COASTAL EYE GROUP, P.C.

Patient Name _____ SS#_____

Birthdate_____ Age ____ Race ____ Female _____ Male _____ Marital Status _____

Mailing Address _____

City_____ State_____ Zip_____

Home Phone_____ Work Phone _____Cell phone _____

Employer _____ Workers Comp _____Yes _____No
Spouse Name _____
Spouse: SS#_____ Birthdate _____ Phone#_____
Guardian (If under age 18) _____ DOB_____ SS#_____
Guardian Employer _____ Phone _____
Emergency Contact Name & Phone_____
Your Email Address _____
Pharmacy Name/Location _____
Primary Medical Dr. & Phone# _____
If you have either: Diabetic Dr. _____ **Cardiologist** _____

Consent to Call, Email, or Text

Consent to Call or Email indicates the patient is giving permission for the practice to use information provided as part of the check in process to email and call the patient. This includes: Entry of any telephone contact number constitutes written consent to receive any automated, prerecorded, and artificial voice telephone call initiated by the practice, or third parties, and more.

Consent to Text indicates whether the patient has agreed to receive automated text alerts from the practice, or third parties on their mobile phone. Depending on the features the practice offers, text alerts may be about appointments, test results, and more.

By signing below, the patient is giving permission for the practice to use information provided as part of the check in process to email, call, or text the patient. Depending on the features the practice offers, calls, emails, or texts may be about appointments, test results, and may extend to third parties or more.
Preferred methods of contact: Home#___Work#___Cell#___Text___

Circle One *- Yes or No - OK to leave message*

_____ _____

Patient Signature Required **Date**

COASTAL EYE GROUP, P.C.

INSURANCE INFORMATION

Please provide cards and a picture ID**Coastal Eye Group require these to file your insurance**
Primary Insurance _____ Secondary Ins. _____

Claims will be filed for payment to those insurance plans with which Coastal Eye Group, PC is a contracted participating provider. Co-Insurance amounts, Non-covered amounts, and Deductible amounts will be collected at the time of service.

I request evaluation and treatment necessary by Coastal Eye Goup, PC. I hereby authorize payment of insurance benefits directly to Coastal Eye Group, PC for services rendered, including applicable Medi-Gap policies. I further authorize the use or disclosure of my health information for the purpose of treatment, payment, or healthcare operations. **I understand that I am responsible for payment of any amounts not covered by insurance.**

****MAY WE RELEASE YOUR HEALTH INFORMATION TO ANYONE OTHER THAN YOURSELF?****

_____ Yes ____ No If yes, please list 1:_____ 2: _____

WERE YOU REFERRED BY ANOTHER PHYSICIAN? ____ Yes ___No
If yes, please list _____

_____ _____
Patient Signature Required **Date**

MEDICAL HISTORY QUESTIONNAIRE

Patient Name _____
Date of Birth _____ Date of **last eye exam** _____
List any **medications** you currently take (Rx and over-the-counter with dosages):
_____
_____
Do you have **allergies** to any medications? **YES NO**
If YES, list the medications with **reactions** _____
_____
List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.):
_____
List any **surgeries** you have had (cataract, appendectomy): _____

Do you ***currently*** have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, stents,etc.)			
RESPIRATORY (congestion, wheezing, short of breath, use oxygen, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, **KIDNEY**, **BLADDER** (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, **BONES, JOINTS** (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, stroke, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply) ? **YES NO UNKNOWN**
List Mother (M), Father (F), Brother (B), Sister (S), Grandparent (GP)
Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis
Other heritable disease:

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES NO**
Have you ever had a blood transfusion?..... **YES NO**
Do you drink alcohol? ..... **YES NO** If YES, how much? _____
Do you smoke?.....**YES NO** If YES, how much? _____ How many years? _____
Have you ever smoked?..... **YES NO** If Yes, when did you stop? _____

Patient's Signature: _____ **Date** _____

Physician's Signature: _____ **Date** _____

Privacy Notice – Protected Health Information – Coastal Eye Group, P.C.

This notice describes how health information about you may be used, disclosed and how you can get access to this information. We are required by law to give you this notice. Please review it carefully.

Introduction:

At Coastal Eye Group, P.C. (CEG), we are committed to treating and using Protected Health Information (PHI) about you responsibly. Under the HIPAA privacy regulations, we are required by federal law to maintain the privacy of your Protected Health Information (PHI). PHI is information about you that may identify you and that relates to your past, present, or future physical or mental health condition and related healthcare services. Federal law also requires us to provide you with notice of our legal duties and privacy practices with respect to PHI, and we are required to abide by the terms of the notice currently in effect. We reserve the right to change our Notice of Privacy policies and this change will affect all PHI that we maintain. Before we make a material change in our policies, we will change our Notice and post the new Notice in the waiting area. You may request a copy of the Notice at anytime. Your PHI may be used and disclosed by your physician(s), our office staff and others outside of our office that are involved in your care for the purpose of **T**reatment, **P**ayment and Healthcare **O**perations (TPO).

For Treatment:

We may use your PHI in rendering treatment to you. For example, we are permitted to use your PHI in providing you medical care when you visit our office. This includes the coordination or management of your healthcare. For instance, we can disclose your PHI to third parties for treatment, such as a specialist we may refer you to. We may disclose your PHI when we contact you about appointment reminders, no-show appointments, or treatment alternatives. We may disclose your PHI information to your family or friends that are in the examination room with you or that are assisting you with appointments, surgical procedures, diagnostic testing or your care. We may also disclose your PHI to optical or contact lens vendors or companies for the processing of your eyeglass or contact lens order. We may disclose your PHI to, but are not limited to, health care facilities, and laboratories for the continuing of your healthcare.

For Payment:

We may disclose your PHI for payment purposes. For example, PHI may be disclosed to your insurance provider so we may be reimbursed for services rendered to you. If someone else is responsible for your payment, we may contact that person. We may disclose PHI to an outside collection agency as deemed necessary. We may need to disclose your PHI to your health plan when obtaining pre-approval for diagnostics or surgical procedures. Bills sent to you or a third party payer may include information that identifies you, as well as your diagnosis and procedures performed.

For Health Care Operations:

We may disclose or use your PHI to support the business activities of this office. These activities include, but are not limited to, quality assessment activities, training of medical professionals, auditing functions, or other business aspects of running our practice. An example would include a periodic assessment of our documentation protocols, etc. Additionally, we may use a sign-in sheet at the registration desk, where you will be asked to sign your name when you arrive. We may also call you by name from the lobby or other area in the building.

Disclosure of PHI for special circumstances:

We may disclose or use Protected Health Information about you without your permission for the following special circumstances, subject to all applicable legal requirements and limitations.

- **Appointment reminders**: CEG may use and disclose your health information in order to contact you and remind of an upcoming appointment for treatment or health care services.
- **Health-related benefits and services**: We may use your health information to inform you of services or programs that we believe would be beneficial to you. For example, we may contact you to make you aware of new services or products.
- **Required by law or law enforcement**: CEG may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. We will disclose PHI about you when required to do so by federal, state or local law.
- **To prevent serious threat to health or safety**: CEG may disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety or the health and safety of the public or another person.
- **Communication with family**: CEG health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. In situations where you are incapable of giving consent, we may, using our professional judgment, determine that a disclosure to your family or friend is in your best interest.
- **Research**: CEG may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
- **Coroners, funeral directors or medical examiners**: CEG may disclose health information to funeral directors consistent with applicable law to carry out their duties.
- **Organ procurement organizations**: Consistent with applicable law, CEG may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation or transplant.
- **Worker's Compensation**: CEG may disclose health information to the extent necessary to comply with laws related to worker's compensation or other similar programs established by law.
- **Public Health**: As required by law, CEG may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.
- **Military, Veterans, National Security**: If you are a member of these, CEG may be required by government authorities to release health information about you.
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- **Health Oersight Agencies**: CEG may disclose PHI to a health oversight agency for audits, investigations, inspections or licensing purposes. Disclosure may be required by state or federal agencies to monitor health care, government programs and compliance with laws.
- **Legal, Lawsuits, Disputes**: CEG may disclose PHI about you in response to a court order, administrative order or subpoena.

Your Health Information Rights:

Although your medical record is physical property of CEG, you have the right to:

- **Obtain a copy of this privacy notice**
- **Inspect and receive a copy or your health record as provided. 45 CFR 164.524**
  You must submit a written request and a fee may be charged. Requests may be denied in limiting circumstances.
- **Amend your health record. 45 CFR 164.528**
  To request an amendment, complete and submit a medical record amendment/correction form which is available at CEG
  We may deny your request if you ask information to be amended that:
  1. *CEG did not create*
  2. *Is not part of your PHI or medical record.*
  3. *Is already accurate and complete.*
- **Obtain an accounting of disclosures. 45 CFR 164.528**
  This is a list of disclosures CEG made of medical information about you for purposes other than treatment, payment and healthcare operations. To obtain this list, you must submit your request in writing. It must state a time period, not longer than six years and may not include dates before April 14, 2003. We may charge you for the costs of providing this list.
- **Request communications of your health information by alternative means or at alternative locations.**
  You have the right to request we communicate with you regarding your medial health in certain ways or at certain locations. Example: You may ask that we only contact you at home or by mail, not at work.
- **Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522**
  You have the right to request restrictions on disclosures. Example: You may request we not disclose information about your surgical procedure.
- **Revoke your authorization to disclose health information except to the extent that action has already been taken.**
  To request restrictions, these restrictions will need to be listed on the consent form. We are not required to agree to your request. If we do agree, we will comply with your request unless the PHI is needed to provide you emergency treatment.

Our Responsibilities:

CEG is required to:

- **Maintain the privacy of your health information. Privacy cannot be ensured for calls to CEG on a cellular phone.**
- **Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,**
- **Abide by the terms of this notice,**
- **Notify you if we are unable to agree to a requested restriction, and**
- **Accommodate reasonable requests you may have to communicate health information by alternative means.**

CEG reserves the right to change our practices and to make the new provisions effective for all protected health information we maintain.

Should our information practices change, we will supply you with a revised notice.

CEG will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue usage or disclose your health information after we have received a written revocation of the authorization according to the procedures included in this authorization.

For More Information or to Report a Problem:

If you have any questions or would like additional information, you may contact the following staff:

Privacy Officers:

Dena Turner
Coastal Eye Group, P.C.
1200 Highmarket Street
PO Box 2900
Georgetown, SC 29442
(843) 546-8421
also, Coastal Eye Group
123 Epps Street
Lake City, SC 29560
843-374-5487

Kay Roderick
Coastal Eye Group, P.C.
4055 Hwy. 17 South
P.O. Box 1919
Murrells Inlet, SC 29576
(843)652-3937

Debra Norwood
Coastal Eye Group, PC
401 79th Ave. N.
Myrtle Beach, SC 29572
(843)449-7115

Mary Musante
Coastal Eye Group, PC
90 Cedar Light Lane
Little River, SC 29566
(843) 280-8779

If you believe your privacy rights have been violated, you can file a complaint with the Practice's Privacy Officer. Or you may file a complaint with the Secretary of Department of Health and Human Services.

Secretary of the Department of Health and Human Services:
PO Box 8206
Columbia, SC 29202-8206

ACKNOWLEDGEMENT

I hereby acknowledge receipt of the Notice of Privacy Practices.

_____ _____ _____

Signature Print Name Date

NO SHOW POLICY

Coastal Eye Group schedules appointments so that each patient receives the appropriate time to be seen by our physicians. It is very important that you keep your scheduled appointment with us and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, Coastal Eye Group sends reminder calls and text messages 2 days in advance of your appointment.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and to accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least 24 hours notice.

If you do not cancel or reschedule your appointment with at least 24 hours notice, we may assess a $30.00 "NO SHOW" service charge to your account. This "NO SHOW" charge is not reimbursable by your insurance company. You will be billed directly for it.

I UNDERSTAND THE "NO SHOW" POLICY OF COASTAL EYE GROUP AND I UNDERSTAND THAT I MUST CANCEL OR RESCHEDULE ANY APPOINTMENT AT LEAST 24 HOURS IN ADVANCE IN ORDER TO AVOID A POTENTIAL NO SHOW CHARGE.

Date:_____

Patient Name(please print):_____

Patient Date of Birth:_____

Patient Signature:

_____

7/1/2022