Carolina Cataract & Laser Center, P.A.

4700 Falls of Neuse Road • North Tower Suite 180 • Raleigh, NC 27609 • 919-862-9090 • 919-862-9011 fax

Today's Date: _____

PATIENT INFORMATION

Patient Name (Last)	First	MI	Name Normally Used (Nickname)

Mailing Address	City	State	Zip Code

Home Phone (Area Code and Phone #)	Cell Phone (Area Code and Phone#)	Work Phone (Area Code and Phone#)

Patient's Date of Birth	Sex	Marital Status	Social Security Number	Email Address

Ethnicity: ☐Hispanic ☐Non Hispanic

Preferred Language: ☐English ☐Spanish ☐Other:

Race: ☐White/Caucasian ☐Hispanic ☐African American ☐American Indian ☐Asian Indian ☐Chinese ☐Japanese ☐Korean ☐Vietnamese ☐Filipino ☐Other Asian ☐Native Hawaiian ☐Other

EMERGENCY INFORMATION

Emergency Contact Name	Relationship	Phone Number (If Spouse, please put Spouse's Cell Phone)

Occupation (Patient)	Patient's Employer	Employer Address

Name of Last Eye Doctor Seen Area Code and Phone # ( ) Address	Name of Last Medical Doctor Area Code and Phone # ( ) Address

PHARMACY YOU PREFER TO USE

Name	Address	Phone

HOW DID YOU HEAR ABOUT CCLC (PLEASE CHECK ONE BELOW)

_____Optometrist/Ophthalmologist (Name_____)

_____Medical Doctor (Name_____)

_____Previous Patient _____Family Member _____Friend

_____Insurance Company _____Yellow Pages _____Newspaper _____Internet

Carolina Cataract & Laser Center, P.A.

Clinical Financial Policy for Patient Issue

Thank you for choosing **CCLC** as your healthcare provider. We are committed to providing you with the best possible medical care at the lowest possible cost. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

In order to achieve the practice goals of providing the finest medical care at the lowest possible cost, we need your assistance, and your understanding of our payment policy.

Full Payment for professional services is due at the time of service. We accept cash, checks, Visa, MasterCard, etc. We also offer an extended payment plan with prior approval. We do accept Medicare assignment. We participate with Medicaid and various other insurance companies.

All patients must complete our Patient Information and Insurance Form before seeing the physician.

In order to keep our fees to a minimum, we require that you make available to our office any and all insurance information on the date of treatment. All patients who have accounts with outstanding balances will have statements mailed on a monthly basis to their permanent address. You must remember that you are responsible for the bill unless special arrangements have been made and approved on your behalf. If special arrangements are made, a financial form must be completed, signed, and witnessed by a representative of Carolina Cataract & Laser Center, P.A.

If you have insurance we are anxious to help you receive your maximum allowable benefits and we will file the claim as a courtesy to you. Any insurance remittance will be posted to your account and you will be billed for the balance. Your insurance policy is a contract between you and your insurance company. If an insurance problem occurs, you will be asked to assist us in contacting your insurance carrier. We feel that it is necessary for us to work together to resolve any insurance problem. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to a statement bill and mailed to you. In regards to insurance plans where we are a participating provider, all co-pays and deductibles are due the day of treatment. We will file a follow up on the claims for a reasonable amount of time as the contract directs.

Your employer or group plan administrator can only address any insurance coverage issues. Our staff is trained to help you with issues such as how your claim was filed and additional information the carrier might need to process your claim.

Our practice believes that a good physician/patient relationship is based upon understanding and good communication. Thank you for understanding our Financial Policy. If you have any questions about financial arrangements, please feel free to talk with the appropriate staff regarding this matter. We will make every effort available to you to clarify any questions that you may have concerning your balance.

Please list your insurance company/companies below:

_____

_____

_____**Medicare Patients:** The information that we obtain is used to identify you and to determine your eligibility. It is also used to decide f the services and supplies you received are covered by Medicare and to insure that proper payment is made. I authorize the holder of medical information about me to release to Medicare and/or it's agents the information needed to determine benefits on my behalf. I do understand that Carolina Cataract & Laser Center, P.A. does accept Medicare assignment and that I am responsible for any deductibles, co-insurance and non covered services.

_____**Treatment:** I authorize Dr. Vincent Dahringer to give me treatment according to proper medical care standards.

_____By signing this form, I authorize release of any medical information necessary to process my insurance claims. My signature means that I request Medicare, Medigap or any other insurance company listed above to make payment directly to Dr. Vincent Dahringer at Carolina Cataract & Laser Center, P.A.

I have read, understand, and agree to this Financial Policy:

_____ _____

Signature of Patient or Responsible Party **Date**

Carolina Cataract and Laser Center, P.A.

NOTICE OF PRIVACY PRACTICES THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY ME USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CARFULLY.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this Note of Privacy Practices will be made only with authorization from the individual.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the Practice or the hospital. For example: we may disclose medical information about you to people outside the Practice who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations: We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the Practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students and other Practice personnel for review and learning purposes. For example: we may review your record to assist our quality improvement efforts.

WHO WILL FOLLOW THIS NOTICE. This notice describes our Practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other Practice personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with the quality care and to comply with certain legal requirements. This notice applies to all of

the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to or for: coroners, medical examiners and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donations; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for an amendment.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Removal from Fundraising Communications. You have the right to opt out of receiving fundraising communications from the Practice.

Right to Restrict Disclosures to Health Plan. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of health care operations and pertains to a health care item or service for which the individual has paid out of pocket in full.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the Practice's waiting room.

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 the Privacy Officer at 919-862-9090, 4700 Falls of the Neuse Rd, Suite 180, Raleigh, NC 27609. All complaints must be submitted in writing. 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 use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission in writing at any time. If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that I have received the **Notice of Privacy Practices and Notice of Individual Rights.**

_____ _____

Patient or Patient's Personal Representative Date