Patient Registration

Patient Name: _____ SS#: _____-_____-_____

Home Phone: _____ Cell Phone:_____

Date of Birth: _____ Age: _____ Gender at Birth: ☐ Male ☐ Female

Address: _____ City: _____ State: ___ Zip: _____

E-mail Address: _____@_____.com

Appointment Reminder Preference: ☐ Phone ☐ Email ☐ Text

Occupation: _____ Work Phone: _____Retired: Y N

~ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Student

~ May we leave messages on your home phone? (circle) Y N Cell phone? Y N

~ Who should we contact in case of an emergency? Name: _____

Phone: _____ Relationship to you_____

~ Who do you authorize us to discuss your personal health information with?

Name: _____ Phone: _____ Relationship: _____

Insurance

Guarantor for insurance & bills: ☐Patient ☐Spouse ☐Mother ☐Father ☐Guardian

Guarantor's Name: _____ Date of Birth: _____

Primary Insurance: _____ I.D.# _____

Does your insurance require a referral for specialist visits? Y N

Secondary Insurance: _____ I.D.# _____

MINORS ONLY: Child lives with: ☐ Both Parents ☐Mother ☐ Father

Guardian: _____ Address (if different): _____

Home phone: _____ Cell: _____ _____

Other Providers

Primary Care Physician: _____ Phone: _____

Pharmacy: _____ Location: _____ Phone: _____

Optometrist: _____ Did they refer you here? Y N

Identify your physicians/health care entities who we may share your medical information with:

Provider: _____ Phone: _____

Please note, we require a **photo I.D. at time of appointment**

(FTC) "Red Flags" Rule in effect since January 1, 2008. Revised 2023 NR

Patient Name: _____ Date of Birth: ___/___/_____ Today's date: ___/___/_____

Please answer ALL of the following questions regarding your general and ocular health.

Please describe the reason for your visit today: _____

_____

_____

Do you have any drug allergies? Y N If yes, please list: _____

Surgical History Year Year Year

_____ _____ _____

_____ _____ _____

Have you ever had any of the following medical problems? (Please circle yes or no)

AIDS or HIV+	Y	N	Emphysema	Y	N	Low Blood Pressure	Y	N
Anemia	Y	N	Eye Injury	Y	N	Migraine Headaches	Y	N
Arthritis	Y	N	Eye Surgery	Y	N	Pregnant or Nursing (presently)	Y	N
Asthma	Y	N	Glaucoma	Y	N	Seizure	Y	N
Bleeding tendency	Y	N	Heart attack (year) _____	Y	N	Stroke	Y	N
Blood transfusions	Y	N	Heart disease	Y	N	Thyroid disease	Y	N
Bronchitis	Y	N	Hepatitis (circle) A B C	Y	N	TIA	Y	N
Cancer of _____	Y	N	High blood pressure x ___ yrs	Y	N	Tuberculosis (year) _____	Y	N
COPD	Y	N	Hives or Eczema (circle which)	Y	N	Ulcer	Y	N
Diabetes x ____ years	Y	N	Kidney Disease	Y	N	Venereal Disease	Y	N

Are you currently experiencing any of the following symptoms? (Please circle yes or no)

Sensitivity to light	Y	N	Eye strain	Y	N	Eye pain, burning or itching	Y	N
Poor vision	Y	N	Floaters or spots in vision	Y	N	Double vision	Y	N
Eye discharge	Y	N	Excessive tearing	Y	N	Depression	Y	N
Fever / Chills	Y	N	Mouth ulcers	Y	N	Genital ulcers	Y	N
Weight Loss	Y	N	Shortness of breath	Y	N	Muscle aches	Y	N
Sinus congestion	Y	N	Diarrhea	Y	N	Rash or other skin problems	Y	N
Cough	Y	N	Abdominal pain	Y	N	Enlarged lymph nodes	Y	N
Dry mouth	Y	N	Bloody or black stool	Y	N	Immune problems	Y	N

Family History (Has one of your blood relatives had any of the following): Please note relation

Blindness _____	Y	N	Macular Degeneration _____	Y	N	Cancer _____	Y	N
Cataract _____	Y	N	Retinal Detachment _____	Y	N	Heart Disease _____	Y	N
Glaucoma _____	Y	N	Diabetes _____	Y	N	Other _____		

Do you use or have you ever used:

Tobacco or tobacco products	Y	N	___packs/day X _____ years
Alcohol	Y	N	___ drinks per week
Illegal drugs	Y	N	please list type and number of years _____

Please list ALL current medications (this includes prescription and over the counter)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Moses – Mouser & Associates Inc.

Patient Financial Policies

PLEASE REVIEW IT CAREFULLY

Payment Guarantee: For services rendered *by Moses – Mouser & Associates Inc.*, you guarantee payment of your account at the time of services are provided for the entire costs that will not be paid by an insurance carrier, government payer (including Medicaid) or other third party payer (all called "PAYER"), or if at a later date after initial approval, your Payer denies the claim. You further understand that any out-of-network charges may be your responsibility as determined by your PAYER. You acknowledge that if your dependent is provided services you will be responsible for payment under these same terms and conditions. The "Responsible Party" listed on the Patient Data Sheet will be sent the bill and agrees to pay it. If the Responsible Party is not you and that person does not pay the bill, YOU agree to pay the bill.

Assignment of Benefits: To the extent there is third party coverage for payment of services, you agree that all medical and related benefits *PAID* by PAYER will be assigned to Moses – Mouser & Associates Inc. on your behalf.

Billing Information: It is essential that you provide us with complete and accurate information to submit billing to your insurance company (i.e. home address, phone numbers, member ID and group #). We will make every effort to submit claims to your insurance company and promptly provide you our statements. However, if for any reason the statement is returned to our office because of a problem with an address you provided, you may be dismissed and referred to a collection agency. To avoid this, please keep all of your information up-to-date.

Please be sure to bring your government-issued photo identification and your insurance cards to every visit so that we may properly bill your insurance company. If you do not have your insurance card with you, you may be required to make payment in full that day.

Insurance Billing: As your healthcare provider we will file your claims with your insurance company as a courtesy after services are provided. It is your responsibility to understand what services are covered under your medical insurance policy. If you have any questions whether a service will be covered we urge you to contact your insurance company, before the service is provided. (for example, Medicare does not cover the cost of a refraction).

The codes that are listed for the services that are provided to you are based on the guidelines of the American Medical Association. There are several factors involved when making the decision for the type of services to be billed. Among those deciding factors is whether you are a new patient (not seen within the last three years) or established patient, the reason for the visit, the amount of time the service takes and the complexity of the medical problem.

Insurance companies make their payment decision about a specific medical service by looking at what your insurance policy provides. Example: If the reason for your visit is a "routine eye exam" and your insurance company does not cover that service we cannot go back and change the reason for your visit. It is your responsibility to find this out ahead of time.

Be advised that your insurance company may require a pre-certification, prior authorization, or referral for some services, such as: radiology, surgery, or specialist visits. Receiving prior authorization does not guarantee that your insurance company will pay for it. Patients have the responsibility to ensure that prior authorization has been obtained prior to services rendered. If we bill any Payer and are not paid within 60 days, you will be billed and you will be responsible for full payment for the services.

You should normally receive a response from your insurance company within 30 days. This is in the form of an "Explanation of Benefits" (or "EOB"). If you do not receive it, we would appreciate you contacting your insurance company to check the status of your claim in order to expedite payment. Please call our Billing Department, if you encounter any difficulty with your insurance company. We will try to assist you. You are responsible for payment until the account is paid in full by your insurance company.

Payment terms: Depending on your insurance policy benefits, you may be responsible for a co-payment, coinsurance, deductible, or for the entire services rendered. We may require payment for these items at the time of your office visit. If you fail to make payment at the time of service we may charge a processing fee to cover our extra expense of preparing and sending out a bill.

Once we have received an EOB from your insurance company, which indicates the amount you will be responsible for, a statement for the balance will be sent to you and payment is expected by the due date as stated on your bill.

If amounts due for services rendered become delinquent and the amounts are referred to an attorney and/or collection service, you agree that you will be responsible for all reasonable costs and expenses incurred in the collection efforts, including and interest charges due, court costs and attorney fees.

Note to divorced parents of dependents. Unless you provide us with a court order, the statement will be sent to the "Responsible Party" listed on the Patient Data Sheet and that person agrees to pay the bill. If the Responsible Party is not you and that person does not pay the bill, YOU agree to pay the bill.

Workers Compensation Injury: If you believe you are being seen for an injury/illness as a result of your job, we must have written authorization from your employer to confirm this and their directions as to how to bill for this service. If we do not have this information we will bill you and/or your insurance company.

Self Pay Patients: Self Pay Patients are those not covered by any insurance policy or third party payer. Self Pay Patients will receive a 20% discount across the board for professional services rendered, when payment is made in full *at the time services are rendered* (and when no claim form is prepared or billing statement has to be mailed).

Payment is your responsibility: Our relationship is with you, to provide quality healthcare to you and/or your dependent. Consequently, all charges incurred are your responsibility. The obligation to ensure payment in a timely manner lies with you. Unfortunately, we cannot always depend on your insurance company to make timely payments on your behalf. We are not responsible for delays, misplaced claims, or the need for additional information from you by your insurance company.

Making Payments: Patients may pay by cash, money order, check or personal credit card, which can include credit cards to pay from your "flexible spending account" and/or "health savings account" if you have these. One, or all, of these cards may be used to pay your bill, and may be kept on file to facilitate billing. Patients agree if they have a credit balance after paying for a service, *James L. Moses, M.D. Inc.,* can apply it to any outstanding balances on their account.

Fees Assessed by Moses-Mouser & Associates Inc.: You may be charged fees for the following: 1) Returned checks 2) Completion of Forms (i.e. Disability or Family Medical Leave) 3) Copying of Medical Records 4) Failure to Cancel Appointment ("No Show") $20.00 – We call all of our patients and remind them of their next appointment as a courtesy. You may be charged, if you fail to give us 24 hours notice of cancelled appointments or No shows.

The patient (or representative) agrees to these terms as evidenced by signature below.

Patient/Guardian: _____ Date: _____

If not patient, relationship to patient: _____

Moses-Mouser MD's Inc.

NOTICE OF PRIVACY PRACTICES

PLEASE REVIEW IT CAREFULLY

OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION

We create a record of the care and services you receive at Moses-Mouser MD's Inc. We understand that this health information about you is personal and protected by law (it is called the protected health information or "PHI"). We are committed to protecting PHI. This Notice will tell you about the ways in which we may use and disclose your PHI. We also describe your rights and certain obligations we have regarding the use and disclosure of PHI.

We are required by law to:

Make sure that PHI that identifies you is protected; give you this notice of our legal duties and privacy practices with respect to your PHI; and follow the terms of the Notice that is currently in effect.

HOW MAY WE USE AND DISCLOSE PHI ABOUT YOU?

The following categories describe different ways that we use and disclose PHI.

For Treatment:

We may use your PHI to provide you with treatment or services, including sharing PHI with doctors, nurses, medical students, or other personnel who are involved in taking care of you.

For Payment:

We may use and disclose your PHI to bill and collect payment for treatment and services provided to you.

For Health Care Operations:

We may use and disclose PHI about you for our business operations. These uses and disclosures are necessary to run our practice and make sure our patients receive quality care.

Business Associates:

We contract with outside organizations, called business associates, to perform some of our operations task on our behalf. Examples would include billing agencies. When these services are performed, we disclose the necessary health information to the companies so that they can perform the tasks we have asked them to do. To protect your PHI, however, we require the business associate to appropriately safeguard your information.

Appointment Reminders:

We may use and disclose your PHI to remind you of things like appointments, annual exams, and or prescription refills.

Treatment Alternatives:

We may use and disclose your PHI to tell you about or recommend possible treatment options or alternatives that may be of interest to you. For example, this may include specific brand name or over-the-counter pharmaceuticals.

Health Related Benefits and Services:

We may use and disclose PHI to tell you about health-related benefits or services. For example patient assisted drug programs or low vision services.

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your PHI that directly relates to the person's involvement in your health care or payment related to you care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based upon on our professional judgment. We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals directly involved in your health care.

Research:

Under certain circumstances, we may use and disclose PHI about you for research purposes. All research projects, however, are subject to a special approval process. Before we use and disclose PHI for research, the project will have been approved through a research approval process.

THE FOLLOWING USES AND DISCLOSURES ARE REQUIRED BY LAW

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

Military and Veterans:

If you are a member of the armed forces, we may release PHI about you as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

Public Health Risks:

We may disclose PHI about you for public health activities. We will make these disclosures when required or authorized by law. Examples of these activities generally include the following: To prevent or control disease, injury or disability; To report births and deaths; 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 or neglect.

Health Oversight Activities:

We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with laws.

Lawsuits and Disputes:

If you are involved in a lawsuit or dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone involved in the dispute.

Law Enforcement:

We may release PHI 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 the death we believe may be the result of criminal conduct; 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 PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

National Security and Intelligence Activities:
We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others:
We may disclose PHI about you to authorized federal officials so they may provide protection to the President, or to other authorized persons.

Inmates:
The rights listed in this Notice will not apply to inmates of a correctional institution.

In Any Other Situation Required By Law:
We will disclose PHI about you when required to do so by federal, state or local law.

YOUR RIGHTS REGARDING YOUR PHI

Right to Inspect and Obtain a Copy.
You have the right to inspect and have a copy of PHI that may be used to make decisions about your care. This includes medical and billing records, but does not include psychotherapy notes (if applicable). This right does not apply to information that may be used in a civil, criminal or administrative action or proceeding and information that is no part of the records maintained by or on behalf of *Moses-Mouser & MD's Inc.* about you. In some cases copies may be made available in electronic format in addition to paper. To inspect and have a copy of PHI that may be used to make decisions about you, you must submit your request in writing to the location's medical records supervisor. If you request a copy of the information, we may charge a fee for the cost of copying, mailing or other supplies associated with your request. We have a reasonable time-period to make a response to your request.
We may deny your request to inspect and have a copy in some limited circumstances. If you are denied access to your PHI, you may request that the denial be reviewed. Another licensed health care professional chosen by *Moses-Mouser & MD's Inc.,* will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Request an Amendment:
If you feel that PHI we have about you is incorrect you have the right to request an amendment (a change to your record). To request an amendment, your request must be made in writing and submitted to the Privacy Officer. In addition, you must provide a reason that supports your request.
We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask to us to amend information that:
Was not created by us, unless the person or entity that created the information is no longer available to make the amendment to those records not created by us; is not part of the information which you would be permitted to inspect and copy; or *Moses-Mouser MD's Inc.* believes the current record is accurate and complete.

Right to Receive Notice of a Breach:
We may give you written notice in the event we learn of any unauthorized acquisition, use or disclosure of your PHI that has not otherwise been properly secured as required by HIPPA (a "breach"). In that event, we would notify you as soon as reasonably possible but no later than sixty (60) days after the breach has been discovered.

Right to an Accounting of Disclosures:
You have the right to request an "accounting of disclosures." This is a list of people who saw your records who you did not specifically authorize. For example, if we responded to a legal request for your records.

Right to Request Restrictions on Uses and Disclosures of PHI:
You have the right to request a restriction or limitation on how we use your PHI. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a procedure that you had performed in our office. Although we will consider your request carefully, 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 emergency treatment.

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. For example, you can ask that we only contact you at your work phone number or by mail.

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.

Complaints:
If you believe your privacy rights have been violated, you may file a complaint with Moses-Mouser MD's Inc., or the Secretary of the Department of Health and Human Services.
Attn: Scott Williams, Privacy Officer. 1600 Gateway Circle Grove City, OH 43123
YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT.

I understand that this practice may refuse me services if I refuse to sign this consent.

Patient/Guardian _____ Date: _____

Name Printed: _____