Keystone Eye Care Group
Zodiac Optical

1600 6th Ave Professional Center, Suite 113, York PA, 17403 ~ (717) 718-2EYE (2393)

Today's Date ____________ Patient ID # ____________ HIPAA Signed YES______ NO______

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How did you hear about us? ____Newspaper ____Friend/Relative ____Primary Doctor* ____Optometrist*

*Referring Doctor ____________ Reason For Visit ______Routine ______Problem ______Other

Patient Name ____________ Prefer To Be Called ____________
LAST FIRST MIDDLE

Address ____________ Home Phone ____________

City ____________ State ______ Zip ______ Cell Phone ____________

Patient Social Security # ____________ Office Phone ____________

Birthdate______/______/______ Age______ Race______ Marital Status S M D W Sep
MONTH DAY YEAR

Employer ____________ Address ____________

Spouse/Guardian Name ____________ Telephone # ____________

Address ____________ City ____________ State ______ Zip ______

Name, Address & Phone of your Medical Doctor ____________

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In case of Emergency:

Contact Name ____________ Phone # ____________ Relationship ____________

Primary Insurance	**Secondary Insurance**
Name of Insurance Co:____________	**Name of Insurance Co:**____________
ID#:____________**Group#:**____________	**ID#:**____________**Group#:**____________
Responsible Party Name/Address:____________ ____________	**Responsible Party Name/Address:**____________ ____________
Responsible Party SS#:____________	**Responsible Party SS#:**____________
Responsible Party Birthdate:____________	**Responsible Party Birthdate:**____________
Responsible Party Telephone#:____________	**Responsible Party Telephone#:**____________
Relationship to patient: ____________	**Relationship to patient:** ____________

Do you have a Vision Plan with your current insurance coverage? Yes______ No______

____________ Signature of Patient ______ Date ____________ Signature of Responsible Party ______ Date
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Keystone Eye Care Group
Zodiac Optical

Effective Date: December 12, 2005

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how to get access to this information. If you have any questions regarding this notice, you may contact our privacy officer at: Keystone Eye Care Group, 1600 6th Avenue Professional Center, Suite 113, York, PA 17403. Phone: 717-718-2393 or via Fax: 717-718-7150.

I. Your protected Health Information

Keystone Eye Care Group is required by HIPAA – The Privacy Act to maintain the privacy of your health information that is protected by HIPAA – The Privacy Act, and to provide you with notice of our legal duties and privacy practices with respect to your protected health care information. We are required to abide by the terms of the notice currently in effect.

Generally speaking, your protected health information is any information that relates to your past, present or future physical or mental health or condition, the provision of health care to you, or payment for health care provided to you, and individually identifies you or reasonably can be used to identify you.

Your medical and billing records at our practice are examples of information that usually will be regarded as your protected health information.

II. Uses & Disclosures of your Protected Health Information

A. Treatment, Payment, and Health Care Operations – This section describes how we may use and disclose your protected health information for treatment, payment, and health care operations purposes. The descriptions include examples. Not every possible use or disclosure for treatment, payment, and health care operations purposes will be listed.

1. Treatment – We may use and disclose your protected health information for our treatment purposes as well as the treatment purposes of other health care providers. Treatment includes the provision, coordination, or management of health care services to you by one or more health care providers. Some other examples of treatment uses and disclosures include:

- We may page you in the reception area when it is time for you to go to an examining room.
- We may contact you to provide appointment reminders.
- We may transport your medical records to the hospital if you are being treated there for any reason.
- We will make every effort to ensure that other patients do not overhear our discussions with you about your healthcare while you are in our office.

2. Payment – We may use and disclose your protected health information for our payment purposes as well as the payment purposes of other health care providers and health plans. Payment uses and disclosures include activities conducted to obtain payment for the care provided to you or so that you can obtain reimbursement for that care, for example, submission of a claim form to your health insurer.

3. Health Care Operations – We may use and disclose your protected health information for our health care operation purposes as well as certain health care operation purposes of other health care providers or health plans. Some examples of health care operation purposes include:

- Quality assessment and improvement activities
- Health care fraud and abuse detection and compliance programs

We may use and disclose your protected health information for other purposes. This section generally describes those purposes by category.

1. Individuals involved in care or payment for care – such as a spouse, a family member, or a close friend. For example, if you have surgery, we may discuss your physical limitations with a family member assisting in your post-operative care.

2. Notification purposes – to notify a family member, a personal representative, or another person responsible for your care regarding your location, general condition, or death.

3. Required by law or law enforcement purposes – when required by federal, state, or local law. For example, we may disclose protected health information in response to a court order.

4. Public health activities – for example, filing communicable disease reports with public health agencies.

5. Business associates – certain functions of the practice performed by a business associate such as a consulting firm, an accounting firm, or a law firm. We may disclose protected health information to our business associates and allow them to create and receive protected health information on our behalf. For example, we may share with our consultants the information contained in your record for the purpose of medical chart reviews.

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Notice of Privacy Practices

III. Patient Privacy Rights

A. Further Restriction On Use or Disclosure – You have a right to request that we further restrict use and disclosure of your protected health information to carry out treatment, payment, or health care operations, to someone who is involved in your care or the payment for your care, or for notification purposes. We are not required to agree to a request for a further restriction.

To request a further restriction, you must submit a written request to our privacy officer. The request must tell us: (a) what information you want restricted; (b) how you want the information to be restricted; and (c) to whom you want the restriction to apply.

B. Confidential Communication – You have a right to request that we communicate your protected health information to you by a certain means or at a certain location. For example, you might request that we only contact you by mail or at work. We are not required to agree to requests for confidential communications that are unreasonable.

To make a request for confidential communications, you must submit a written request to our privacy officer. The request must tell us how or where you want to be contacted. In addition, if another individual or entity is responsible for payment, the request must explain how payment will be handled.

C. Accounting of Disclosures – You have a right to obtain, upon request, an "accounting" of certain disclosures of your protected health information by us (or a business associate for us). This right is limited to disclosures within six years of the request and other limitations. Also, in limited circumstances we may charge you for providing the accounting. To request an accounting, you must submit a written request to our privacy officer. The request should designate the applicable time period.

D. Inspection and Copying – You have a right to inspect and obtain a copy of your protected health information that we maintain in a designated records set. This right is subject to limitations and we will impose a charge for the labor and supplies involved in providing copies.

To exercise your right of access, you must submit a written request to our privacy officer. The request must:
(a) describe the health information to which access is requested; (b) state how you want to access the information, such as inspection, pick-up of copy, mailing of copy; (c) specify any requested form or format, such as paper copy or an electronic means, and (d) include the mailing address, if applicable.

E. Right To Amendment – You have a right to request that we amend protected health information that we maintain about you in a designated records set if the information is incorrect or incomplete. This right is subject to limitation. To request an amendment, you must submit a written request to our privacy officer. The request must specify each change that you want and provide a reason to support each requested change.

F. Paper Copy of Privacy Notice – You have a right to receive a paper copy of our Notice of Privacy Practices. To obtain a paper copy, contact our privacy officer.

IV. Changes To This Notice

We reserve the right to change this notice at any time. We further reserve the right to make any changes effective for all protected health information that we maintain at the time of the change – including information that we created or received prior to the effective date of the change.

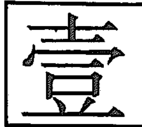
We will post a copy of our current notice in the reception area of the practice. At any time, patients may review the current notice by contacting our privacy officer.

V. Complaints

If you believe that we have violated your privacy rights, you may submit a complaint to the practice or the Secretary of Health and Human Services. To file a complaint with the practice, submit the complaint in writing to our privacy officer. We will not retaliate against you for filing a complaint.

VI. Legal Effect of This Notice

This notice is not intended to create contractual or other rights independent of those created in HIPAA – The Privacy Act.



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York, PA 17403
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ACKNOWLEDGEMENT OF RECEIPT OF KEYSTONE EYE CARE GROUP'S NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of Keystone Eye Care Group's Notice of Privacy Practices.

______________________	______________________	______________
Name (Print)	Signature	Date

Keystone Eye Care Group Use Only

Date acknowledgement received: ________________ Initials: ________________

-OR-

Reason acknowledgement was not obtained:

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Keystone Eye Care Group Financial Policy

We appreciate you choosing Keystone Eye Care Group. Please take a moment to review the financial policy statement and sign the back of this form.

- Please provide our office with complete information on your medical and Vision plan insurances including primary and secondary insurances. You need to let us know which one are your primary and secondary insurances.
- You need to provide us with any changes in your insurances as soon as possible.
- Your bill is based on the services you received. You are responsible for paying the bill if your insurance company does not cover all the costs.
- What your health insurance covers is based on an agreement between you and the health insurance company you have received or purchased it yourself.
- You need to contact your insurance company with any questions about what they will cover.
- **If you have financial hardships you need to contact us at once so we can help you with this problem. We will help you arrange a budget plan.**
- Any bill not paid by the due date is sent to a collection agency.
- Some insurance have a deadline to submit and follow up on unpaid claims. If you failed to correct your information with us and/or your health insurances, we will be denied payments. If we are denied payments due to your negligence, you will be responsible for paying your bills even if you had the coverage.
- **If your insurance have been cancelled on the day of service and you failed to inform us and the service was provided, then you will be responsible for your bills.**
- **Insurances that requires referral.** Referral from your primary medical doctor is mandatory for us to be paid. It is your responsibility to get your referral from them. If payment is denied because you did not get the referral then you will be held responsible for your bills. Please let the front desk staff know that you have brought the referral with you and please give it to them. You will be rescheduled if you do not have a referral.

IF YOU DO NOT HAVE HEALTH INSURANCE

Your Responsibility

- You must pay your entire bill at the time of service

Our Responsibility

- Keystone Eye Care Group will provide services you need, even if you cannot pay. We will not provide services if you are able to pay but chose not to pay.
- We are willing to talk to you about ways to pay, if you cannot pay the full amount.

IF YOU HAVE HEALTH INSURANCE

We participate with many insurance companies. This means we will Submit claims for you. However, we cannot guarantee that all services We provide are covered. Some services may not be covered with your Insurance company and you need to call them for your coverage.

Your Responsibility

- You must pay any co-payment at the time of service.
- You must pay any deductible amount or any amount that you know is not covered at the time of service.
- You must pay any amount not paid by your insurance within 20 days of getting your bill.

Our Responsibility

- We will send bill to your insurance company for all services rendered by our practice.

IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE PLAN

Your Responsibility

- You must pay for the service at the time it is given.

Our Responsibility

- After you have paid us, we will send your bill to your insurance company. Your insurance will then pay you.

We accept Cash, Checks, Bank drafts, Visa and MasterCard payments. We will charge you $ 25 fee for returned checks. All unpaid balances must be paid in 20 days. Overdue payments will be turned over to a collection agency. If Keystone Eye Care Group needs to use a collection agency or attorney to collect the unpaid amount, the patient may be charged for all fees and costs to Keystone Eye Care Group either by us or the agency or attorney.

Statement of Financial Responsibility:

I am a patient of Keystone Eye Care Group and I have read and understood the financial policy as outlined above. I agree to receive services from this practice and agree to pay any charges that I am responsible or charges that is not paid by my insurances or any other party.

Signature:____Date:____________

Keystone Eye Care Gr
Zodiac Optical

Patient Name:________________________ **Date:**____________

Please list your eye problems for today's visit: ________________________

____

Who is your current eye doctor? ____________ Date of your last Eye Exam? ____________

How old are your current glasses? ____________ Any problems with your current glasses? Yes ______ No ______

Do you wear contacts? ____________ Do you wear Sun Glasses? ____________

When do you wear your glasses? Please circle them below.

Driving Computer Work While Watching T.V. Near Work All the time

Your Eye History

~Glaucoma	Yes ______	No ______
~Cataract	Yes ______	No ______
~Diabetic Retinopathy	Yes ______	No ______
~Dry Eyes	Yes ______	No ______
~Macular Degeneration	Yes ______	No ______
~Color Blindness	Yes ______	No ______
~Strabismus	Yes ______	No ______
~Amblyopia (Lazy Eye)	Yes ______	No ______
~Cross Eyed	Yes ______	No ______
~Eye Tumor	Yes ______	No ______

~Retinal Detachment Yes ______ No ______
*If Yes, Which Eye/When? ____________
~Corneal Abrasion/Injury Yes ______ No ______
*If Yes, Which Eye/When? ____________
~Blindness Yes ______ No ______
*If Yes, When/How? ____________
~Eye Injury Yes ______ No ______
*If Yes, Which Type/When? ____________
~Other ____________

____

Your Medical History

~Diabetes	Yes ______	No ______
~Heart Disease	Yes ______	No ______
~Kidney Disease	Yes ______	No ______
~Rheumatoid Arthritis	Yes ______	No ______
~ Hepatitis	Yes ______	No ______
~ HIV /AIDS	Yes ______	No ______
~Cancer	Yes ______	No ______

*If Yes, Which Type? ____________

~High Blood Pressure	Yes ______	No ______
~High Cholesterol	Yes ______	No ______
~Lupus	Yes ______	No ______
~Sarcoidosis	Yes ______	No ______
~Lung Disease	Yes ______	No ______
~Stroke	Yes ______	No ______

*If Yes, When? ____________
~Other Disease(s) ____________
~ Tobacco /Alcohol Use Yes____No_____

Not just pertaining to eyes
List all your previous surgery: ________________________

____

List all your medications: ________________________

____

____

List all your allergies: ________________________

Family History: **Is there a history of any of the above diseases in your family? If yes, please list them here.**

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