Harmon Ophthalmology, PC/Harmon Optical Corp.

Instructions: Fill in the blanks.

Patient Information:

Name: _____ _____ _____
LAST MIDDLE FIRST

Date of Birth: _____ **Circle One**: Married Single Divorced Widowed

Social Security #: _____

Sex: ☐Female ☐Male ☐Genderqueer/Non-Binary ☐Prefer not to disclose ☐_____

Address:_____
Street City State Zip

Phone #: (_____) _____-_____ **Cell #**: (_____) _____-_____

E-Mail: _____

Patient's Employer: _____ **Work #**: (_____) _____-_____

Employer's Address: _____

Government regulation contained in the Patient Protection and Affordable Care Act have mandated that we collect the following additional demographic information:

Preferred Language: _____

Race (please check the appropriate box below):

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White or Caucasian
- ☐ Other Race
- ☐ Decline to Answer

Ethnicity (please check the appropriate box below):

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to Answer

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

Emergency Contact Name: _____Phone #: (_____) _____

Relationship: _____ Work #: (_____) _____-_____

Referring Physician: _____Phone #: (_____) _____-_____

Address: _____Fax #: (_____) _____-_____

Pharmacy Information:

Pharmacy Name: _____ **Tel # __ _____ Fax #_____**

Insurance Information:

Primary Insurance: _____Effective Date: _____

Claim
Address:_____

Policy #: _____ Group #: _____ Policy Holder's S.S. #: _____

Insured's Name: _____ Date of Birth: _____

Relationship to Insured: □Spouse □Parent □Other:_____

Secondary Insurance: _____ Effective Date: _____

Policy #: _____ Group #: _____Policy Holder's S.S. #: _____

Claim Address:
_____

Insured's Name: _____ Date of Birth: _____

Relationship: □Spouse □Parent □Other:_____

Worker's Compensation Information (if applicable):

Is the reason for this visit due to a work-related accident? (Please Circle) YES NO

Date of Injury/Onset of Illness:	**Employers Insurance Carrier Name & Address**
WEB Case No:	**Carrier Case No:**
Are you currently working? (Circle) Yes No	**Last Day Worked:**
Briefly describe how and where patient's injury occurred:	

ASSIGNMENT OF BENEFITS and
AUTHORIZATION FOR RELEASE OF INFORMATION BY HARMON OPHTHALMOLOGY, P.C.

I hereby authorize and direct the above named clinical practice, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such treatment. Upon my request for release of my medical records, I hereby authorize Harmon Ophthalmology PC and/or Harmon Optical, Corp. to furnish all records and results to the parties I specify.

I hereby assign, transfer and set over to the above named clinical practice sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are financially liable for my medical costs of the care and treatment rendered to myself or my dependent in said practice. I understand I am responsible for any services not covered by my insurance. I accept responsibility for payment of my account.

PATIENT'S SIGNATURE:_____ **DATE:**_____

REVIEW OF SYSTEMS

Patient Name: _____ **Date:** _____

- **Reason for Today's Visit:**

Are you currently experiencing any of the following? If so, please check off the symptoms below that you are experiencing:

- ☐ Eye Pain
- ☐ Burning, itching or scratching sensation
- ☐ Redness
- ☐ Tearing
- ☐ Discharge
- ☐ Blurred or fuzzy vision
- ☐ Double Vision
- ☐ Flashing Lights
- ☐ Cobwebs, dark spots or dark veils
- ☐ Headache
- ☐ Problems with glasses or contact lenses
- ☐ Other _____
- ☐ No, I am not currently experiencing any particular symptoms.

- **Are you currently experiencing any of the following symptoms?**

Please answer by putting a ✓in the YES or NO column

Body System	Symptom	YES	NO
Constitutional Symptoms	Fever		
	Fatigue		
	Weight Loss		
	Chills		
Skin	Itching		
	Dryness		
	Rashes		
Eyes	Visual Changes		
Neurological	Headache		
	Dizziness		
Respiratory	Shortness of Breath		
	Congestion		
Gastrointestinal	Difficulty Swallowing		
	Nausea		
	Vomiting		
Hematologic/Lymphatic	Bleeding Disorder		
Genitourinary	Urinate Frequently		
Endocrine	Hormonal or Thyroid Problems		
Musculoskeletal	Joint Pain/Swelling		
	Arthritis		
Auditory	Hearing Changes		
Psychiatric	Depression		
	Anxiety		
	Insomnia		
Cardiovascular	Chest Pains		
	High Blood Pressure		
	Rapid Heart Beat		

- **Do you have a history of:**
  Cancer **YES NO**
  If yes, what type of cancer? _____
  High Blood Pressure **YES NO**
  Diabetes **YES NO**
  Thyroid Disease **YES NO**
  Eye Disease **YES NO**
  Other: _____

- **Do you have a <u>FAMILY</u> history of:**
  High Blood Pressure **YES NO Who: _____**
  Heart Disease **YES NO Who: _____**
  Diabetes **YES NO Who: _____**
  Eye Disease **YES NO Who: _____**
  Other: _____ **Who:** _____

- **Have you had Surgery?: YES NO**
  If yes, what type of surgery did you have? _____ Date of Surgery: _____
- **Do you currently smoke? YES NO**
  If yes, how many packs per day do you smoke? : _____
  When did you start smoking? _____
  Total years smoking: _____
- **Have you ever smoked previously?** YES NO
  Total years smoking? : _____
  When did you quit? : _____

- **Do you drink? YES NO**

- **What medications are you currently taking and what is the dosage?**
  _____ _____
  _____ _____
  _____ _____
  _____ _____

- **Do you have any allergies to medications? YES NO**
  If yes, which medications are you allergic to? _____

Patient's Signature: _____

Reviewed by M.D.: _____ Date: _____

Gregory K. Harmon, M.D.

Signature on File, Assignment of Benefits, Financial Agreement

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to HARMON OPHTHALMOLOGY, P.C., for services furnished me by HARMON OPHTHALMOLOGY, P.C. . I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. HARMON OPHTHALMOLOGY, P.C. accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to HARMON OPHTHALMOLOGY, P.C., if possible or otherwise to me.

3. RELEASE OF INFORMATION: HARMON OPHTHALMOLOGY, P.C. may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to HARMON OPHTHALMOLOGY, P.C. for reimbursement for services rendered, and (2) any health care provider for continued patient care. HARMON OPHTHALMOLOGY, P.C. may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. OTHER INSURANCE: The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by HARMON OPHTHALMOLOGY, P.C. if I belong to a plan that HARMON OPHTHALMOLOGY, P.C. does not participate with.

5. NON-COVERED SERVICES: I understand that HARMON OPHTHALMOLOGY, P.C.'s contracts with health insurance plans relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with HARMON OPHTHALMOLOGY, P.C. to obtain necessary health care service plan authorizations.

6. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by HARMON OPHTHALMOLOGY, P.C., I will pay my account at the time service is rendered or will make financial arrangements satisfactory to HARMON OPHTHALMOLOGY, P.C. for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to HARMON OPHTHALMOLOGY, P.C. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to HARMON OPHTHALMOLOGY, P.C. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

_____

Patient Name (Printed)

_____ _____

Patient Signature **Date**

Harmon Ophthalmology, P.C.
205 East 64th Street, Suite 101
New York, NY 10065

Missed Appointment & Appointment Cancellation Policy

Harmon Ophthalmology, P.C. is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from getting much needed treatment.

Please call us at (212) 888-4100 by 2:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00 p.m. on the preceding Friday.

If prior notification is not given, you will be charged a **$50.00 fee** for the missed appointment; this fee will not be covered by your insurance carrier.

Please sign below to consent to these terms.

_____

Patient Signature (Patient's Parent/Guardian if under 18)

_____

Date

Harmon Ophthalmology, P.C.
205 East 64th Street, Suite 101
New York, NY 10065

HIPAA 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 REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition related health care services.

Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other reuse required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of you physician's practices. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your projected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law: Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation:

Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164,500.
Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights Following is a statement of your rights with respect to your protected health information:

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or preceding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. Disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Service if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying your privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before July 7th, 2007

We are required by law to maintain the privacy of, and provide individuals with, this notice of your legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone number.

Signature below is only acknowledgement that you have received and reviewed this Notice of our Privacy Practices:

Print Name: _____

Signature: _____

Date: _____