

## **Sarrell Regional Dental and Eye Center Office Policy**

**Welcome to our office! We would like to thank you for giving us the opportunity to provide you and your child/children with the most up-to-date Eye care possible. It is our commitment to provide your child with the best treatment, and care available.**

**Please understand that our average patient is between the ages of 3 and 5 and we can only work as fast as each child will allow. With that said, please note we can only provide you with an estimate of your child's appointment time.**

**PARENTS, it is our policy to try to encourage a one-on-one relationship between your child and our staff. To obtain this we often ask the parent to wait in the lobby until their presence is needed and requested by the doctor or staff. This does not mean you are not allowed to check in on your child at any time, but please keep in mind your child's reaction to your entrance. It has been our experience that most children often behave better in this one-on-one environment.**

**For children under the age of 18 years, a PARENT/GUARDIAN must remain on the premises at all times while treatment is under way. We understand the conflict of work schedules and appointments, but your child cannot and will not be treated unless someone who is able to make LEGAL decisions is present.**

**Please consider your scheduled appointments carefully. These appointments are reserved exclusively for your child. Missed/cancelled/rescheduled appointments (broken appointments) without a 24-hour notice leaves "care-time" unused, time that could be used for another child. We also have special doctors who commute solely for special cases. Without a 24 hour notice these doctors make a special trip and set aside time specifically for child and thus this time goes unused.**

**Thanks again for trusting Sarrell Regional Dental and Eye Center and giving us the privilege to serve your child's dental needs. If you have any concerns, please feel free to ask our qualified, professional staff.**

## Patient Information

Patient Name \_\_\_\_\_ Date: \_\_\_\_\_  
Last, First MI (Preferred Name)

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell) \_\_\_\_\_ (Other) \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #

City State Zip Code

## Health Information

**Please check any condition that applies to yourself or any members of yourself or any members of your immediate family:**

	Self	Family		Self	Family
Diabetes	_____	_____	Retinal detachment	_____	_____
High blood pressure	_____	_____	Eye surgery	_____	_____
Cataracts	_____	_____	Lazy Eye	_____	_____
Heart problems	_____	_____	Double vision	_____	_____
Respiratory problems	_____	_____	Blindness	_____	_____
Thyroid problems	_____	_____	Head/Eye injury	_____	_____
Glaucoma	_____	_____	Headaches	_____	_____
Loss of vision	_____	_____			

- Do you have any allergies to medications?  Yes  No  
If yes, please explain: \_\_\_\_\_

- Please list any medications you/your child is currently taking:  
\_\_\_\_\_

- Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No  
If yes, please explain: \_\_\_\_\_

- Are you now under the care of a physician?  Yes  No  
If yes, please explain: \_\_\_\_\_

- Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

- List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eye, glaucoma, retinal disease, cataracts, eye infections or eye injury: \_\_\_\_\_

**\*To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.**

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_

Are you pregnant and/or nursing?  Yes  No  
Do you wear glasses?  Yes  No  
Do you wear contact lenses?  Yes  No  
Type of contact lens:  Soft  Rigid  Extended Wear  Other  
Are they comfortable?  Yes  No  
Date of Last Eye Exam \_\_\_\_\_ Reason? \_\_\_\_\_ Doctor? \_\_\_\_\_

### Parent or Guardian Information

The following is for:  parent  legal guardian

Name: \_\_\_\_\_  
 Male  Female  Married  Single  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell): \_\_\_\_\_ (Other): \_\_\_\_\_

Address: \_\_\_\_\_  
Street \_\_\_\_\_ Apartment # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### Consent for Services

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental/eye office of any changes in my child's medical status and new medications. I authorize the dentist /optometrist to release any information including the diagnosis and records of any treatment of examination rendered to my child during the period of such dental/eye care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental/eye group, insurance benefits otherwise payable to me. I understand that my dental/eye insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss related matters to this form.

I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

### Insurance Information (Skip if only insured by Medicaid or All Kids)

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Insured's Birth Date: \_\_\_\_\_  
Last First MI Insured's Social Security #: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Plan #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## HIPPA OFFICE POLICY: PLEASE READ AND SIGN THE FOLLOWING PAGE

Effective April 14, 2003

We are required by law to maintain the privacy of your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related care services. We are required to abide by the terms of our Notice of Privacy Practices ("Notice") currently in your protected health information ("PHI"). We will post each revised Notice in our office, make copies of the revised Notice available upon request and post the revised Notice on our web site.

### USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION WITHOUT YOUR CONSENT.

*Treatment.* We may use or disclose your PHI to provide and coordinate your health care and related services. This may include communications with other health care professionals regarding your health care, including referral to another health care provider. For example, we may share PHI with other health care providers involved in your treatment, such as disclosing certain PHI to a laboratory that is conducting your tests or with a pharmacy when calling in your prescription.

*Payment.* We may use or disclose your PHI to obtain payment or be reimbursed for the health care and related services we provide for you. Such disclosures can be made to billing services, collection departments or credit bureaus. For example, even before you receive services, we may disclose your PHI with your health plan(s) to determine coverage eligibility.

*Health Care Operations.* We may use or disclose PHI in connection with certain administrative, financial, legal and quality improvement activities that are necessary for us to run our practice and to support our functions of treatment and payment. For example, we may use or disclose your PHI for quality assessments and improvement activities, employee training programs, licensing requirements, or conducting a medical review or audit.

*Incidental Use or Disclosure.* An "incidental use or disclosure" is a use or disclosure that cannot reasonably be prevented, is limited in nature and occurs as a result of another permissible or required use or disclosure. We have set up reasonable safeguards that protect against impermissible uses and disclosures and limits incidental uses or disclosures. We also have policies and procedures that set limits to ensure that, as applicable, only the reasonable minimum necessary amount of your PHI is used, disclosed and requested for certain purposes.

*You can object to Certain Uses or Disclosures.* For each of the uses or disclosures of your PHI listed below, if you present and able, we will either (1) obtain your oral permission, (2) give you the opportunity to object, or (3) reasonably infer from the circumstances, based on our professional judgment, that you do not object. If you are unable to object, we will use our professional judgment to disclose only such PHI as is directly related to such person's involvement in your health care. For uses or disclosures:

- to a relative, friend or other person identified by you only your PHI that is directly relevant to the person's involvement in your health care or payment for health care or payment for health care;
- to a family member, personal representative, or other person responsible for your care only your PHI necessary to notify such individuals of your location, general condition or death; or
- to a private or public agency for disaster relief purposes. (Even if you object, we are still permitted to share your PHI as necessary for emergency circumstances.)

*Required Uses or Disclosures.* We are required by law to disclose your PHI to you pursuant to your patient right of access and accounting as described below. We are also required to disclose your PHI to the Secretary of the Department of Health and Human Services when required for their investigation of our compliance with privacy laws.

*Our Contact with You.* We may use or disclose your PHI to provide with appointment reminders (such as sending postcards or leaving a voicemail message, etc.) to provide you information regarding treatment alternatives or other health-related benefits and services that may be of interest to you, and to raise funds for us.

*Business Associates.* We may use and disclose your PHI with our business associates. A "business associate" is a person or entity that provides certain functions, activities or services on our behalf pursuant to a written agreement that contains terms regarding protection of your PHI.

Your PHI may be used or released for the following:

- for medical research;
- to coroners, medical examiners or funeral directors;
- for cadaveric organ, eye or tissue donation purposes;
- to avert a serious threat to the health or safety of a person or the public;
- for specialized governmental functions; or
- for workers compensation.

**ALL OTHER USES AND DISCLOSURES OF YOUR PHI REQUIRES YOUR WRITTEN AUTHORIZATION.** You may authorize us to use or disclose your PHI for other purposes. You may revoke this authorization in writing at any time; however, your revocation will not apply to any uses or disclosures that were being processed before we receive your revocation.

### **YOUR PATIENT RIGHTS.**

*Restrictions.* You have the right to ask us to restrict our uses or disclosures of part or all of your PHI for treatment, payment, health care operations or to individuals involved in your care. However, we are not required to agree to your requested restriction. If we do agree to your restriction, we will only use and disclose your PHI in accordance with such restriction, unless otherwise permitted or required by law. (You may request a restriction by contacting our Privacy Officer.)

*Confidential Communications.* You have the right to request that communications about your PHI be delivered by an alternative means or at alternative locations. For example, you may request that we contact you at your workplace about appointments, you must make such requests in writing. We will accommodate reasonable requests, but may condition such accommodations upon receipt of satisfactory explanation of how payments for your services will be handled and an alternative address or other method of contact. (Please contact our Privacy Officer to request a Confidential Communications Request Form.)

*Access.* You have the right to inspect and obtain a copy of you PHI contained in clinical, billing and certain other records used to make decisions about you, except in certain limited situations. Your request must be in writing and we will charge you reasonable cost-based fees for expenses (such as copying and employee time). Instead of copies we may provide you with a summary of your PHI, if you agree to the form and cost of such summary. We may, in some cases, deny your request and will notify you in writing of the reasons for our denial and provide you with information regarding your rights to have our denial of your request reviewed. (You may request to see and receive a copy of PHI by contacting our Privacy Officer.)

*Amendments.* You have the right to request an amendment to your PHI contained in clinical, billing and certain other records used to make decisions about you, except in certain limited situations. Your request must be in writing and provide a reason to support the requested amendment. We may, in some cases, deny your request for amendment and will notify you in writing of the reasons for our denial, provide you with information regarding your rights to submit a written statement disagreeing with such denial and provide information on how to file such statement. (You may request an amendment of your PHI by contacting our Privacy Officer.)

*Accounting.* You have the right to receive a listing of disclosures of your PHI made for purpose other than treatment, payment, health care operations, upon your request, your authorization, to individuals involved in your care or as allowed by law. You may request all such disclosures made during the last 6 years (but not any disclosures made prior to April 14 2003). If you request this list more than once in a 12-month period, we may charge you reasonable cost-based expenses to comply with you additional requests. (You may request a listing of disclosures by contacting our Privacy Officer.)

*Electronic Notice.* If you received this notice by email or off our web site, you have the right to receive this notice in written form upon your request. You may request a written copy of this Notice by contacting our business office.

### **Questions and Complaints.**

If you have any questions or feel that your privacy rights have been violated by us or want to complain to us about our privacy practices, you can contact our Privacy Officer by writing to the following address:

Sarrell Regional Dental/Eye Center 230 E. 10<sup>th</sup> St. Suite 106 Anniston, AL 36207

Sarrell Regional Dental/Eye Center  
230 E. 10<sup>th</sup> Street  
Anniston, AL 36207  
(256) 741-7340

## **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES/ HIPPA POLICIES**

I have had access to and read the HIPPA/Privacy Practices of this office.  
I understand and agree to the said policy.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

- Responsible party refused to sign.  
 An Emergency Situation prevented us from obtaining a signature.  
 Other. Explain \_\_\_\_\_

**NOTICE: THE SARRELL REGIONAL DENTAL/EYE CENTER RESERVES  
THE RIGHT TO REFUSE DENTAL TREATMENT TO ANYONE**

## Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I would prefer to discuss my Social History Information directly with my doctor. (Check box)

Do you drive?  no  yes If yes, do you have visual difficulty driving?  no  yes If yes, please describe:

Do you use tobacco products?  no  yes If yes, type/amount/how long: \_\_\_\_\_

Do you drink alcohol?  no  yes If yes, type/amount/how long: \_\_\_\_\_

Have you ever been exposed to or infected with:  Gonorrhea  Hepatitis  HIV  Syphilis

### Review of Systems

Do you currently, or have you ever had any problems in the following areas;

SYSTEM				SYSTEM			
CONTITUTIONAL				EARS, NOSE, MOUTH, THROAT			
Fever, Weight Loss/Gain				Allergies/Hay Fever			
INTEGUMENTARY (skin)				Sinus Congestion			
NEUROLOGICAL				Runny Nose			
Headaches				Post-Nasal Drip			
Migraines				Chronic Cough			
Seizures				Dry Throat/Mouth			
EYES				RESPIRATORIO			
Loss of Vision				Asthma			
Blurred Vision				Chronic Bronchitis			
Distorted Vision/Halos				Emphysema			
Loss of Side Vision				VASCULAR/CARDIOVASCULAR			
Double Vision				Diabetes			
Dryness				Heart Pain			
Mucous Discharge				High Blood Pressure			
Redness				Vascular Disease			
Sandy or gritty Feeling				GASTROINTESTINAL			
Itching				Diarrhea			
Burning				Constipation			
Foreign Body Sensation				GENITOURINARY			
Excess Tearing/Watering				Genitals/Kidney/Bladder			
Glare/Light Sensitivity				BONES/JOINT/MUSCLES			
Eye Pain or Soreness				Rheumatoid Arthritis			
Chronic Infection of Eye or Lid				Muscle Pain			
Sties or Chalazion				Joint Pain			
Flashes/Floaters in Vision				LIMFATICO/HEMATOLOGIC			
Tired Eyes				Anemia			
ENDOCRINE				ALLERGIC/IMMUNOLOGIC			
Thyroid/Other Glands				PSYCHIATRIC			

If you answered YES to any of the above or have a condition not listed, explain & list medications:

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