OCN OPHTHALMIC CONSULTANTS NORTHWEST

Diseases and Surgery of the Cornea and External Eye
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Dear New Patient,

Welcome and thank you for choosing Ophthalmic Consultants Northwest for your eye care. Our commitment is to provide you with an accurate assessment and evaluation coupled with immediate, early intervention and the best possible medical care in a compassionate and caring manner.

Please take a few minutes to read the enclosed information regarding the services offered at OCN and our general information and policies.

Again, thank you for your trust in Ophthalmic Consultants Northwest and we look forward to serving you.

Sincerely,

The Physicians and Staff of OCN

PLEASE BRING THE FOLLOWING INFORMATION TO YOUR APPOINTMENT

- **Insurance card**
- **Drivers license or other photo identification**
- **Completed Patient Registration Forms and signature pages**
- **Completed Current Medication and Allergy list**

****** Please make sure to bring the enclosed forms to your appointment or fax them to 206.386.2515. If you are unable to complete the forms please plan to arrive 20 minutes prior to your appointment time to fill out this paperwork before you are seen

PATIENT INFORMATION FORM

First: _____ Middle: _____ Last: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

What doctor or facility referred you today? _____

Do you need an interpreter? ☐Yes ☐ No If yes, what language? _____

*Primary Phone Number: _____ ☐Home ☐Cell ☐Work ☐Caregiver

*Secondary Phone Number: _____ ☐Home ☐Cell ☐Work ☐Caregiver

*The Primary Phone Number will be used for all calls, including appointment confirmations.

Email Address: _____ (This will be used for appointment reminders.)

Date of Birth: _____ Occupation: _____

Sex: ☐Male ☐Female Social Security #:_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Domestic Partner

Employed: ☐Full time ☐Part Time ☐ Retired Student: ☐Full Time ☐Part Time ☐None

Employer Name: _____ Phone #:_____

Do you live in a nursing home or hospice? ☐ Yes ☐No

Emergency Contact (<u>Not</u> living with you):_____Phone_____

Primary Care Physician: _____Phone:_____

Complete this area only if the patient is under 18, <u>OR if someone other than the patient is responsible for the bill:</u>

First: _____ Middle: _____ Last: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ ☐Home ☐Cell ☐Work

Date of Birth: _____ Sex: ☐Male ☐Female Social Security #:_____

Relationship to patient: _____

Does someone have Power of Attorney for you? ☐Yes ☐No Name: _____

INSURANCE

Primary Insurance: _____ID#_____

Group #:_____ Subscriber: _____ Date of Birth: _____

Subscriber's Employer: _____ Phone: _____

Secondary Insurance: _____ID#_____

Group #:_____ Subscriber: _____ Date of Birth: _____

Subscriber's Employer: _____ Phone: _____

PATIENT MEDICAL HISTORY FORM

PATIENT NAME:_____ **DATE:**_____

DOB: _____/_____/_____

Present eye problem:_____

_____

How long have you had this problem? _____

Have you ever had similar symptoms in the past? ☐ YES ☐ NO If YES, describe:_____

_____

Do other members of your family have similar problems? ☐ YES ☐ NO

List any <u>EYE SURGERY</u> you have had in the past:

Date:_____ ☐ **Left eye** ☐ **Right eye** **Describe:**_____

Date:_____ ☐ **Left eye** ☐ **Right eye** **Describe:**_____

Date:_____ ☐ **Left eye** ☐ **Right eye** **Describe:**_____

List any other major surgery <u>NOT RELATED TO YOUR EYE</u>

Date:_____ **Describe:**_____

Date:_____ **Describe:**_____

Date:_____ **Describe:**_____

List all medications you are currently taking including eye medication:_____

_____

_____

Have you ever taken **Flomax?** ☐ YES ☐ NO

Are you allergic to **IODINE**? ☐ YES ☐ NO

Are you allergic to any medication? If YES, please list: _____

_____

Do you have any adverse reactions to anesthesia? ☐ YES ☐ NO If YES, please describe:_____

_____

Do you smoke? ☐ YES ☐ NO Have you smoked in the past? ☐ YES ☐ NO

Do you consume alcohol? ☐ YES ☐ NO

Have you been **<u>tested</u>** for HIV? ☐ YES ☐ NO [Result was ☐ Negative ☐ Positive]

Have you been **<u>tested</u>** for Hepatitis C? ☐ YES ☐ NO [Result was ☐ Negative ☐ Positive]

Have you ever been diagnosed with:

☐ Yes ☐ No **Cataracts**

☐ Yes ☐ No **Glaucoma**

☐ Yes ☐ No **Macular Degeneration**

☐ Yes ☐ No D**iabetic Retinopathy**

☐ Yes ☐ No **Retinal Pathology**

☐ Yes ☐ No **Corneal problems**

Does your physician recommend antibiotics prior to surgery and/or dental work? ☐ **YES** ☐ **No**

If YES, indicate which type of antibiotic: _____

_____

PATIENT MEDICAL HISTORY QUESTIONNAIRE

DATE:_____

PATIENT NAME:_____

PLEASE CHECK ALL THAT APPLY

Cardiovascular

- ☐ Heart Disease
- ☐ Heart Attack Date:_____
- ☐ Angina Date of last episode:_____
- ☐ Mitral Valve Prolapse
- ☐ Artificial Heart Valve
- ☐ Stroke Date:_____
- ☐ High Blood Pressure
- ☐ Pacemaker

Immunologic

- ☐ HIV/AIDS
- ☐ Lupus
- ☐ Rheumatoid Arthritis

Genitourinary Problems

- ☐ Kidney
- ☐ Bladder
- ☐ Prostate

Musculoskeletal

- ☐ Arthritis
- ☐ Joint replacement

  Surgeon:_____

  Date:_____

Neurological/Psychiatric

- ☐ Seizures/convulsions
- ☐ Parkinson's disease
- ☐ Alzheimer's
- ☐ Other (please list)

_____

_____

Endocrine

- ☐ Diabetes
- ☐ Thyroid

Skin Problems

- ☐ Scarring
- ☐ Keloids

Ear/Nose/Throat

- ☐ Hearing loss
- ☐ Hearing aids
- ☐ Sinus problems
- ☐ Sore throat

Respiratory

- ☐ Lung disease
- ☐ Tuberculosis
- ☐ Chest
- ☐ Shortness of breath

Gastrointestinal

- ☐ Ulcers
- ☐ Colitis
- ☐ Diverticulitis
- ☐ Liver/Hepatitis

Hematologic

- ☐ Anemia
- ☐ Bleed/bruise easily

Cancers Please list:

_____

_____

Family Medical History

Please mark if anyone in your family has had the following:

- ☐ Cataracts
- ☐ Diabetes
- ☐ Anemia
- ☐ Kidney disease
- ☐ Arthritis
- ☐ High blood pressure
- ☐ Bleeding disorders
- ☐ Cancer
- ☐ Liver disease
- ☐ Blindness
- ☐ Stroke
- ☐ Rheumatic fever
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Gout
- ☐ Blood transfusion
- ☐ Epilepsy
- ☐ Migraines
- ☐ Glaucoma
- ☐ Pacemaker
- ☐ Heart murmur
- ☐ Heart attack
- ☐ Asthma
- ☐ Jaundice

Current Medications and Allergies

Current Medications: Include prescription, over-the-counter, vitamins and supplements

Drug Name	**Dose** (mg, units, drops, mcg)	**How Often** (daily, bedtime, as needed)	**Reason**
Example: Tylenol	Example: 650 mg	Example: As needed	Example: headache

Allergies: ☐ **Check this box if None** **OR list below:**

Drug: _____ **Reaction:** _____

Drug: _____ **Reaction:** _____

Drug: _____ **Reaction:** _____

Drug: _____ **Reaction:** _____

PATIENT FINANCIAL POLICY

Ophthalmic Consultants Northwest (OCN) is committed to providing you with the best possible medical care. The following information outlines financial responsibilities related to payment for professional services that you, the patient, are ultimately responsible for and charges associated with your care regardless of insurance coverage.

Patient Responsibilities

- Providing us with your picture identification, insurance card and Social Security number enables us to submit your claims timely and accurately
- Know your insurance benefits and limitation
- If required by your insurance, ensure there is a proper **Referral** or **Authorization** on file for our providers to treat you
- Pay your estimated portion of the charges at the time of service
- Maintain a current account with Ophthalmic Consultants Northwest at all times
- Provide us with at least 24 hours advance notice should you need to cancel or reschedule your appointment
- Complete required incident/accident forms within 30 days of the date of service
- Complete all required Patient Registration and Policy forms

Please note that co-payments, co-insurance and deductibles are a contractual agreement between you and your insurance carrier. OCN cannot change or negotiate these amounts.

Patients WITH Insurance

OCN will bill your primary and secondary insurance carrier. If you are disputing payment with your insurance carrier or have a balance over $100, you must notify our business office to make payment arrangements.

Co-Pay/Deductible/Co-Insurance – Patients are required to pay their portion of these charges on the date of service.

Surgical Procedures – If surgery is indicated, a pre-payment of the physician fee is required for all elective, non-emergent procedures prior to the surgery being performed. Your out-of-pocket cost is estimated based on your benefits and our fees. Hospital and Anesthesia fees are separate.

Non-Participating Insurance – If we do not participate with your insurance company, we will file a claim as a courtesy. All unpaid claims will become your responsibility 45 days following the filing of the claim, and will be immediately due upon receipt.

Patients WITHOUT Insurance

Office Visits – A $200 deposit is required upon checking in for your appointment. Office visits may include photographs, x-rays, and materials at an additional charge. Charges are not finalized until chart notes are completed.

Surgery – for uninsured patients having surgery, we offer a 20% discount when charges are paid in full before or on the day of service (see exclusions)

Exclusions

- The discounts referenced above do not apply in cases of motor vehicle accidents, third party insurance claims or in other cases when the patient may be reimbursed in full.
- Patients who receive retroactive Medicaid coverage need to immediately notify our business office at 206.812.0707
- If the patient is insured but wishes OCN to not bill insurance, they are not eligible for the discount

Motor Vehicle Accidents (MVA) Insured and Third Party Patients

We do not extend discounts for MVA-insured accidents, third party insurance claims or in other cases when patients may be reimbursed in full. We will bill the MVA insurance carrier one time. After 30 days from the filing of the claim, the full amount will become patient responsibility and payment will be due upon receipt.

Worker's Compensation

If your visit is work-related, we will need the case number, injury date, and carrier name prior to your visit in order to bill the worker's compensation insurance. We will need information on your 'approved conditions' and/or 'body specific coverage' at your first visit. If your worker's compensation claim is not yet accepted and you have no other insurance, we require a $200 deposit that will be refunded after the claim has been opened.

Treatment of a Minor

If the patient is a minor (under 18 years of age), the parent or guardian must sign below. The parent, guardian, or unaccompanied minor is responsible for any payment due at the time of service, and providing required referrals, insurance and picture ID cards. We can discuss only billing information (no medical information) on an account for a patient over 18 years of age, regardless if the patient's parent, guardian or the subscriber is financially responsible.

Other Charges

No Show –Please provide us with at least 24 hours advanced notice if you need to cancel or reschedule an appointment. We may charge a fee for missed appointments.

Please provide us with at least 48 hours advance notice if you need to cancel or reschedule an appointment where an interpreter has been ordered. Otherwise, you may be charged for the interpreter.

Forms – Please note that there are charges related to the completion of forms for both the provider and/or the administration staff. We require payment of these charges before returning the completed form to you. Please allow five to seven business days for us to complete forms.

Payment

Payment Options – We accept cash, checks, major credit/debit card and money orders. We do not accept post-dated or third party checks. OCN charges a $40.00 NSF fee for any returned checks.

Delinquent Accounts – Patient accounts will be assigned to collections if balances are unpaid after 90 days. Patients assigned to collections may be denied additional services.

Payment Arrangements – If you are unable to pay your balance when due, please contact the business office at 206.812.0707 to make alternative arrangements. Any patient with a past due amount may be denied additional service until the amount is paid or the patient is complying with payment plan arrangement.

Bankruptcy/Prior Bad Debt – Patients who have previously filed for bankruptcy or never satisfied their payment obligations for prior services with OCN may be required to pay for their portion of new charges at the time of service.

If you have questions about your insurance or this document, our Business Office will help you and can be reached at (206) 812-0707. However, specific coverage issues should be directed to your insurance company member services department (typically, the number is found on the back of the insurance card). If your insurance changes during your course of treatment, please notify our Business Office immediately.

REFRACTION PAYMENT POLICY

Refraction is the process of determining the best possible visual acuity and function of your eye as well as the need for corrective glasses and/or contacts. Congress has determined that the refraction is NOT a covered service by Medicare; most medical insurance plans follow Medicare guidelines as well. Our fee for refraction is $45 and will be collected at the time of service in addition to any co-pays or deductibles your insurance plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

DILATING EYE DROP CONSENT

Dilating drops are used to dilate or enlarge the pupils of the eye to allow your physician to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your physician to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you make arrangements not to drive yourself when you leave our office. If your child is dilated, he/she will have difficulty in completing schoolwork and homework. In addition, he/she should not participate in contact sports on the day of dilation.

I hereby authorize the physicians, and/or such assistants as may be designated by the physicians, of Ophthalmic Consultants Northwest to administer dilating eye drops. I understand that the eye drops are necessary to diagnose my condition and/or examine my eyes and that dilating drops may be put into my eyes each time I am examined or treated at the office of Ophthalmic Consultants Northwest.

_____ _____

PRINT: Patient Name (or person authorized to sign for patient) Date

Signature this field after printing

_____

SIGNATURE: Patient (or person authorized to sign for patient)

Consent for Minor or Incompetent

If the patient is unable to sign, or is a minor, complete the following:

Patient is a minor _____ years of age.

Patient is unable to sign because: _____

_____ _____

PRINT: Name of Closest Relative or Legal Guardian Date

Signature this field after printing

_____

SIGNATURE: of Closest Relative or Legal Guardian

Release of Information:
I give permission to the following person(s) to speak with anyone from Ophthalmic Consultants Northwest about my eye condition, billing information, and any other relevant information.

1. **Name** _____ **Relationship**: _____
2. **Name** _____ **Relationship**: _____
3. **Name** _____ **Relationship**: _____

Patient Initials: _____

Patient Financial Responsibilities:
I acknowledge that I have received and reviewed the Patient Financial Policy.
I accept full financial responsibility for all items or services which my insurance company has determined are not covered. Examples of non-covered services include, but are not limited to, services not specific as being covered in the patient's contract with an insurance plan or in the benefit summary the insurance plan has furnished to the patient; and treatment or tests not authorized by the insurance plan.

Patient Initials: _____

Referral Policy:
I, the undersigned patient/responsible party, acknowledge that my insurance may require a referral or authorization before it will pay for my treatment. If a referral or authorization is required and not received before my treatment, I understand that I may be financially responsible for the total amount of the exam, tests, and/or procedures rendered.

Patient Initials: _____

Acknowledgment of Notice of Privacy Practices:
Our Notice of Privacy Practices provides information about how we may use and disclose the medical information that we maintain about you. It also explains how you can access this information.

By signing, you acknowledge that you have reviewed the Notice of Privacy Practices of Ophthalmic Consultants Northwest.

_____

Print Patient's Name Date of Birth

Signature this field after printing
_____

Signature of Patient or Guardian

GENERAL INFORMATION AND PATIENT GUIDELINES

Welcome to our practice. Our staff is made up of professionals who work together to bring you the highest quality ophthalmic care. This information is provided to answer questions most frequently asked by patients. If you have any questions on this information, please contact our information desk at 206.812.2990.

Our office staff will need to make a copy of your insurance information and photo identification. We will ask for this information **at each visit**. If you cannot provide current insurance information and we cannot verify coverage, you may need to reschedule your appointment or make payment in full for that day's services.

At every visit, it is important that you provide an up-to-date list of all medications you are taking, including any over-the-counter medication, vitamins or herbal supplements. This will help your providers decide upon the best treatment options and watch for any interactions. Please list the amount of the medication you are taking (the dosage) and how often you are taking it.

Registration Packet

At your first appointment, or if you have not been in the office within the last 12 months, you will be asked to complete a patient information form and patient history and physical form. This information assists your physician in your care, therefore complete and accurate information is important. To facilitate the registration process, you may go to www.seattlecornea.com to download our registration packet, complete and bring it in with you. If you are unable to download and complete our registration packet, please come to your appointment 20 minutes early to allow time to complete.

Office Hours and Making an Appointment

Seattle: Office hours are from 8:30am to 4:30pm Monday through Friday. To schedule an appointment please call 206.812.2990

Tacoma: Office hours are from 9:00am to 5:00pm Tuesdays only. To schedule an appointment please call 206.812.2990

Your appointment schedule may vary depending on the doctor's hospital rounds and surgery schedule. We believe that everyone's time is valuable and in the event of a delay, we will do our best to notify you in advance. Please notify us as soon as possible in the event you need to reschedule your appointment. If you need to be seen immediately, we will do our best to accommodate you. Follow-up appointments should be made when you check out.

Self-Referrals

If your insurance carrier allows self-referrals, you may contact OCN directly without a referral from another doctor.

Physician-Referrals

If you insurance carrier requires primary care physician referrals, please contact your PCP prior to scheduling your appointment to obtain authorization.

Canceling an Appointment

Cancellations should be made at least 24 hours prior to your scheduled appointment time. If you know you will not be able to keep your appointment, please contact our office as soon as possible. If you cancel or fail to show for three consecutive appointments, we reserve the right to not reschedule your appointment.

Office Locations

OCN has two locations to serve you:

Seattle: 1221 Madison Street, Suite #1420
Seattle, WA 98104
206.386.2516

Tacoma: 1901 South Union Avenue, Suite #A-224
Tacoma, WA 98405
253.459.6484 (**Tuesdays only**)

Billing and Insurance Information

In general, fees charged in this office are reasonable and customary and are comparable with those charged in other ophthalmic practices in our region. As a courtesy, we do submit insurance claims for our patients, however we will not re-bill for denied claims due to incorrect insurance information obtained by the patient. It is important that you have your correct insurance information at the time of your appointment and to notify our staff if your insurance coverage changes anytime during your care at OCN. We participate with most insurance plans; however, it is the patient's responsibility to ensure proper authorization and physician participation before making an appointment. We recommend patients to read their policy book or call their insurance company to learn about benefits and coverage of their policy. Patients are expected to pay all co-pays, co-insurance and deductibles at the time of service. Monthly statements are mailed to each patient with patient balance due expected within 30 days. Please see the enclosed Patient Financial Policy for more details. Our business office experts will be happy to assist you with any questions regarding services provided at our clinics. The business office can be reached at 206.812.0707 Monday thru Friday, 8:00 AM – 5:00 PM

Payment Policy

It is our payment policy to collect the appropriate payment due from the patient at the time services are rendered. This may only be your co-payment, deductible and/or co-insurance, but we do require payment at the time of your visit. We accept all major credit cards. **If you are unable to make your payment at the time of service, you appointment will be rescheduled.**

No Insurance or Failure to Provide Insurance Information

You must bring a current insurance card to each appointment. Unfortunately, we cannot accept written information. If you do not have insurance or do not have a current copy of your insurance card, you will be required to pay a $200 fee for services upon checking in [This fee may not cover all services performed during your visit. Any charges over and above the $200 will be billed to you]. If you have insurance this fee may be refunded when you provide us with your insurance card. If you provide us with the incorrect insurance information at the time of your visit and the claim is denied, all services will be billed to you, the patient, and payment will be due upon receipt. **Our office will not re-bill insurance after initial claim submission.**

Waiting Time

At OCN, we realize your time is valuable and that every patient, and their condition, is unique with different needs which may require more time than planned. Therefore, we will make every effort to provide you with the highest quality care and to minimize your waiting time. In the event of a delay or unforeseen emergency we will notify you and give you an option to reschedule. As this is a surgical practice, there may be times that a surgery may take longer than expected which may cause a delay in clinic time. Every effort will be made to accommodate for this. We will do our best to notify you if/when this occurs

Your Medical Records (Privacy and Safeguards)

We want you to know that we are committed to doing our best to safeguard the accuracy and security of your health information. Because of many new rules in place, there may be times we ask you to fill out acknowledgements that you haven't had to fill out in the past. We apologize in advance for any inconvenience this may cause you, and thank you for your patience and understanding as we work together to keep your information safe and secure. Please refer to our Privacy Notice which will provide the details of when we can and cannot release your information according to HIPAA. When requesting copies of your medical records, we ask that you please allow a minimum of three business days to prepare your request for pick-up. For your convenience, you may call and place your request by calling 206.812.2990

Filling Your Prescriptions

All new prescriptions are given to the patient at the time of the appointment. If you need a refill on your prescription, please call during the office hours of 8:30 AM to 4:30 PM, Monday thru Friday by dialing 206.812.2993. It is OCN's general policy not to refill lost or stolen prescriptions or fill any requests made after office hours.
To facilitate efficient handling, please provide the following information at the time of the request:

1) Your full name and date of birth
2) The name of medication(s) you need refilled (including strength)
3) The pharmacy you use (name and phone number)
4) A number where you can be reached

We will contact you to inform you if your prescription will not be called in or if we have further questions regarding your condition. Otherwise the prescription will be called in within 48 hours. You will want to check with your pharmacy after 5:30 PM. Certain prescriptions are available by written refills only and will require you to pick up the prescription. At times, a refill may not be given if the patient has not had a visit within the past three months, therefore you may be asked to make an appointment prior to receiving your prescription.

Telephone Calls and Medical Questions

Each physician has a dedicated clinical team to assist in providing your care. When you call with a routine medical question or request, the receptionist will connect you with the clinical team. Except in emergencies, our physicians or clinical teams do not accept calls while they are in clinic with patients. If you call when your team is in clinic the receptionist will send an electronic phone message to the clinical team or you will be directed to the appropriate department to leave a message to be returned by the clinical staff. The team will respond to your call either between patients (time permitted) or at the end of clinic (around lunch time or at the end of the day).

Request for Completion of Forms

It is OCN's policy to timely fulfill patient requests for completion of forms.
There is a 5 business day turnaround on forms needing completion. Also, a charge of $10 per form (unless WC or Family Medical Leave). Forms will not be released to the clinical staff for completion until the $10 fee has been paid.

Emergencies (Outside of Office Hours)

A physician is on-call 24 hours a day, seven days a week to handle emergencies. If you are hurt or have a problem that necessitates seeing a physician, please call our office number at (206) 386.2516 and the answering service will page the physician on-call. We encourage you to call during office hours so that you have a better chance of reaching your regular physician and he/she will have your medical records available. If you believe the emergency is serious or life threatening go directly to an emergency department for immediate care or call 911

Surgery

If you should require surgery, your clinical team will assist you in obtaining any preauthorization your insurance carrier may require. It is your responsibility to obtain your private insurance pre-authorization or second opinion requirements. We will be pleased to assist you as needed. Please understand that while your insurance company may only allow what they consider usual and customary fees – the patient is responsible for the patient responsibility balance.

In case you have no insurance, a down payment will be required prior to scheduling surgery and our billing department will assist you in setting up a payment plan. Our financial policy will answer any questions you may have regarding your account.
The billing department can be reached by calling 206.812.0707
In addition to oral instructions, your physician's clinical team will provide you with a surgery packet including instructions for pre-testing, day of surgery and post-surgery instructions. Every effort will be made to keep your surgery on schedule; however, we are dependent on the surgical facility to ensure we have the facilities and staff available to conduct your surgery. In rare cases your surgery may need to be cancelled but you will be informed as to the reason of cancellation and to reschedule your surgery.

For more information about your provider, any of our services or to find these enclosed forms please visit www.seattlecornea.com

Privacy Policy Notice

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

Ophthalmic Consultants Northwest respects your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law requires and/or authorizes us to do so.

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses and treatment, health information from other providers, and billing and payment information relating to these services.

Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

For help with any information in this brochure during normal business hours, please contact the Office Manager by calling (206) 386-2516

Information for Treatment, Payment, and Health Operations.

Information obtained by a nurse, technician, physician or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.

- We may also provide information to others providing your care. This will help them stay informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed or recommended care.

For health care operations:

- We use your medical records to assess and improve services.

- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.

- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.

- We may use and disclose your information to conduct or arrange for services including:

    1. Medical quality review by your health plan;
    2. Accounting, legal, risk management and insurance services;
    3. Audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health care billing records we create and store are the property of Ophthalmic Consultants Northwest. The protected health information in it, however, generally belongs to you. Under certain circumstances we have the right to deny you access. You have the right to:

- Receive, read and ask questions about this Notice;
- Restrict certain uses and disclosures. We are not required to grant the request. In this case, your medical records will be released directly to you;
- Request and receive from us a paper copy of the most current Privacy Policy Notice for Protected Health Information;
- Request that you be allowed to see and get a copy of your protected health information. This request must be in writing. We have a form available for this type of request
- Have us review a denial of access of your health information.
- Ask us to change your health information. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payers. You may receive this information, as well as a copy of your health information, without a charge once every 12 months. We will notify you in advance of any cost involved if you request this information more than once every 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

Other Disclosures and Uses of Protected Health Information

Notification of Family and Others

- Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to assist in disaster relief. If you object, we will not use or disclose it.

We may use & disclose your protected health information without your authorization as follows:

- Another physician within Ophthalmic Consultants Northwest may review records for the purpose of random review as part of quality improvement.
- To medical researchers: if the request has been approved and has policies to protect the privacy of your health information.
- To funeral directors/coroners
- To organ procurement organizations
- To the Food & Drug Administration (FDA)
- To comply with Workers' Compensation Laws: if you made a workers' compensation claim
- For Public Health & Safety purposes as allowed or required by law and Health & Safety Oversight Activities.
- To report suspected abuse or neglect
- For law enforcement purposes & to correctional institutions
- For work-related conditions that could affect employee health
- To the military authorities of U.S. and Foreign Military Personnel as required by law
- In the course of judicial administrative proceedings at your request or as directed by a subpoena or court order.
- For specialized government functions
- Uses and disclosures not in this Notice will be made only as allowed or required by law with your written authorization

Our Responsibilities:

- Keep your health information private
- Give you this notice
- Follow the terms of this Notice

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling Ophthalmic Consultants Northwest.

To Ask Questions or Complain

If you have questions, want more information, or want to report a problem/complaint about the handling of your protected health information, you may contact: Clinic Manager at (206) 812.2990

If you believe your privacy rights have been violated, you may discuss your concerns with the clinic manager. You may also deliver a written complaint to either office location. You may also file a complaint with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.