**Kimberly Ann Lucey M.D., P.C.**

**PATIENT REGISTRATION**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_

MAILING ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STEET ADDRESS (IF DIFFERENT) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE:\_\_\_\_\_\_\_\_\_\_ ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE: HOME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***GOVT. REQUIRED DEMOGRAPHIC CHANGES***: **To meet increased requirements for the government, several mandated items have been added to the Patient Registration. These include added choices for Race/Ethnicity and new fields for Sexual Identification and Gender Orientation.**

RACE: □ Black or African American □ American Indian □ Alaskan Native □ Caucasian □ Chinese

 □ Japanese □ Native Hawaiian or Other Pacific Islander □ Other/Undetermined \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ETHNICITY: □ Hispanic or Latino □ Non-Hispanic or Latino □ Other/Undetermined\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SEXUAL IDENTIFICATION: □Straight or heterosexual □Lesbian, gay, or homosexual □Bisexual

 □Something else, please describe □Don't know □Decline

GENDER ORIENTATION: □Male □Female □Transgender male/Trans man/Female-to-male

 □Transgender female/Trans woman/Male-to-female □Genderqueer, neither exclusively male nor female

 □Additional gender category/ (or other), please specify □Decline

EMPLOYER NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OCCUPATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PRIMARY CARE PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RESPONSIBLE PARTY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MARITAL STATUS: □ Single □ Married □ Divorced □ Widowed □ Other

SPOUSE’S NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SPOUSE’S EMPLOYER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMERGENCY CONTACT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP:\_\_\_\_\_\_\_\_\_

PREFERRED METHOD OF COMMUNICATION: □ Phone □ Mail □ Email □ Fax

PREFERRED PHARMACY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHARMACY ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Mail-Order Pharmacy

ARE YOU ALLERGIC TO ANY MEDICATIONS?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU WEAR GLASSES? □ Yes □ No CONTACT LENSES? □ Yes □ No HOW LONG?\_\_\_\_\_\_\_\_\_\_

**REFERRAL FROM PRIMARY CARE PHYSICAN: □ Yes □ No**

INSURANCE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TELEPHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SUBSCRIBER SS#\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_

SUBSCRIBER D.O.B:\_\_\_\_\_\_\_\_\_\_\_ SUBSCRIBER RELATIONSHIP TO PATIENT: □ Self □ Spouse □ Child

MEMBERSHIP#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECONDARY INSURANCE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TELEPHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

SUBSCRIBER NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SUBSCRIBER SS#\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_

SUBSCRIBER D.O.B:\_\_\_\_\_\_\_\_\_\_\_ SUBSCRIBER RELATIONSHIP TO PATIENT: □ Self □ Spouse □Child MEMBERSHIP#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GROUP#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL DIRECTIVES**: Please check all that apply.

\_\_Organ Donor\_\_ Living Will \_\_ Power of Attorney \_\_ Do not resuscitate \_\_ Not Discussed

 \_\_ Discussed No decision made

 **CONSENT FOR TREATMENT AND RELEASE OF INFORMATION**

I AUTHORIZE Kimberly Ann Lucey M.D., P.C. to perform medical treatment.

I CONSENT to Kimberly Ann Lucey M.D., P.C.’s use of disclosure of all individually identifiable personal, health, financial, and demographic information (known as Protected Health Information or PHI) for the purposes of ● Providing medical treatment ● Obtaining payment and reimbursement ● Obtaining authorization from my insurance for tests (where required) ● Requesting healthcare services from other providers ● Cooperating with other providers in my medical treatment ● Fulfilling requests for information when specifically authorized by me ● In addition, doing all other things directly related to providing healthcare to me

The above purposes and all other uses are known collectively as Treatment, Payment, and Other healthcare operations or TPO.

I AUTHORIZE any physician or healthcare facility to provide upon request any PHI to Kimberly Ann Lucey M.D., P.C., when needed for the purposes of TPO.

I CONSENT to Kimberly Ann Lucey M.D., P.C. discussing any or all of my medical care including my evaluation, treatment; diagnosis even if related to psychiatric or psychosocial impairments, substance abuse, acquired immunodeficiency virus (HIV), HIV-related opportunistic infections, or pregnancy with the following person(s).

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_ 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_

I have been given the opportunity to review and agree with the terms and conditions of Kimberly Ann Lucey M.D., P.C.’s Patient Information Protection Plan.

I understand my rights to restrict the use and disclosure of PHI and to revoke this consent at any time in writing.

I understand that should I choose not to consent to the terms and conditions of Kimberly Ann Lucey M.D., P.C.’s Patient Information Protection Plan, the practice has the right to and will withhold treatment except where required by law.

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT’S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURED OR GUARDIAN’S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Health Insurance Portability and Accountability Act of 1996 prohibits the use and disclosure of protected health information for treatment, payment, and other healthcare operations without a signed consent and prohibits the use and disclosure of protected health information for non-healthcare related activities without specific and explicit authorization.

 KIMBERLY ANN LUCEY, M.D.

***Board Certified Ophthalmologist***

I, ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand that as part of my health care, Kimberly Ann Lucey M.D., P.C., originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

* A basis for planning my care and treatment,
* A means for communication among the many health professionals who contribute to my care,
* A source of information for applying my diagnosis and surgical information to my bill,
* A means by which third-party payer can verify that services billed were actually provided,
* A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a ***Notice of Information Practices*** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

* The right to review the notice prior to signing this consent,
* The right to object to the use of my health information for my directory purposes,
* The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Kimberly Ann Lucey M.D., P.C., is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Kimberly Ann Lucey M.D., P.C., reserves the right to change its notice and practices. Prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations should Kimberly Ann Lucey M.D., P.C., change its notice, it will send a copy of any revised notice to the address I have provided by U.S. mail.

I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization’s treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and **accept/decline** the terms of this consent.

Signature ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 KIMBERLY ANN LUCEY, M.D.

 Board Certified Ophthalmologist

 OFFICE POLICIES-EFFECTIVE 7/31/2015

CANCELLATIONS:

Our office requires a 24-hour notice for cancelled appointments. Patients will be charged a $50.00 FEE for appointments cancelled without 24 hour notice. Fees may be waived due to emergent situations. This will be at the Doctor’s discretion. Thank you for your understanding.

INITIAL: \_\_\_\_\_\_

NO-SHOWS:

Our office will confirm your appointment two days prior to your office visit. If you cannot keep your appointment due to an emergency, please notify our office promptly. There will be a $50.00 CHARGE for all No-Show appointments. This charge must be paid in full before any future appointments. INITIAL: \_\_\_\_\_\_

SECONDARY INSURANCES:

Our Practice accepts a limited number of secondary carriers whose claims are automatically forwarded to them by Medicare or Commercial Insurance. As the patient, **you are ultimately responsible for all secondary balances**. Please contact the secondary carrier if you have not heard from them after you receive your Medicare or Commercial Explanation of Benefits statement from your Primary insurance. If the secondary balance is unpaid by the Insurance carrier for ANY reason, or the secondary balance becomes 90 days past due, our office will send you a billing statement. The patient will assume responsibility for the balance of the payment. An additional fee of $10.00 may be added to past due accounts. Thank you for your cooperation.

INITIAL: \_\_\_\_\_\_

CHANGES/UPDATES:

It is the patient’s responsibility to notify our office of any changes with your ADDRESS, PHONE NUMBER OR INSURANCE INFORMATION. If your insurance denies your visit, you will be responsible for unpaid balances. Patients are responsible for obtaining referrals.

INITIAL: \_\_\_\_\_\_

PRESCRIPTION REFILLS:

We will only refill prescription requests during normal business hours. Prescription refill requests after hours will be filled the next business day. Please DO NOT CALL the on-call physician for prescription refills. INITIAL: \_\_\_\_\_\_

AFTER HOURS:

Calls received after normal business hours will be referred to the on-call physician. Please limit these calls to emergent situations only. The on-call physician may not be a physician of this practice and will not have access to patient records. INITIAL: \_\_\_\_\_\_

I have read all of the above office policies, and understand office procedures as outlined above.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**KIMBERLY ANN LUCEY, M.D.**

**Board Certified Ophthalmologist**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Kimberly Ann Lucey M.D., P.C. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not signed by patient, please indicate your relationship to the patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Office Use Only:**

□ Signed form received by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 □ Acknowledgement refused:

 Efforts to obtain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Reasons for refusal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_