Rowan Eye center

New Patient Forms

For Office Use Only
Patient Chart Number _____

Thank you for choosing the Rowan Eye Center for your ophthalmic care. The staff makes every effort to provide you with personalized service while ensuring compliance with HIPPA guidelines. To better serve you, please fill out the following forms to the best of your ability.

Patient Information

1. Patient's Name: _____
   First Middle Last
2. Patient Information Only:
   a. Patient's Address: _____
   Number and Street
   _____
   City State Zip
   b. Patient's Sex: (Please check.) ☐ Male ☐ Female
   c. Patient's Home Phone: (_____) _____
   d. Patient's Work Phone: (_____) _____
   e. Patient's Mobile Phone: (_____) _____
   f. Patient's Email: _____
   g. Patient's Marital Status: (Please check one.)
   ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed
   h. Patient's Date of Birth: _____
   i. Patient's Social Security Number: _____
3. Do you have a legal guardian or does someone other than yourself have power of attorney? (Please check.)
   ☐ Yes (If yes, please continue) ☐ No

4. Legal Guardian Information Only:
   a. Legal Guardian's Name: _____
   First Middle Last
   b. Legal Guardian's Address: _____
   Number and Street
   _____
   City State Zip
   c. Legal Guardian's Sex: (Please check.) ☐ Male ☐ Female
   d. Legal Guardian's Date of Birth: _____
   e. Legal Guardian's Social Security Number: _____
   f. Legal Guardian's Home Phone: (_____) _____

Please check one box and proceed to Page 3.

Referrals

5. How were you referred to the Rowan Eye Center?

_ Billboard

_ Emergency Room

_ Insurance Company

_ Medical/Osteopathic Physician (MD/DO) My referring physician is Dr._____
First Name Last Name

_ Neighbor

_ Optometrist (OD) My referring physician is Dr._____
First Name Last Name

_ Pasco Medical Guide 2008

_ Patient

_ Queen of Peace Newsletter

_ Radio Advertisement

_ St. Pete Times

_ St. Vincent de Paul Newsletter

_ Suncoast News

_ Television Advertisement

_ Village Lantern

_ Website

_ Yellow Pages

_ Other (Please specify.)_____

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New Patient Forms

Please Sign at Arrows

PERMISSION FOR TREATMENT

I, understand and hereby voluntarily consent to medical care/diagnostic treatment and or minor surgical treatment by **Rowan Eye Center, Inc.** as deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of any of my past/current medical records for treatment purposes at the Rowan Eye Center. Our primary concern as your healthcare provider is to provide you with the best possible care. Follow-up visits and services for treatment of your medical problems are scheduled to provide that care. On occasion, your insurance company may limit the number of visits, services, or drugs for which it will reimburse. However, more frequent visits and services, or specific drugs may be needed to properly treat your condition. Your insurance company may consider these visits, services or specific drugs "not reasonable and necessary" under your policy, and may deny payment for them.

In particular, please note that the annual exam is considered by insurance companies to be a health screening and wellness visit. Many patients, quite logically, use this visit to discuss other problems, such as visual abnormalities, eyelid abnormalities, skin cancer concerns, and many others. There are proper billing codes to reflect these additional services, which we will submit. Some health plans, however, will not cover additional services which may be ultimately denied by the insurer for this visit. Unfortunately, we are unable to verify ahead of time whether or not charges for these services will be covered or denied by your insurer. Some insurance plans will cover the additional services only if performed in a separate visit. You have the option to schedule a separate appointment to discuss these issues with your physician. However, unless you instruct us otherwise, we assume that you wish to have all the issues addressed at this time, and are happy to do so, if the schedule permits. Thus we will proceed accordingly. Please be aware, however, that if your health plan denies payment for these services, payment of these charges will be your responsibility. Since we believe each scheduled visit and service provided in our office is both reasonable and necessary, we will try to assist you in collecting these charges from your insurance company in the event that payment is denied. However, you will be personally responsible for payment if your insurance requires that you indicate your agreement by reading and signing the following paragraph:

"I have been informed by Rowan Eye Center, Inc. that my insurance may deny payment for services provided to me today. Since both Rowan Eye Center, Inc. and I believe these services are necessary for the proper treatment of my condition, I agree to be personally and fully responsible for payment of these services in the event my insurance does deny payment."

➤ Signature: _____ Date: _____

AUTHORIZATION AND ASSIGNMENT

I request that the payment of Authorized Medicare/Insurance Benefits be made either to me or on my behalf for any services furnished by Rowan Eye Center, Inc. I authorize any holder of medical information about me to release to CMS/Insurance Carriers and its agents any information needed to determine these benefits or benefits related to services. I hereby authorize Rowan Eye Center, Inc. to furnish information to Medicare/Insurance carriers concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize (assign) my insurance carrier (S)/Medicare to make payment directly to Rowan Eye Center, Inc. for medical/diagnostic/surgical benefits payable for the ser ices rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or other insurance carriers do not cover all office services/procedures. I agree to take full responsibility for any unpaid balances that such payment will be made to this physician's office for services. I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status or other personal information.

➤ Signature: _____ Date: _____

DESIGNATED RELATIVE

I authorize discussion of my general medical condition, diagnosis, treatment, payment and healthcare operations with my:

_ Spouse _ Children _ Other _____

Please list the family member or significant others, if any, whom we may inform about your medical condition.

NAME_____ PHONE NUMBER _____

NAME _____ PHONE NUMBER _____

PRIVACY NOTICE

I have received a copy of Rowan Eye Center, Inc.'s office privacy notice as required by HIPAA.

➤ Signature: _____ Date: _____

Rowan Eye center

Carey T. Rowan, M.D.
Board Certified Ophthalmologist
General Ophthalmology
Cataract & Laser Surgeon

Advanced Beneficiary Notice (ABN)

Patient Name _____ Date _____

NOTE: You need to make a choice about receiving certain health care services. We expect that your insurance will not cover all services rendered. The fact that your insurance may not cover all services does not mean you should not receive it. There may be a good reason your doctor has recommended it.

The purpose of this form is to help you make an informed choice about whether or not you want to receive these service(s), knowing that you may have to pay for them yourself. Before making your decision, read this letter carefully, ask us to explain if you don't understand, and ask the cost of each test.

Patients: Please see list of non-covered services. There are several diagnostic tests that are not part of the routine eye exam.

Your insurance does not cover the following diagnostic tests. If necessary you will be notified before it is done.

Refraction. Cost $42.00 flat fee. The process to determine the eye's need for corrective glasses.
It is an essential part of an eye examination, but it is NOT a covered service by most insurance companies, including Medicare. This fee is collected in addition to the patient's co-pay.

Schirmer Test. Cost $35.00 flat fee. If your complaint is dry eyes symptoms such as burning, excessive tearing, foreign body sensation, transient blurring of vision.
The test is to measure tear production coming from secretion glands, to determine if you are deficient in the proper type of tear production. Please note you may have dry eye syndrome even if your eyes are watering.

Pachymeter. Cost $45.00 flat fee. The process of measuring the thickness of the cornea.

Prism Exam. Cost $75.00 flat fee. If you are experiencing double vision.
A prism exam may be done in order to determine the amount of imbalance there is between each eye.

External Photos. Cost $100.00 flat fee.

PLEASE NOTE: This is a list of diagnostic testing, most procedures either in office or outpatient will require authorization from certain insurances.

Please choose one option:

- ❑ Option 1. Yes. I want to receive these services. I understand that my insurance may not cover all services rendered and I will be responsible for any costs out of pocket. A claim will be sent to my insurance company and I will be responsible and billed for any services that are not covered.
- ❑ Option 2. No. I have decided not to receive these services.

Patient's Signature _____ Date _____

5305 Grand Boulevard • New Port Richey, FL 34652 • (727) 847-0889 • (800) 785-4108 • Fax (727) 846-8458
www.RowanEyeCenter.com

Rowan Eye center

Carey T. Rowan, M.D.
Board Certified Ophthalmologist
General Ophthalmology
Cataract & Laser Surgeon

John M. Erhart, M.D.
Board Certified Ophthalmologist
General Ophthalmology

NOTICE OF HEALTH INFORMATION 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

Understanding Your Health Record/Information
This notice describes the practices of the Rowan Eye Center with respect to your protected health information created while you are a patient at the Rowan Eye Center. Dr. Rowan and all personnel authorized to have access to your medical chart are subject to this notice.

We create a record of the care and services you receive at the Rowan Eye Center. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the records of your care at the Rowan Eye Center.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your right and certain obligations we have regarding the use and disclosure of medical information.

Your Health Information Rights
Your health record is the physical property of the Rowan Eye Center. You have certain rights regarding the information maintained in the record:

- Request a restriction on certain uses and disclosures of your information for treatment, payment, health care operations and as to disclosures permitted to persons, including family members involved with your care and as provided by law. However, we are not required by law to agree to a requested restriction;
- Obtain a paper copy of this notice of information practices;
- Inspect and request a copy of your health record as provided by law;
- Request that we amend your health record as provided by law. We will notify you if we are unable to grant your request to amend your health record;
- Obtain an accounting of disclosures of your health information as provided by law;
- Request communication of your health information by alternative means or at alternative locations. We will accommodate reasonable requests; and
- Revoke your consent or authorization to use or disclose health information except to the extent that action has already been taken in reliance on your consent or authorization.

You may exercise your rights set forth in this notice by providing a written request, except for requests to obtain a paper copy of the notice, to the practice manager at the Rowan Eye Center.

Our Responsibilities

In addition to the responsibilities set forth above, we are also required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on certain uses and disclosures;
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change. Should our information practices change we are not required to notify you, but we will have the revised notice available for you to request at the Rowan Eye Center. The revised notice will also be posted at the Rowan Eye Center.
- We will not use or disclose your health information without your written authorization, except as described in this notice.

Examples of Disclosures for Treatment, Payment, Health Care Operations and As Otherwise Allowed By Law

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information should fall within one of the categories.

We will use your health information for treatment.

For example: We may disclose medical information about you to doctors, nurses, technicians, or other personnel who are involved in taking care of you at the Rowan Eye Center. We may share medical information about you in order to coordinate different treatments, such as prescriptions, lab work and imaging. We may also provide your physician or a subsequent health-care provider with copies of various reports to assist in treating you once you are discharged from care at the Rowan Eye Center. We also may disclose medical information about you to people outside the 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.)

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health care operations.

For example: We may use the information in your health record to assess the care and outcome in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

We will use your health information as otherwise allowed by law. The following are some examples of how we may use or disclose medical information about you.

Business associates: There are some services provided in our organization through agreements with business associates. Examples include a transcription service and a laboratory. To protect your health information, however, we require business associates to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Research: We may disclose information to researchers when the research has been approved by the Rowan Eye Center review board that has reviewed the research proposal and established protocols to protect the privacy of your health information.

Communications for treatment and health care operations:

We may contact you to provide information about treatment alternatives or other health related benefits and services that may be of interest to you. 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, or otherwise and may involve the leaving of a message on an answering machine, or otherwise which could (potentially) be received or intercepted by others.

Food and Drug Administration (FDA):

We may disclose to the FDA health information relative to adverse events with respect to food, medications, devices, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Worker's compensation:

We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Public health:

As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability. 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.

Abuse, neglect or domestic violence:

As required by law, we may disclose health information to a governmental authority authorized by law to receive reports of abuse, neglect, or domestic violence.

Judicial, administrative and law enforcement purposes:

Consistent with applicable law, we may disclose health information about you for judicial, administrative and law enforcement purposes.

Required or allowed by law:

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

For more information or to report a problem:

If you have questions and would like additional information, you may contact the practice manager or the medical records manager at the Rowan Eye Center at:

5305 Grand Blvd.
New Port Richey, FL 34652
Telephone: 727-847-0889

If you believe your privacy right have been violated, you may file a complaint with the practice manager or the medical records manager at the Rowan Eye Center or with the Secretary of Health and Human Services.
There will be no retaliation for filing a complaint.