As a patient of Eye Physicians of Northampton, you have the right to:

- Receive care in a safe setting regardless of race, color, sex, national origin, religion, or sexual preference.
- Be treated with respect and dignity, free from abuse, neglect or harassment.
- Be provided appropriate personal privacy.
- Expect disclosures, information and records to be treated confidentially and, except when required by law, be given the opportunity to approve or refuse their release.
- Review your records and receive a copy of them. You may also ask to amend your healthcare record.
- Expect to know the names, professional status and responsibilities of your healthcare providers.
- Seek another medical opinion and change primary or specialty healthcare providers.
- Receive, to the degree known, complete information concerning your diagnosis, evaluation, treatment and expected outcome. When medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person who may participate in the decision making.
- Refuse a recommended treatment or plan of care, to the extent permitted by law, and to be informed of any medical consequences related to the decision.
- Voice grievances regarding care or service which is (or fails to be) provided, without fear of reprisal or discrimination. Grievances will be investigated and a response provided within 14 days. Complaints and grievances may be verbal or written and directed to: Virginia Poirier, Office Manager 413-584-6422, Ext. 109

As a patient of Eye Physicians of Northampton, you have the responsibility to:

- Provide complete and accurate medical information.
- Participate with providers in making decisions about your treatment or plan of care.
- Follow the treatment plan to which you agreed or let us know if you do not understand or cannot follow your healthcare instructions.
- Arrive for scheduled appointments (Eye Physicians has the right to terminate services if you miss two or more appointments without calling in advance to cancel).
- Know your health plan benefits, provide complete insurance information and timely notification of any changes.
- Pay your bill in a timely fashion or seek assistance for discussing payment options.
- Treat our staff and physicians with respect and dignity and respect the rights of others.
- Let us know if you have concerns or complaints about any aspect of your care.
- Follow facility policies which prohibit smoking, the use of alcohol or illegal drugs and carrying firearms or other weapons.
PATIENT INFORMATION FORM

First:________________ Middle:______ Last:____________________ Date:__________________

Address:___________________________________________________________________________

City:___________________________________ State:___________ Zip:____________________

Daytime Phone Number:__________________________ Home  Cell  Work

Other Phone Number:__________________________ Home  Cell  Work

*Phone number to use for appointment reminder calls: Daytime Other

Email Address:______________________________________________________________________

Date of Birth:_______________________ Occupation:______________________________________

Sex:  Male  Female  Social Security Number:___________________________________________

Race: American Indian  Asian  Black  Hispanic  Other  Pacific Islander  White

Ethnicity:  Hispanic  Not Hispanic

Marital Status:  Single  Married  Divorced  Widowed  Domestic Partner

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

Employer:____________________________________ Phone:________________________________

Parent’s Employer (if applicable):____________________________________ Phone:__________________

Do you live in a nursing home or hospice:  Yes  No  Do you speak English?  Yes  No

Emergency Contact Person:____________________________________ Phone:__________________

Primary Care Physician:____________________________________ Phone:__________________

Referring Physician:____________________________________ Phone:__________________

If different from Patient, Person Responsible for Payment:______________________________

Date of Birth:___________ Social Security Number:___________ Relationship:___________

Address:____________________________________ Phone:______________________________

City:____________________________________ State:___________ Zip:____________________

Do you have a Healthcare Power of Attorney?  *Yes  No

*If yes, please bring a copy so we can have it on record.
INSURANCE

Primary Insurance:______________________________ ID#:_________________________
Group #:____________ Subscriber Name:______________________ Date of Birth:______________
Subscriber’s Employer:______________________________ Phone:__________________

Secondary Insurance:______________________________ ID #:________________________
Group #:____________ Subscriber Name:______________________ Date of Birth:______________
Subscriber’s Employer:______________________________ Phone:__________________

Your eyes may or may not be dilated for examination at each visit. If you are dilated, your vision may be affected causing temporary visual impairment therefore, you may wish to make alternative transportation arrangements.

FINANCIAL POLICY

Thank you for choosing Eye Physicians of Northampton for your eye care needs. We are committed to providing you with the best treatment available. The following is a statement of our Financial Policy.

All new patients must complete our Patient registration forms before seeing the physician.

- All Co-Pays are due at time of service.
- Unless we are billing your insurance, payment in full is due at the time of service.
- For your convenience we accept, Cash, Visa, Mastercard and Discover.

REGARDING INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will bill your insurance plan for you as long as you provide us with the correct information. Please be aware that some, and perhaps all, of the services provided may be a non-covered service and/or not considered medically necessary under your insurance plan. You, as the patient, are ultimately responsible for payment of all services provided by Eye Physicians of Northampton. While payment is your responsibility, we will assist you in negotiating a settlement with your insurance company for any disputed claim.

USUAL AND CUSTOMARY RATES: Eye Physicians of Northampton is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary rates.

MEDICALLY NECESSARY CARE: We will only provide you with a service if we consider it medically necessary. We routinely perform diagnostic test, such as refractions, that some insurance carriers will not cover. We use refraction as a diagnostic tool rather than to prescribe glasses. Therefore, if your insurance company arbitrarily determines that a service we have rendered to you is not a covered benefit, you will be responsible for the bill.

Patient Initials ________________ Date ________________
ASSIGNMENT OF BENEFITS

Please Read and Sign

I request the payment of authorized Medicare or other insurance company benefits, including Medigap, be made on behalf of me or my dependent(s) to Eye Physicians of Northampton for any services furnished. Regulations pertaining to Medicare assignment of benefits apply. Eye Physicians of Northampton accepts Medicare Part B assignment.

I authorize Eye Physicians of Northampton to release medical or other information pertaining to me or my dependent(s) to insurance carriers for related Medicare or other insurance company claims. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment. I understand that it is mandatory to notify the health care provider or any other party who may be responsible for paying for me or my dependent(s) treatment. I agree to pay all fees and charges for such treatment. I agree that I will not withhold or delay payments if Medicare or other insurance companies deny payment on any of my or my dependent(s) charges.

Signature________________________  Date____________________
HIPAA
PRIVACY POLICY NOTICE AND PATIENT RIGHTS AND RESPONSIBILITIES
ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Eye Physicians of Northampton.

Our Privacy Policy Notice describes in more detail how your health information may be used and disclosed, and how you can access your information.

Our Patient Rights & Responsibilities provides guidelines for your care in our facility and contact information for concerns.

By my signature below I acknowledge receipt of the Privacy Policy Notice and Patient Rights & Responsibilities.

________________________________________________  __________________________
Patient or legally authorized individual signature                  Date

________________________________________________  __________________________
Printed Name if signed on behalf of the patient                  Relationship (parent, legal guardian, etc.)

This form will be retained in your medical record.
CONSENT FOR LEAVING MESSAGES
CONSENT TO LEAVE MESSAGES/SHARE INFORMATION
WITH FAMILY/ FRIENDS

I understand that my healthcare information at Eye Physicians of Northampton is protected and I have received a copy of their Notice of Privacy Practices.
In order for Eye Physicians of Northampton to leave detailed messages on my voicemail or answering machine, I need to give permission to Eye Physicians of Northampton to do so.

Consent for Leaving Messages
☐ I consent to information regarding my or my child’s (under the age of 18) test results or detailed appointment reminders/ instructions be left on my voicemail or answering machine. I understand that “sensitive” information as noted below will be excluded.

Consent for Shared Information with Family and Friends
☐ I wish family members or friends to have access to my healthcare information. Name(s) listed below are family members or friends to whom I grant access to my healthcare information. I will rely on the professional judgment of my provider and his/her designee to share such information as they deem necessary.

I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information Form.
I understand that some information is considered “sensitive”. I understand that I must check the specific boxes in order for my provider, or his/ her designee, to release any “sensitive” information.

☐ Mental Health/ Psychiatric Disorders (including depression)
☐ Chemical Dependency (drug and/ or alcohol abuse/ treatment)
☐ Pregnancy Information
☐ Sexually Transmitted Diseases
☐ HIV/ AIDS virus

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<thead>
<tr>
<th>NAME</th>
<th>RELATIONSHIP</th>
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Patient Name ______________________  Date ____________________

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at anytime. It will be my responsibility to keep this information up-to-date, as I recognize that relationships and friendships change over time.
Personal Medication Record

Name:__________________________________________      Date form completed:__________
Date of Birth:______________________
Height:_______  Weight:__________
Pharmacy Name:__________________________
Pharmacy Address:__________________________
Phone:_____________________
Fax: ______________________

☐ No Known Drug Allergies

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<thead>
<tr>
<th>Allergic To/ Describe Reaction:</th>
<th>Allergic To/ Describe Reaction:</th>
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Are you allergic to latex?
Are you allergic to iodine?

List ALL medications you are currently taking:

Include prescription medications, over-the-counter medications (examples: aspirins, antacids), vitamins and herbal supplements (examples: ginseng, ginko)

☐ Not currently taking any medications, vitamins, or supplements

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dose (mg)</th>
<th>Frequency (i.e. daily, twice daily, etc)</th>
<th>Reason for taking this medication</th>
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