Specializing in Medical and Surgical Care of the Eye

PATIENT HEALTH QUESTIONNAIRE

Date__________________________

Name____ Date of Birth: ____________________

PRIMARY CARE PHYSICIAN: ___________________________________

Please list all **medications** you are currently take (including eye medications & Vitamins)?

____ ____
____ ____
____ ____
____ ____
____ ____
____ ____

Do you have any **allergies** to medications? _____YES _____NO
If YES, list the medications:

____ ____
____ ____

Please list any **illnesses** or **injuries** you have had?

____ ____
____ ____

Please list all **hospitalizations** and **operations** you have ever had?

____ ____
____ ____
____ ____
____ ____

Please check if you or anyone in your Family (BLOOD RELATIVE) have ever had any of the Following?

	You	**Family**		**You**	**Family**
Diabetes			Inherited disease		
High Blood Pressure			Mental impairment		
Heart Disease			Crossed eyes		
Stroke			Cataracts		
Asthma			Glaucoma		
Bronchitis			Blindness		
Hepatitis			Ulcer Disease		
Tuberculosis			Alcoholism		
HIV infection/AIDS			Other eye disease		
Thyroid disease			Cancer		
Migraine headaches			Bleeding disorder		
Arthritis			History of anesthesia complications		
Latex Allery			High Cholesterol/ Triglycerides		
Rheumatoid Arthritis			Other________________________________		

Do you have any other Disease or condition not listed? _____Yes _____No
If yes, please explain:____
____

Please list your occupation: ____

Have you ever done any of the following?

Taken Oral Flomax	YES/ NO
Consumed Alcohol	YES/ NO
Smoked	YES/NO
Been exposed to excessive sun	YES/NO
Been exposed to hazardous materials	YES/NO

Do you presently:

Smoke YES/NO How many per week? ___________
Drink Alcohol YES/NO How many per week? ______

Please check if you have a problem with any of the following.

Fever		Weight Loss		Tiredness	
Ears		Nose		Mouth	
Throat		Heart		Blood Vessels	
Lungs		Esophagus		Stomach	
Intestines		Kidney		Bladder	
Genital System		Muscles		Bones	
Skin		Breasts		Nervous System	
Psychiatric System		Endocrine		Blood System	
Lymph System		Allergies		Immune System	

_______________________________________ _______________________________
Signature of person completing this form Print Name

_______________________________________ _______________________________
Relationship to patient Date

(Do not write below line)

I have reviewed and confirmed the information above.

__________________________ __________________________
Physician Signature Date

REGISTRATION FORM

(PRINT CLEARLY, USE BLACK INK ONLY)

Today's date:	PCP:

Preferred Pharmacy: *Phone: (   )   -*

PATIENT INFORMATION

Patient's last name: First: Middle:	Marital status (circle one): Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If no, what is it?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Social Security #:	Home phone: ( ) -		Cell phone: ( ) -
City State: Zip Code:		Email address:			

Occupation: Employer:

Employer phone no.: (   ) ____ - _________

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _________________
❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑
Other:___________________________________

Other family members seen here:

INSURANCE INFORMATION

(Give your insurance card to the receptionist.)

1.Primary Insurance Company:		**Phone: ( ) -**	
Address:		State:	Zip:
Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( ) -
Subscriber's name:		Policy No:	Group No:
Patients Relationship to Subscriber:	_____ Self ______ Spouse ______Child ______ Other		
2.Secondary Insurance Company:		**Phone: ( ) -**	
Address:		State:	Zip:
Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( ) -
Subscriber's name:		Policy No:	Group No:
Patients Relationship to Subscriber:	_____ Self ______ Spouse ______Child ______ Other		

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( ) -	( ) -

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, any and all financial liability rests with the patient.
Our office participates with most major insurance plans. We provide MEDICAL and SURGICAL ophthalmologic care to our patients, as well as Routine Eye Exams.
It is the patient's/parent's/guardian's responsibility to:

1. Bring insurance cards and picture ID to ALL visits.
2. To know what my co-pay, co-insurance and deductibles are.
3. Have copayment and/or any payment that may due at the time of service

I understand that if I am unable to make payment (co-pay, co-insurance, deductible) at the time of service or provide a picture or insurance card that my appointment may be rescheduled and subject to a $35.00 additional billing fee.

Refractions:
Refraction is the process of testing an individual's ability to see an object at a specific distance. The test involves looking through a device called a phoropter to read letters or recognize symbols on a wall chart through lenses of differing strength which are contained within the device to determine your best corrected visual acuity. It is an essential part of an eye examination and is necessary in order for us to completely evaluate your ocular health. This procedure may result in a new prescription or a change in your present prescription for glasses. This procedure is also necessary to determine your contact lens prescription as well. Since this a non-covered charge with Medicare and most Medical Insurance companies, it is a billable fee of $100.00 and we offer a discount if it is paid at the time of service. I understand that I am responsible for this fee and it is due at the time of service.

Non-Covered Services:
I understand that some services may be considered non-covered services by my insurance plan. I understand that it is my responsibility to know what my insurance does or does not cover and I understand that I am financially responsible for paying all non-covered services.

Past due balance:
We appreciate prompt payment in full for any outstanding balance. All accounts are considered past due if not paid within 90 days of service. If your account is turned over to our collection agency, you agree to pay any fees imposed by the collection agency in order to collect the overdue amount. Past due accounts may result in the refusal of future appointments until old balances have been paid in full. The practice does not accept postdated checks.

Return Check Policy:
Any check payments that do not clear will be subject to a $55 returned check fee.

Vision Plans:
The practice participates in a number of vision plans. It is your responsibility to know which vision plans are accepted and which physician participates in the plan. I understand that some medical plans do have routine benefits; however, sometimes these vision benefits are with a different carrier than your medical plan. We may be participating providers with your medical plan but not your vision plan. You are responsible for contacting your carrier to verify your benefits and whether the practice is a provider for

both your medical and vision plan. Our practice cannot bill your Vision and Medical plans on the same day of service.

Medical Insurance Plans:
If we are not a participating provider with your insurance plan, I understand that I will be responsible for filing my own claims and I will be responsible for paying in full at the time of service. .

Medical Insurance Referrals:
I understand that if my insurance company requires a referral form for treatment that it is my responsibility to obtain this referral prior to my appointment. If the required referral form is not received, I understand that my appointment will be rescheduled until such time as the referral can be obtained.

Forms and Fees:
There is a charge for completing/ processing any medical record release request or forms (employment, disability, life insurance, DMV, etc). This charge is determined by the complexity of the form, letter, or communication. Prepayment is required prior to completing forms, or for extra written communication by the doctor.

Missed Appointments:
I understand that I may be given a return appointment in order to follow-up on my eye status or condition. In the event that, for any or no reason, I do not keep that return appointment and do not promptly reschedule, I agree to not hold Kaz Vision and Laser Center, its physicians, and/or staff responsible for any resulting consequences. Appointments cancelled with less than 24 hours notice may be charged to my account.

By Signing below, I am acknowledging that I have read and understand the above financial policy.

____ ____________________

Patient or Authorized Representative Signature Date

____

Patient Name

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on April 14, 2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make significant change, this notice will be amended to reflect the changes and we will make the new Notice available. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Kian M. Kaz M.D. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know "standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgement to disclose only that information directly relevant to your care. We will also our professional judgement to make reasonable inferences of your best of your best interest by allowing someone to pick up filled prescriptions, x rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public health Responsibilities: We will disclose your health care information to report problems with products, reactions to medication, product recalls, disease / infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

NOTICE OF PRIVACY PRACTICES

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $ _______ for each page and the staff time charged will be $_____ per hour including the time required to locate and copy your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee schedule.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-Routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS.

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us, in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in anyway if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US.

Practice Name: Kian M. Kaz M.D., Eye Physician & Surgeon, P.C. - Privacy Officer.
Telephone: 757-875-7700 Fax: 757-875-7721
Address: 12690 McManus Blvd. Newport News VA 23602

PRIVACY STATEMENT

Dear Patient:

The Privacy Act of 1977 was designed to protect you. To give you a feeling of security, be assured that when you come into this office your medical and financial affairs will not be discussed without your permission. This means that your spouse, your personnel director and even your parents have to have an authorization signed by you before they may receive information regarding your medical care.

For those of you who wish for your spouse, social worker, personnel director, parent, etc. to call this office and receive information about you and your bill, please complete the form below. In order for us to give out information, anyone who in calls will have to provide our staff with your date of birth. If there is not anyone whom you would like to receive information about you, please draw a line through the bottom portion and sign and date it.

Thank you for your cooperation in this matter.

I, ____________________________, give permission for Dr. Kaz or staff to release medical information to my

____________________________, ____________________________.
Relationship Name

I, ____________________________, give permission for Dr. Kaz or staff to release medical information to my

____________________________, ____________________________.
Relationship Name

I, ____________________________, give permission for Dr. Kaz or staff to release medical information to my

____________________________, ____________________________.
Relationship Name

I, ____________________________, give permission for Dr. Kaz or staff to release medical information to my

____________________________, ____________________________.
Relationship Name

____ ________________
Patient or Authorized Representative Signature Date

____ ________________
Patient Name Date of Birth