Patient Information

Victor A. Crosby, M.D.

Personal Information:

Dr. Mr. Mrs. Miss. Ms:_____Date:_____

Date of Birth:_____ Age: _____ M/F_____

Mailing Address:_____City:_____State:_____Zip:_____

Home Phone: (_____)_____Work Phone: (_____)_____

Cell Phone: (_____)_____ Email Address:_____

OK to to contact by E-mail?_____ or Text:_____

Occupation:_____ Employer:_____

Address:_____ City:_____State:_____Zip:_____

Are you?: (please circle one) Minor Single Married Widowed Divorced

Spouse Name:_____ Work Phone:_____

Referred By: Doctor Name: _____ Friend:, Relative or Website (name):_____

Primary Care Physician :_____ Phone:_____

Name of Parent/ Guardian(or Caregiver):_____

Address:_____City_____ State:_____ Zip:_____

Home Phone:_____ Work phone:_____

Insurance Information: *Present card to front office staff.*

Are you personally responsible for payment of your fees? YES_____ NO_____ If No , who is?

Name:_____ Relationship:_____

Address:_____ City:_____State:_____Zip:_____

Home Phone:_____Work or Cell Phone:_____

Who to notify in case of emergency?_____Phone:_____

Financial Assignment and Agreement:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-pay insurance, or any other balance not paid for by your insurance.
2. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
3. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorized said assignee to release all information necessary to secure the payment.

Patients and/or Guardian Signature:_____**Date:**_____

PATIENT MEDICAL HISTORY RECORD

PATIENT'S NAME SEX AGE

EYE HISTORY

Thank you for choosing our office for your eye care. To better serve you, please answer the following questions:

1. Do you wear glasses? **yes** _____ **no** _____

2. Do you wear contact lenses? **yes** _____ **no** _____

3. Do you have problems reading? **yes** _____**no** _____

4. Are you currently experiencing any eye symptoms? Please circle all that apply:

Eye Pain Blurred Vision Eyelid Crusting Flashes of light Halos Floaters

Discharge Light Sensitivity Double Vision Decreased Vision

5. Have you ever had an eye injury? Please describe:_____

6. Have you ever had eye surgery? Please list type, which eye, and approximate dates:
_____

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc.)
_____**YES** _____**NO** IF **YES**, please explain: _____
2. Have you ever had any eye disease (e.g., glaucoma, cataract, wandering, or "lazy" eye, retinal detachment)?
_____**YES** _____**NO** IF **YES**, please explain:_____

3. Have you ever had any surgery? _____**YES** _____**NO** IF **YES**, please provide date and reason:
_____
_____

4. Have you ever been hospitalized? _____**YES** _____**NO** IF **YES**, please provide date and reason:
_____
_____

5. Do you take ANY medications? _____**YES** _____**NO** IF **YES**, please list:_____
_____

Do you use any eye medications? _____**YES** _____**NO** IF **YES**, please list:_____

6. Do you have any drug or food allergies? _____**YES** _____**NO** IF **YES**, please list:_____
_____

Family and Social History

Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, or macular degeneration)? _____**YES** _____**NO** IF **YES**, please explain:_____
_____

Do you smoke? _____**YES** _____**NO** IF **YES**, how much?_____

Do you drink alcohol? _____**YES** _____**NO** IF **YES**, how much?_____

Do you or have you ever used recreational drugs? _____**YES** _____**NO** IF **YES**, type and when:_____

If employed, how many hours a week do you work?_____

_____ _____
Signature Date

11/18

VICTOR A. CROSBY M.D.

PAYMENT POLICY

Thank you for choosing Dr. Crosby for your Ophthalmology care.

We participate with Medicare, Medicaid, Blue Cross PPO, HMO, POS, United Healthcare, and many other health plans. Please call your insurance company to verify your benefits and our participation with your insurance company. If we do not participate with your company, payment is due at the time of service. In the event that we file your insurance and our office does not get a response from your insurance company within 45 days, you will be billed for the balance due.

We require payment at the time of service for co-pays, refractions and deductibles. We accept cash, checks, Visa, MasterCard and Discover.

Any amount that is past due more than 60 days; and, we have been unable to contact you either by phone or mail, will be turned over to a collection agency. All charges from the agency to collect this debt will be added to the balance due.

Fraudulent checks will be accessed a $30 bank return check fee. The total balance due must be paid in cash.

SIGNATURE:_____ DATE:_____

VICTOR A. CROSBY, M.D.

REFRACTION POLICY

A refraction is a measurement of the lens power necessary to prescribe glasses or corrective lenses. Most medical insurance plans, including Medicare, DO NOT cover routine refraction's or routine eye examinations (when no medical eye problem is known or suspected). Medicare, and most medical insurance plans, allow that we charge separately for that portion of the examination, since it is not a covered service.

If you have any questions regarding Medicare, insurance policies, and procedures, please do not hesitate to ask. We will do our best to assist you.

By signing this I understand that I am responsible for the refraction charge of $40.00 that is stated in the above policy.

SIGNATURE: _____ **DATE:**

11/2018

VICTOR A. CROSBY, MD

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 needed to treat you, obtain payment for services, for health care operations and for other purposes permitted by law. The term "protected health information" means any information about you, including information that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

The practice provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our practice is required to comply with the terms of this Notice of Privacy Practices.

This Notice of Privacy Practices will apply to:

- Any health care professional authorized to enter information into your chart (including physicians, PAs, RNs, etc.);
- All areas of the Practice (front desk, administration, billing and collection, etc.);
- All employees, staff and other personnel that work for or with our Practice;
- Our business associates (including a billing service, or facilities to which we refer patients), on-call physicians, and so on.

Changes To Our Notice Of Privacy Practices The practice may change the terms of this Notice at any time. The new notice will be effective for all protected health information that we maintain at that time with the last revision date in the lower left corner. The current notice will always be posted in our office. To request a revised Notice of Privacy Practices you may:

1. Call the office at 706-546-0170 and request a copy be sent to you at your mailing address or e-mail address
2. Ask for a copy at your next visit to our office

Our Commitment To You: We understand that your medical information is personal to you, and we are committed to protecting the information about you. You should be comfortable in sharing any information about your health with your doctor in order to help him/her provide the most appropriate health care. As our patient, we create paper and electronic medical records about your health, our care for you, and the services and/or items we provide to you as our patient. We need this record to provide for your care and to comply with certain legal requirements.

All of our medical and administrative staff understands that the practice is required by law to:

- make sure that the protected health information about you is kept private;
- provide you with a Notice of our Privacy Practices and your legal rights with respect to protected health information about you; and
- follow the conditions of the Notice that is currently in effect.

How Your Medical Informations May Be Used Or Disclosed: We will use your medical information as part of rendering patient care. This explanation is provided only to help you understand how the practice may use or disclose your protected information in compliance with any authorizations or consents required by law. . For example, your medical information may be used for:

Medical Treatment. We will use medical information about you that was on file prior to this notice or which may be obtained after this the date of this Notice to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with others that have already obtained your permission to have access to your protected health information. Therefore, we may disclose medical information about you to doctors, nurses, laboratory or imaging technicians, medical students, hospital or home health personnel who are involved in taking care of you. We may also disclose information to other doctors who may be treating you or to who we may refer you for care. These doctors may need information from your medical record to provide appropriate care.

Different areas of our practice also may share medical information about you including your record(s), prescriptions, requests for lab work and x-rays. We may also discuss your medical information with you to recommend possible treatment options or alternatives that

may be of interest to you. We also may disclose medical information about you to people outside our practice who may be involved in your medical care after you leave the practice; this may include your family members, or other personal representatives authorized by you or by a legal mandate (a guardian or other person who has been named to handle your medical decisions, should you become incompetent).

Payment. We may use and disclose medical information about you to for services and procedures so they may be billed and collected from you, an insurance company, or any other third party. For example, we may need to give your health care information, about treatment you received at the Practice, to obtain payment or reimbursement for the care. We may also tell your health plan and/or referring physician about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment, to facilitate payment of a referring physician, or the like.

Health Care Operations. We may use and disclose medical information about you so that we can run our Practice more efficiently and make sure that all of our patients receive quality care. These uses may include reviewing our treatment and services to evaluate the performance of our staff, deciding what additional services to offer and where, deciding what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. When business associates are used, we will advise them of their continued obligation to maintain the privacy of your medical records.

Appointment and Patient Recall Reminders. We may ask that you sign in at the Receptionists' Desk, a "Sign In" log on the day of your appointment with the Practice. We may use and disclose medical information to contact you as a reminder that you have an appointment for medical care with the Practice or that you are due to receive periodic care from the Practice. This contact may be by phone, in writing, e-mail, or otherwise and may involve the leaving an e-mail, a message on an answering machines, or otherwise which could (potentially) be received or intercepted by others. Please let us know, in writing, if this is not acceptable or if there is another telephone number, e-mail address, or method of notification you prefer.

Emergency Situations & Disaster Relief. In addition, we may disclose medical information about you to an organization assisting in a disaster relief effort or in an emergency situation so that your family can be notified about your condition, status and location.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes regarding medications, efficiency of treatment protocols and the like. All research projects are subject to an approval process, which evaluates a proposed research project and its use of medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We will obtain an Authorization from you before using or disclosing your individually identifiable health information unless the authorization requirement has been waived. If possible, we will make the information non-identifiable to a specific patient. If the information has been sufficiently de-identified, an authorization for the use or disclosure is not required.

Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. Law or public policy may require us to disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Investigation and Government Activities. We may disclose medical information to a local, state or federal agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the payor, the government and other regulatory agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. This is particularly true if you make your health an issue. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We shall attempt in these cases to tell you about the request so that you may obtain an order protecting the information requested if you so desire. We may also use such information to defend ourselves or any member of our Practice in any actual or threatened action.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the Practice; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the Practice to funeral directors as necessary to carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager, who will direct you on how to file an office complaint. All complaints must be submitted in writing, and all complaints shall be investigated, without repercussion to you.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission, unless those uses can be reasonably inferred from the intended uses above. If you have provided us with your permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

01/01/2012

VICTOR A. CROSBY, M.D.
OPHTHALMOLOGY

NOTICE OF PRIVACY PRACTICES:

ACKNOWLEDGEMENT OF RECEIPT

By signing this form you acknowledge you have had the opportunity to view the *Notice of Privacy Practices of Victor A. Crosby, M.D., l*ocated in our lobby. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Should you like a copy, please ask the receptionist and we will be happy to provide you with a copy.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting the office at 706-546-0170.

Should you have any questions regarding the *Notice of Privacy Practices*, please contact our office at 706-546-0170.

I acknowledge receipt of the *Notice of Privacy Practices of Victor A. Crosby, M.D.*

Signature:_____ Date:_____
(patient/parent/conservator/guardian)

CONSENT FOR DISCLOSURE TO FAMILY MEMBERS OR PERSONAL REPRESENTATION

I have agreed to let certain individuals participate in discussions and decisions related to my medical care. Therefore, I hereby give my permission to Dr. Crosby and his staff to disclose my personal medical and financial information to the following individual(s). (This includes discussion of account information, making of appointments, prescriptions concerns, etc.)

Names: _____ Relationship:_____

Names: _____ Relationship: _____

Names: _____ Relationship: _____

Conditions for Disclosure (check the item(s) that apply):

----- The practice may disclose information to the individual(s) above **only** in my presence.

----- The practice may disclose information to the individual(s) above in discussion in my presence and when I am not physically present, including disclosures by telephone, facsimile, or mail.

----- Other conditions:_____

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual(s) acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgment, and the reason why the acknowledgment was not obtained:

Signature of provider representative: _____Date:_____

_____