**BLUEGRASS RETINA CONSULTANTS, PSC**
**PATIENT REGISTRATION**

| *For office use only* | | |
|---|---|---|
| Ins Card Scanned: | ❒Yes | ❒ No |
| Photo ID obtained: | ❒Yes | ❒ No |
| Check-In Staff Initials: | _____ | |

**Last Name:**_____ **First Name:**_____**Middle Name:**_____

**Sex:** ❒ M ❒ F **Birthdate:** _____/_____/_____ **Age:**_____ **Social Security:**_____

**Mailing Address:**_____ **Zip Code:**_____
Street / PO Box City State

please check a call preference:
❒ **Home Phone**: _____ ❒ **Cell Phone:** _____ ❒ **Work Phone**:_____

**Email Address**: _____

**Marital Status:** ❒Single ❒Married ❒Divorced ❒Widow(er)

The following questions are required by the Federal Government HIPAA regulations:
**Race**: ❒American Indian or Alaskan Native ❒Asian ❒Black or African American ❒Hispanic
❒Native Hawaiian or Pacific Islander ❒White/Caucasian ❒Unknown ❒ Decline to Specify

**Ethnicity:** ❒Hispanic ❒Non-Hispanic ❒ Decline to Specify

**Language**: ❒English ❒Spanish ❒ Decline to Specify
❒Other_____

**Name of Emergency Contact Person (Not living at same address):**_____

Relation to patient: _____ Phone:_____

**Referring Physician:** _____ City:_____Phone:_____

**Primary Care Physican**: _____ City:_____Phone:_____

**Pharmacy Name:** _____ City:_____ Phone:_____

**Is the Patient under the Age of 18?** ❒ Yes ❒ No If yes, please complete the following:

Parent/Guardian Name:_____ Birthdate:_____

Social Security #:_____ Relationship to patient:_____

**Is the Patient Insured under someone else? (e.g. Spouse, Parent, or Guardian)** ❒ Yes ❒ No If yes, please complete the following:

Name:_____ Birthdate:_____

Social Security #:_____ Relationship to patient:_____

**Is patient in a Skilled Nursing Facility?** ❒Yes ❒No If yes, please complete the following:

Name of Facility: _____Phone #_____

Address:_____

**If Workers Compensation or Auto Accident Claim, please provide:**

Date of injury/accident :_____ Time of Accident: ____:____ ❒ AM ❒ PM State where accident occurred: ❒ KY ❒ _____

❒ **Workers's Comp:**
Employer's Name: _____ Phone: _____
Employer's Address:_____ Claim #: _____

❒ **Auto Accident:**
Auto Insurance: _____ Phone: _____
Policy Holder Name: _____ Claim # : _____

**Bluegrass Retina Consultants, PSC**
**Privacy Policy**

Our "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. This notice contains a "Patient Rights" section describing your rights under the law. You have the right to review our notice before signing this consent (see copy underneath this paperwork on clipboard). The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**Consent to Release Information**

By signing this form, I permit the practice to release any medical information to the physicians involved in my care, I consent that the practice may call my house or other designated locations and leave a message on voicemail or in person in reference to appointment reminders and insurance items. In addition, the practice may mail to my home appointment reminders and patient statements.

**Authorization to discuss/disclose protected health information**

I give Bluegrass Retina Consultants permission to discuss my entire medical record and billing information with the following specified persons or agencies.

Name:_____Relationship:_____Phone #_____

Name:_____Relationship:_____Phone #_____

Name:_____Relationship:_____Phone #_____

Name:_____Relationship:_____Phone #_____

**If Bluegrass Retina Consultants needs your records:**

I,_____, DOB_____
give Bluegrass Retina Consultants permission to obtain my records from other sources in regards to my healthcare.

**Patient's Signature:**_____ **Date:**_____
***(Patient or Legal Representative)***

If no signature above for Privacy Consent,

- ❒ Bluegrass Retina Consultants made a "good faith" effort to obtain the individual's acknowledgement of the Notice of Privacy Practice.

# Bluegrass Retina Consultants Patient Responsibility Agreement

Thank you for entrusting us with your care. We are committed to providing you with quality affordable health care. Please look over our policy, ask any question you have, & sign in the space below to signify that you understand your financial responsibility for services rendered. A copy of this document will be provided to you upon request.

1. Insurance. We participate with most insurance plans including Medicare & most Kentucky Medicaids. We require patients to present current insurance cards upon check-in at every visit. Failure to provide accurate and current insurance information at the time of services rendered will cause responsibility for the entire claim balance to become yours – the patient's – responsibility. Knowing your insurance benefits is your responsibility; please contact your insurance company with any questions you have regarding your coverage including deductibles, copays, etc.
2. Copayments & Deductibles. Co-payments/coinsurance/deductibles must be paid at the time of services rendered. This is due to contractual agreements between our practice and your insurance company. Failure to collect copays/coinsurance/deductibles can be considered fraud. Deductibles & coinsurance will be calculated for all insurance companies at your visit. If you are a new patient and have a deductible of $250 or more remaining, you will be required to pay at least $250 at the time of your check in. Our front desk staff is required to collect your portion at the time of service.
3. Self-Pay Patients. If you do not have insurance or we do not participate with your insurance provider, a **$250** deposit is required at the first visit. Depending on the services rendered, we will collect any additional owed at the end of the visit. For all visits following the first, we will collect your total balance due for services rendered that day.
4. Coverage Changes. If your insurance changes, contact us to update this information. This allows us to provide maximum benefits possible. This includes changes within the same insurance provider company, such as, but not limited to, changing between HMO & PPO. Failure to alert our practice to such changes will result in more financial responsibility on you, the patient.
5. Nonpayment. If you do not uphold your responsibilities per this agreement, your balance will be turned over to collections. At this point, all patient responsibility is referred to an outside source, and a notice is issued to the patient via certified letter that our office is unable to continue treatment for non-emergent conditions past 30 days. When an account is turned over to an outside collection agency, a **40%** charge will be added to the balance for collection costs.
6. Missed Appointments. Patients are charged **$50** for cancelling a surgery without 48 hours-notice. Excessive no-shows and cancellations without 24-hour notice will also result in a **$50** charge. These charges are the patient's responsibility, and must be paid before the next visit.

Our practice is committed to providing quality treatment to our patients. Our prices reflect that which is customary for our area. Please let us know if you have any questions regarding our patient responsibility policy.

Please print your name and sign below to signify that you have read and understand the Patient Responsibility Agreement and agree to abide by these responsibilities:

_____ _____

**Please Print Patient Name & Date of Birth** Date

_____ _____

**Patient or Parent/Guardian Signature** Staff Initials

Dear Patient,

Welcome to Bluegrass Retina Consultants! We are pleased to provide you with our services.

**To make your appointment faster, please visit chkin.com/br3969/login to complete your eRegistration. All you need is your first name, last name and DOB to login and complete all paperwork and upload your insurance cards and ID. You will receive a text and email reminder to complete the eRegistration 5 days before your appointment.**

If you are unable to complete this online, we have enclosed three pages of paperwork for you to complete.
**Please bring this folder and the completed paperwork (if not completed online) with you to your scheduled appointment, along with your insurance cards, photo ID*, current medication list, and sunglasses**. Also, be prepared to pay your **Copay/Coinsurance** and your **Deductible**. If you have not met your deductible or do not have insurance, please bring $250 towards your first visit.

We look forward to seeing you!

If you have any questions, please feel free to call us at (859) 264-0445 or toll-free at (800) 862-0564.

Sincerely,

The staff at Bluegrass Retina Consultants

Note: If you would like to fax your completed paperwork prior to your appointment, you may send it to (859) 264-0447.

*If your photo ID does not match your current address then BRC will need to see a utility bill or other correspondence showing your current address.

**Angelia Thompson, MD, FASRS**
**Brendan Girschek, MD, FACS**
**3290 Blazer Parkway, Suite 100, Lexington, KY 40509**
**(859)264-0445  Fax (859)264-0447**
**465 Centre View Blvd, Crestview Hills, KY 41017**
**(859)360-1407  Fax (859)264-0447**

# PLEASE READ:

**Your appointment will last between 2-3 hours long.**

Due to a widening of the pupil, dilating drops may blur your near/reading vision for about 4-6 hours, and in some cases longer. Because dilation will vary for everyone it is not possible for us to know how much your vision will be affected.

Driving may be difficult after an examination and we recommend that you have someone to drive you. If you still choose to drive while your eyes are dilated, BRC cannot be held accountable for any damages or accidents that may occur due to the dilation.

# HIPAA Notice of Privacy Practices

Effective as of March/1/2013

**Bluegrass Retina Consultants, PSC**
**3290 Blazer Pkwy, Suite 100, Lexington, KY 40509**
**(859) 264-0445 or (800) 862-0564**

**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 condition and related health care services.

## 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 use 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, 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 or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, 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 protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you.

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, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under 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 the 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**

The following are statements of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information (fees may apply) –** Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

**You have the right to request a restriction of your protected health information –** This means you may ask us not to use or disclose any part of your protected health information and by law we must comply when the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full. 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. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

**You have the right to request to receive confidential communications –** You have the right to request confidential communication 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 have the right to request an amendment to 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 –** You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

**COMPLAINTS**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

**We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.**

**Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.**