be submitted in writing. You will not be penalized for filing a complaint.

Revision Date January 11, 2017