One Northgate Park
2120 Northgate Park Lane, Suite 102
Chattanooga, TN 37415
Phone: (423) 702-2020 Fax: (423) 702-2021

David L. Friedrich, MD Dennis L. Cosgrove, OD

Appointment Date: ____________________ Appointment Time: ___________________

Dear New Patient:

We are honored that you have chosen Friedrich Eye Associates, PLLC, to provide your medical and/or surgical eye care needs. To help prepare you for your upcoming visit, please read the enclosed information.

1. To make your visit as efficient as possible, please complete the attached **Patient Registration Form** and **Medical History Questionnaire** and bring them with you to your appointment. We will also need a copy of your **driver's license** and **insurance card (s).**

2. It is common for both of your eyes to be dilated. We, therefore, highly recommend that you have someone accompany you here and drive you home. We also recommend this if you are scheduled for any in-office procedures or surgery.

3. Please bring a list of all medications that you use, their dosage and frequency, and the name of your doctor(s). Also bring any prescription glasses you may wear. We also suggest that you bring sunglasses; if your pupils are dilated, your eyes will be sensitive to light when you leave.

4. Our collection policy: The physicians at Friedrich Eye Associates participate in a variety of insurance plans. As a courtesy to our patients, we file all claims. You will be expected to pay your co-payment and/or deductibles at each visit. If you have any questions about your insurance or account, please feel free to contact us.

We hope this letter of introduction will help make your visit with us as pleasant and efficient as possible. If you have any questions, please do not hesitate to contact us. Again, thank you for allowing us to participate in the care of your eyes.

Sincerely,

Friedrich Eye Associates Physicians and Staff

PATIENT REGISTRATION

Please bring Photo ID, Insurance Cards, and Medication List to your appointment.

Patient Name				**Salutation**	
Birth Date		**Age**		**Birth State**	
Sex				**SS #**	
CURRENT ADDRESS					
Address					
ADDRESS YOUR INSURANCE COMPANY HAS ON FILE ☐ **Same As Above**					
Address					

COMMUNICATION					
Home Phone #		**Work Phone #**		**Extension**	
Cell Phone #		**Carrier**			
Email					

INFORMATION			
Marital Status		**Special Needs**	
Occupation		**Employer**	
Employer Address		**Employer Phone #**	

GOVERNMENT REQUIRED INFORMATION **Check One in EACH Section**			
Primary Language	☐ English ☐ Spanish ☐ French ☐ Other: ______________________		
Race	☐ American Indian or Alaska Native ☐ Black or African American ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Other Race ☐ Decline to Answer	**Ethnicity**	☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown ☐ Decline to Answer

EMERGENCY CONTACT (Please list 2 contacts)		
Name	**Relationship**	**Phone #**

ACCOUNT RESPONSIBLE					☐ Same As Above
Responsible			**Birth date**		
Pt. Relationship			**SS #**		
Address					
Home Phone #		**Work Phone #**		**Extension**	
Email					

PRIMARY INSURANCE			
Name		**Group Name**	
ID #		**Group #**	
Address			
Phone			
Insured		**Date of Birth**	

SECONDARY INSURANCE			
Name		**Name**	
ID #		**Group #**	
Address			
Phone			
Insured		**Date of Birth**	

REFERRAL SOURCE					
Referring MD		**Phone #**		**Fax #**	
Address		**City and Zip**			
Primary MD		**Phone #**			
Address		**City and Zip**			

FINANCIAL AGREEMENT

The financial policy has been fully explained to me and I acknowledge full responsibility for all charges incurred, including any additional charges incurred in the collection of this account, if my insurance later determines my services to be non-covered or not a benefit. I also understand that refractions are a non-covered service, but necessary for my medical care. I agree to pay the refraction fee at the time of service.

PATIENT SIGNATURE: X____ **DATE:** ______________________

PRIVACY POLICY

I understand that HIPAA has implemented procedures that require specific authorization for release of my information. I agree to the following statements and understand that I can revoke these at any time by informing the Privacy Officer in writing.

Home telephone: We may leave a message with a callback number or appointment reminder on voice mail.

Written Communication: We may mail postcards to your home address or send you an e-mail.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.I understand that the last four digits of my social security number will be used as a password to identify persons seeking information regarding my healthcare, test results, prescription refills, billing information. If I would like a different code assigned, I will list it here: ____________________. I will give this code to my family members or friends who may need to call the practice on my behalf. Without this code, the physicians or staff members will not be able to speak to anyone except myself.

PATIENT SIGNATURE: X____ **DATE:** ______________________

LIFETIME INSURANCE AUTHORIZATION

I authorize and request that payments under my medical insurance plan(s) be made directly to pay the provider for any services furnished to me. I also authorize the provider to release any information needed for payment of claims. I further permit copies of this authorization to be used in place of the original.

PATIENT SIGNATURE: X____ **DATE:** ______________________

MEDICAL HISTORY INFORMATION SHEET

Name: ________________________ **D.O.B:** __/__/__ **Today's Date:** __/__/__
Reason For Today's Visit: ____

Medical History: **Please check any illness/condition YOU have.**

__Allergies __Anemia __Arthritis __Asthma __Cancer __Depression

__Diabetes __Headache __Heart Issues __Hepatitis __High Blood Pressure

__High Cholesterol __Mental Illness __Seizures __ Stroke __Thyroid Disease

Please list any other conditions you have:____

Eye History: **Please check any illness/condition YOU currently have.**

__Blindness __Blurred Vision __Burning __Cataracts __Discharge

__Double Vision __Dryness __Flashes of Light __Floaters __Glare/Halos

__Itching __Light Sensitivity __Poor Night Vision __Red Eyes __Watering

Please list any other eye conditions you have:_____________________________________

Eye Surgery History: **Please list any prior Eye Surgeries you have had.**

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Family Eye History: **Please check if your immediate family has ever had.**

__Blindness __Cataracts __Diabetes __Glaucoma __Macular Degeneration

Social History: **Please Check All That Applies.**

Tobacco Use: __Never __Former __Current List Type:______________________
Alcohol Use: __Never __Frequent __Social List Type:______________________
Drug Use: __Never __Former _Current List Type:______________________

Allergic To Latex: **__Yes __No** **Allergy to Meds:** **__Yes __NO**

Please List Drug Allergies: ____

Current Medications: **Please List ALL Current Medications You Are Taking:**

____

____

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FRIEDRICH EYE ASSOCIATES, PLLC

Notice of Privacy Practices

Please keep this page for your records.

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 Health Insurance Portability and Accountability Act of 1966 (“HIPAA”) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

A. How the Practice May Use or Disclose Your Health Information

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.
– **TREATMENT** means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include performing diagnostic tests in our office.

– **PAYMENT** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

– **HEALTH CARE OPERATIONS** include the business aspects of running the Practice, such as conducting quality assessment and improvement activities, auditing functions, cost- management analysis and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

There are times we may be required by law to disclose information for law enforcement or public health reasons without additional authorization from the patient.

B. When the Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, the Practice will not use or disclose health information that identifies you without your written authorization. If you do authorize the Practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. We are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

C. Your Health Information Rights

You have the following rights with respect to your protected health information (“PHI”), which you can exercise by presenting a written request to the Privacy Officer using Practice forms:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of PHI from us by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to obtain a paper copy of this Notice from us upon request. We are required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI.

D. Changes to this Notice of Privacy Practices

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PHI that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from the Practice.

E. Complaints

If you believe there has been a problem with our collection, use or disclosure of your PHI, you have the right to file a complaint with our Privacy Officer. Our Privacy Officer’s name is Debbie Grayson. Here phone number is (423) 702-2020. If we do not respond to your compliant in a satisfactory manner, you may file a complaint with the U.S. Office of Civil Rights. We will not retaliate against you for filing a complaint.
For more information about HIPAA or to file a complaint contact: The U. S. Department of Health & Human Services Office of Civil Rights 61 Forsyth Street, SW, Suite 3B70 Atlanta, GA 30303-8909 Telephone (404)562-7886; (404) 331-2867 (TDD) FAX: (404) 562-7881
www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint

FRIEDRICH EYE ASSOCIATES, PLLC

Patient Acknowledgement Form

Please complete this page and return to the office.

Patient Name: ____ (Please Print)

When you visit the Practice, it is very important that you feel safe in telling your physician personal information that may be required to fully diagnose or treat a problem. The Practice has strict policies and procedures to protect the confidentiality of the information that you have entrusted to us. The Health Insurance Portability and Accountability Act ("HIPAA") rules require that the Practice provide all of our patients with the attached Notice of Privacy Practices on their first visit. The Notice describes how the medical information we receive from you may be used or disclosed by the Practice and your rights related to your access to this information.

Please sign below that we have provided you with a copy of our Notice to review. If you have any questions about our Privacy Practices, please feel free to contact our Privacy Officer. Thank you for your cooperation.

Please Tell Us How to Contact You to Discuss Your Medical Care
It is our policy to not release a patient's confidential and/or unauthorized information by telephone or voice mail except for appointment confirmation. Whenever returning phone calls, we do not leave a message in voice mail if the name or telephone number is not on the recorded message to identify the residence. Information will not be left with an unauthorized person who may answer the telephone. If you would like to have information released to someone other than yourself, please complete the following:
I authorize the Friedrich Eye Associates, PLLC to leave medical information pertaining to my care by the following methods and will assume responsibility to notify the Practice, in writing, whenever this information changes.

Home telephone: yes_____ no_____

Cell phone: yes____ no_____

Voice Mail/Answering machine: yes_____ no_____

Work phone: yes_____ no_____

May we fax medical records for referrals? yes_____ no_____

Please list names of people with whom we can discuss your medical care:

Spouse Name____________________________ Phone Number: ________________________

Parent Name____________________________ Phone Number: ________________________

Other Name: ___________________________Relationship: ________________ Phone Number:_____________

Please list a "unique identifier" to confirm your identity when calling the office. This "unique identifier" must be given before any information can be disclosed.

Unique Identifier: ____(last four digits of your social security number or mother's maiden last name)

I also acknowledge that I have received a copy of the Practice's Notice of Privacy Practices and have been given an opportunity to ask questions.

Signature of Patient or Personal Representative:

X____ **Date:** ___________

If personal Representative, give relationship to patient: ______________________________________

FINANCIAL AGREEMENT

The financial policy has been fully explained to me and I acknowledge full responsibility for all charges incurred, including any additional charges incurred during the collection of this account, if my insurance later determines my services to be non-covered or not a benefit.

Signature: X____ Date: ______________________

PRIVACY POLICY

I understand that HIPPA has implemented procedures that require specific authorization for the release of my information. I agree to the following statements and understand that I can revoke these at any time by informing the Privacy Office in writing:

***Home Telephone:** We may leave a message with a callback number or appointment reminder on voicemail.

***Written Communication:** We may mail postcards to your home address or send you an email.

Signature: X____ Date: ______________________

INSURANCE AUTHORZATION

I authorize and request that payments under my medical insurance plan(s) be made directly to pay the provider for any services furnished to me. I also authorize the provider to release any information needed for payment of claims. I further permit copies of this authorization to be used in place of the original.

Signature: X____ Date: ______________________

CANCELLATION/NO SHOW POLICY

Unfortunately, due to the increasing number or no shows and cancellations, please be aware of the following policies:

Each no-show will be charged a $50.00 fee.

If you cancel for any reason, you must give at least 24-hour notice, or you will be charged $50.00.

2 “no-show” or 3 cancellation appointments within a rolling 12-month period may result in possible dismissal from this practice.

Signature: X____ Date: ______________________