Neuro-ophthalmic Consultants Northwest

A division of Seattle Radiologists, A.P.C.

Welcome to Neuro-ophthalmic Consultants Northwest. You have been referred to us by a member of your care team to investigate your specialized visual concerns. In order to do so, we will need to obtain and review the documentation of your medical workup pertinent to your diagnosis.

Please complete the *Patient Data Collection Form* with the names and phone numbers of the physicians you have seen in relation to this episode of visual disturbance. Your assistance in contacting these physicians to have them forward their notes, along with reports of any tests completed, (visual fields, visual evoked potentials, MRI, etc) is greatly appreciated. Timely arrival of this information will help us determine the urgency of your condition and allow us to appropriately advise an appointment time and some offices require your written authorization.

To enable our physicians to provide the most comprehensive care, please take note of the following instructions:

- Arrive with your completed registration forms and insurance card
- Do not wear contact lenses to your appointment
- If you have had an MRI of the brain and/or orbits or retinal photography it will be necessary for you to arrange with the performing facility to pick up a copy of the images and bring them with you to your appointment. We ask that you do not rely on the mail or courier systems.
- Ensure that we are aware of all the members of your care team and that we have received the documentation from them in regards to your referral

The appointment time will have been reserved especially for you. It is imperative that you arrive at least 30 minutes prior to your first scheduled appointment time to complete your registration and prepare your paperwork. If you are late, we will likely have to re-schedule your appointment. Our physicians make every effort in allowing enough time with each patient for a comprehensive exam and to have every patient seen at their appointed time.

Due to the highly specialized nature of our practice, we have many patients being referred on an urgent basis and on our waiting list. Your cooperation in notifying us 24 hours in advance that you will not be able to keep your appointment will allow us to offer this time to another patient. If you do not show to your appointment you are subject to not being allowed to reschedule.

Insurance policy:

- If you do not have insurance, we require a cash **deposit** at the time of your visit. The amount of the **deposit** will be determined by **estimating** the services you will receive during your visit. The receptionist will advise you on the amount required.

- If you have Secure Horizons, Pac Med, Group Health, Regence Selections, TriWest, Molina or Community Health Plan of Washington, you will need a referral from your primary care physician in place before an appointment will be made.

- If your insurance requires a co-pay, we will be collecting the co-pay at the time of your visit. We apologize, but we do not bill for co-pays. We accept VISA and MASTERCARD.

We look forward to participating in your care. If you have any questions, please call our office at (206) 386-2700.

REGISTRATION FORM

PATIENT:

Name (Last, First, M.I.)_____

Street Address_____

City_____State_____ZIP_____

Phones: home_(_____)_____work_(_____)_____cell_(____)_____

Date of Birth_____/_____/_____ Social Security Number_____/_____/_____

Gender □ Male □ Female Employment Status □ Full time □ Part time □ Other_____

Employer_____

Address_____

Marital Status □ Single □ Married □ Divorced □ Domestic Partner/Life Partner □ Widow(er)

PERSON RESPONSIBLE FOR MEDICAL BILL:

Relation to patient □ Self (Same as above) □ Other_____

Name (Last, First, M.I.)_____

Street Address_____

City_____State_____ZIP_____

Phones: home_(____)_____work__(____)_____cell_(____)_____

Date of Birth_____/_____/_____ Social Security Number_____/_____/_____

Gender □ Male □ Female Employment Status □ Full time □ Part time □ Other_____

Employer_____

Address_____

Marital Status □ Single □ Married □ Divorced □ Domestic Partner/Life Partner □ Widow(er)

SPOUSE/LEGAL NEXT OF KIN: Name:_____

Phone: home _(_____)_____ work_(____)_____

REFERRING PHYSICIAN: Name:_____

Clinic:_____ phone_____

Primary Care Provider: Name:_____

Clinic:_____ phone_____

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New Patient Data Collection Form

Referred by:_____ Insurance:_____

Patient Name:_____ DOB:_____

Phone Numbers: daytime:_____ cell:_____

Documentation of my medical workup pertinent to my eye diagnosis can be found with:

PHYSICIAN	PHONE	DATE CONTACTED
Optometrist:		
Ophthalmologist:		
Neurologist:		

My visual field test was done with Dr. _____

My MRI of the brain was done at _____

Other tests performed are _____

at _____

I understand that I will need to bring my MRI with me to my appointment.

Patient Signature:_____

INSURANCE INFORMATION

PRIMARY INSURANCE: *please provide copy of card*

Insurance company_____

Insurance policy holder (**subscriber**) _____

Relationship to patient _____

Subscriber's SSN _____/_____/_____ **Subscriber's** Date of Birth _____/_____/_____

Employer_____

Insurance claims address (found on back of card) _____

City:_____ State_____ ZIP_____

SECONDARY INSURANCE: *please provide copy of card*

Insurance company_____

Insurance policy holder (**subscriber**) _____

Relationship to patient _____

Subscriber's SSN _____/_____/_____ **Subscriber's** Date of Birth _____/_____/_____

Employer_____

Insurance claims address (found on back of card) _____

City:_____ State_____ ZIP_____

MEDICARE QUESTIONNAIRE

I receive Medicare benefits □ Part A □ Part B □ Both

I receive Medicare benefits due to being age 65 or older □ Yes □ No

I receive medical benefits as the result of my or my spouses current employment □ Yes □ No

Please note: Medicare by be your **secondary** coverage if you are receiving health benefits due to you or your spouse's current employment.

SIGNED_____ **DATE**_____/_____/_____

Neuro-ophthalmic Consultants Northwest

FINANCIAL AGREEMENT WAIVER

Patient Name:_____

Date of Birth:_____ Social Security Number:_____

I give permission to Neuro-ophthalmic Consultants Northwest for medical treatment, including laboratory and x-ray services. I accept financial responsibility for all services provided, including any laboratory, x-ray and other ancillary care provided by other providers that I am referred to by Neuro-ophthalmic Consultants Northwest. I understand that I am responsible for payment if my insurance does not pay or only pays a portion of the services I am provided by Neuro-ophthalmic Consultants Northwest and other contracted providers. I authorize release of medical records by Neuro-ophthalmic Consultants Northwest and other contacted providers. I authorize release of medical records to my insurance company as needed to process claims. I am aware that I will receive a separate bill for any lab or x-ray services.

My current insurance status is as follows:

- ☐ I have insurance and do not need a referral.
- ☐ I have insurance and require a referral for services provided by Neuro-ophthalmic Consultants Northwest. I have informed by primary care physician that a referral is needed and have obtained one.
- ☐ Although my insurance requires a referral to Neuro-ophthalmic Consultants Northwest, I do not have a referral from my primary care provider for services provided by Neuro-ophthalmic Consultants Northwest. I understand that the services I receive from Neuro-ophthalmic Consultants Northwest is entirely my financial responsibility until I obtain an official authorization from my primary care provider listed with my insurance for these services.
- ☐ I did not bring my medical insurance card/coupon and decline to reschedule my appointment with Neuro-ophthalmic Consultants Northwest. I understand that the fee for services provided by Neuro-ophthalmic Consultants Northwest is <u>entirely my financial responsibility</u> unless I can present my medical insurance card/coupon and/or authorization for services.
- ☐ I choose to be seen for services outside the scope of my insurance coverage, provided by Neuro-ophthalmic Consultants Northwest, and understand that I will be required to pay for these services in total. I will pay the pre determined amount of deposit at the time of service.
- ☐ I do not have insurance and will be paying for all services provided by Neuro-ophthalmic Consultants Northwest myself. I will pay the pre determined amount of <u>*deposit*</u> at the time of service **with the remainder of the charges to be billed to me at a later date.**
- ☐ Other:_____

Signed:_____ Date:_____

Neuro-Ophthalmic Consultants Northwest
MEDICAL HISTORY FORM

Name:_____ **Date:**_____

Referred by:_____ **Primary Care MD:**_____

Occupation:_____ **Spouse/Partner Name:** _____

Age:_____ **Dominant Hand:** ☐ **Right** ☐ **Left** ☐ **Ambidextrous**

Reason for this visit:_____

Other Medical Problems	**Past Surgeries**

Medications and dose schedule:

1._____ **4.**_____ **7.**_____

2._____ **5.**_____ **8.**_____

3._____ **6.**_____ **9.**_____

ALLERGIES: _____

Use of Tobacco: **Never_____** **Previously, but quit_____** **Current packs per day_____**
Use of Alcohol: **Never_____** **Rarely_____** **Moderately_____** **Daily_____**
Recreational Drugs: **Never_____** **Yes_____** **Type/frequency**_____

Review of Systems: ***Do you currently have any of the following problems?***

	No	**Yes**	**If yes, please explain:**
Neurological problems (such as headaches, stroke, memory problems)	☐	☐	_____
Eye Disease (such as glaucoma, cataracts, wandering or lazy eye)	☐	☐	_____
Chronic fever, unexpected weight loss, fatigue	☐	☐	_____
Ear/Nose/Throat problems (e.g. hearing loss, sinus problems)	☐	☐	_____
Heart problems (e.g. chest pain, irregular heart beat)	☐	☐	_____
Respiratory problems (e.g. shortness of breath, wheezing, coughing)	☐	☐	_____
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea)	☐	☐	_____
Urinary problems (e.g. pain, incontinence, blood in urine)	☐	☐	_____
Endocrine problems (e.g. diabetes, thyroid disease, menstrual problems)	☐	☐	_____
Psychiatric problems (e.g. depression, anxiety, anger problems)	☐	☐	_____
Hematology problems (e.g. HIV, Hep C)	☐	☐	_____

Family Medical History: ***Any immediate family members with a history of either eye or neurological disease?***
☐ **No** ☐ **Yes (if yes, please explain)**_____

_____

MD initials:_____

NEW PATIENTS

You have been referred to our office for a medical condition requiring the highly specialized services of our physicians. The documentation of evaluations done by the other members of your care team are vital for the delivery of optimal care during your consultation.

Once the medical record from your referring physician is obtained, Drs. Hamilton and May will review the notes to assess how best we can serve you. You may be required to have specialized testing as part of your first visit, and our staff will be guided by those recommendations as they make your appointment.

The *"New Patient Data Collection"* form will help us identify the physicians who have this information. If you are able, we ask that you complete the form and **fax** it to us at **(206) 386-2703.** If faxing is not an option for you, we will obtain this information when you call for an appointment. Your assistance in contacting these physicians and requesting the records be faxed to us will be very helpful as some physician offices will require your permission to release your records.

Please complete the *"New Patient Registration Forms"* and return by email, or print and **fax** them to **(206) 386-2703.** If necessary**, bring** them with you to your appointment. Any questions that you may have after reviewing these forms can be answered when our staff contacts you for your appointment.

We have included an appointment card for you to print off and use as a remind of your appointment:

Appointment Card

I have an appointment with Dr. _____

on _____ at _____

failed appointments are subject to not being rescheduled

Neuro-ophthalmic Consultants Northwest
Nordstrom Medical Tower
1229 Madison Suite 615
Seattle, WA 98104
206-386-2700

PATIENT INFORMATION SECURITY

HIPAA (Health Information Portability and Accountability Act) sets rules and limits on who can look at and receive your health information. We, as a medical practice, are under obligation to provide you with a copy of the regulations and adhere to rules stated therein.

To make sure that your information is protected in a way that does not interfere with your health care, your information can be used and shared:

- For your treatment and care coordination
- To pay doctors and hospitals for your health care
- With your family, relatives friends or others YOU IDENTIFY who are involved in your health care, or your health care bills

To assist us in knowing to whom and how you identify the communication of your medical information, please complete the following :

□ YES □ NO It is permissible to leave detailed information from this office regarding my medical care on my home or work voice mail.

□ YES □ NO It is permissible to contact the other members of my care team or diagnostic facilities for information pertaining to my current eye condition.

□ YES Being over the age of 18, I understand that my medical information cannot be released to any family member, (including my parent, spouse, partner), or friend that I have not designated below.

I have been given a copy of the HIPAA policy. I authorize release of relevant medical information to the following persons/entities:

Name_____ Relationship_____

Phone_____

Name_____ Relationship_____

Phone_____

Name_____ Relationship_____

Phone_____

Name_____ Relationship_____

Phone_____

SIGNATURE: _____ Date_____/_____/_____

Neuro-Ophthalmic Consultants N.W.

NOTICE OF PRIVACY PRACTICES

1. 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. The notice is provided in two layers: This top layer briefly summarizes how we handle you health information, and the attached bottom layer provides further details of our privacy policies and procedures.

2. **How we may use and disclose your health information.** We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for several reasons. Beyond those situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information, you can later revoke it to stop any future uses and disclosures.

3. **Your rights.** In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.

4. **Our legal duty.** We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgment of receipt of this notice. We may change our privacy policies any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy policies, contact Sandra Benson, Administrator-HIPAA Officer.

5. **Privacy complaints.** If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact Privacy Officer. You also may send a written complaint to the U. S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact:

Privacy Officer
Seattle Radiologists, APC
1229 Madison Street, Suite 900
Seattle, WA 98104
Phone: 206-292-8517, Fax: 206-292-7764

Name of Policy Notice Of Privacy Practices REV 1 NOC		Date Originated: 4/11/03	Approved By: S. Benson, Seattle Radiologists	
Review Date:	Review Date:	Review Date:	Review Date:	Review Date: