HUNKELER EYE INSTITUTE

Patient Information

Last Name	First Name	Middle Name	Today's Date

Street Address	SSN#

City	Special Needs ☐ Wheel Chair ☐ Walker ☐ Hearing Impaired ☐ Other ☐ Translator, what language

State	County	Zip Code	Date of Birth	Age	Race	☐ Male ☐ Female

Home Phone ( )	Work Phone ( )	Email

Employer Name/Address	Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed

Spouse's Name	Spouse's Date of Birth	Spouse's Work Phone ( )

Emergency Contact/Relationship	Emergency Contact Phone Number ( )

Preferred Language	Student Yes/No	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other

Billing

Guarantor (Person Responsible for Payment of Bill)	☐ Self ☐Spouse ☐Parent ☐ Other Relationship to Patient

Street Address (if different than Patient)	Phone (if different than Patient)

City (if different than Patient)	State (if different than Patient)	Zip Code (if different than Pt)

Primary Insurance	Policy Holder	Policy ID#	SSN#	Insured's Date of Birth

Secondary Insurance	Policy Holder	Policy ID#	SSN#	Insured's Date of Birth

Send Workers Compensation to:	Authorized by/Position	Date of Incident

Referral

Whom may we thank for telling you about Hunkeler Eye Institute?	☐ Friend/Family ☐ Patient ☐ Yellow Pages ☐ Radio ☐ Newspaper ☐ Sign ☐ Screening ☐ Other

Sign if we have your permission for Hunkeler Eye Institute to send a Thank You letter to the person who referred you.	☐ MD/OD ☐ Optometrist	
Primary Care Physician (PCP) Name	PCP Address	PCP Phone
Optometrist Name	Optometrist Address	Optometrist Phone

Name:	Date:
Date of Birth:	Date of last eye exam:
List major illnesses or injuries:	
List any surgeries you have had:	

Do you or any immediate family members have the following conditions? Circle those affected.

		Details, if needed
Blindness	Self, mother, father , grandparent , sibling	
Cataracts	Self, mother, father , grandparent , sibling	
Glaucoma	Self, mother, father , grandparent , sibling	
Macular Degeneration	Self, mother, father , grandparent , sibling	
Cancer	Self, mother, father , grandparent , sibling	
Diabetes	Self, mother, father , grandparent , sibling	
Hypertension	Self, mother, father , grandparent , sibling	
Heart Disease	Self, mother, father , grandparent , sibling	
Stroke	Self, mother, father , grandparent , sibling	
Thyroid Disease	Self, mother, father , grandparent , sibling	
Arthritis	Self, mother, father , grandparent , sibling	

Other	Self, mother, father , grandparent , sibling	

Social History

	Yes/No	Amount Per Day	Allergies: Yes No
Caffeine			Please list any allergies:
Alcohol			
Drug use: Yes No Former			
Smoke: Yes No Former			

In the past year have you fallen?	Yes No	If yes how many times? _____
Did the fall result in injury?	Yes No	Type of injury

Please list any medications that you currently take. Use the back of the page if necessary.

Name	Dosage	How often

HUNKELER
EYE INSTITUTE PA

Agreement of Responsibility

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductibles and co-insurance may be collected at the time of service. Insurance companies do not guarantee payment of benefits. Patients are financially responsible for all charges whether or not paid by insurance. This is a contract between you and your insurance company…Not Hunkeler Eye Institute. I understand that I am financially responsible for charges not covered by my insurance company.

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her judgment.

Release of Information/Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand that I will receive a monthly statement for any balance due by me.

Medicare Authorization

I request that payment of authorized Medicare benefits be made on my behalf to Hunkeler Eye institute, P.A., for services furnished to me by that physician/supplier. I authorize the holder of medical information, about me, to release to Medicare and its agents any information needed to determine the benefits or benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claims forms or electronically submitted claims, my signature authorizes the release of the information to the insurer to the agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Medigap Authorization

The following is to be filled out if you have a Medigap insurance policy for which you wish to assign benefits. A Medigap or Medicare Supplemental policy is a health insurance policy or other health plan, offered by a private company, to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered by an employer to employees or former employees, as well as a policy or plan offered by a labor organization to members or former members.

This agreement is in effect until revoked in writing by the patient.

Name: _____ Date: _____

Signature: _____

HUNKELER EYE INSTITUTE PA

At Hunkeler Eye Institute we are committed to keeping your personal health information protected.

If you would like us to be able to communicate to someone other than yourself regarding your medical information, please list those people below.

Name:	Phone:
Relationship:	Authorized To Receive: ☐ Medical information ☐ Billing Information

Name:	Phone:
Relationship:	Authorized To Receive: ☐ Medical information ☐ Billing Information

Printed Name_____

_____ _____

Signature Date

(For additional names, use an additional duplicate page.)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED & DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

OUR PLEDGE REGARDING YOUR HEALTH INFORMATION

We understand that information about you and your health is personal. We are committed to protecting the privacy of this information. Each time you visit Hunkeler Eye Institute we create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by Hunkeler Eye Institute whether made by health care personnel or the physician.

OUR RESPONSIBILITIES

Our primary responsibility is to safeguard your personal health information. We must also give you this notice of our privacy practices, and we must follow the terms of the notice that is currently in effect. You may also obtain a copy of this notice at our website, www.hunkeler.com. We are required by law to notify you in the event of a breach of your protected health information.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will have available in our facilities a copy of this notice.

YOU HAVE THE RIGHT TO FILE A COMPLAINT

If you believe your privacy rights have been violated, you may file a complaint with our facility. This complaint must be in writing to: Privacy Official, Hunkeler Eye Institute, 7950 College Blvd. Ste B, Overland Park, Kansas 66210. There will be no retaliation for filing a complaint.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use your health information with Hunkeler Eye Institute and disclose your health information to persons and entities outside of Hunkeler Eye Institute. Each description is of a category of uses or disclosures. We have not listed every use or disclosure within the categories, but all permitted uses and disclosures will fall within one of the following categories.

WITH YOUR WRITTEN ACKNOWLEDGEMENT OF OUR INFORMATION PRIVACY PRACTICES

In compliance with federal Health Insurance Portability and Accountability Act (HIPAA), we will obtain in writing your acknowledgement of receipt of our Notice of Privacy Practices when you first visit Hunkeler Eye Institute. The Notice of Privacy Practice and the Acknowledgement of Receipt are necessary to allow us to use your health information within Hunkeler Eye Institute, and to disclose your health information as requested**. TREATMENT** – We may use health information about you to provide you with medical treatment and services. We may disclose health information about you to doctors, nurses, technicians, medical students, interns, or other personnel who are involved in taking care of you during your visit with us. **PAYMENT** – We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they can process your claim. **HEALTH CARE OPERATIONS** – We may use and disclose health information about you for health care operation, including quality assurance activities; granting medical staff credentials to physicians; administrative activities, including Hunkeler Eye Institute's financial and business planning and development; customer service activities, including investigation of complaints; and certain marketing activities, etc. These uses and disclosures are necessary to operate our health care facility and make sure all of our patients receive quality care. **BUSINESS ASSOCIATES** – There are some services provided in our organization through contracts with business associates. Examples of business associates include accreditation agencies, management consultants, quality assurances reviewers, etc. We may disclose your health information to our business associates so that they can perform the job we've asked them to do. To protect your health information, we require business associates to sign a contract that states they will appropriately safeguard your information and not disclose any information other than as specified in our contract.

APPOINTMENT REMINDERS

We may use and disclose health information to contact you as a reminder that you have an appointment for treatment or medical care at our health care facility**. MARKETING** – We may contact you as part of a marketing effort. As part of our marketing, we may tell you about Hunkeler Eye Institute's health-related products and services that may be of interest to you.

WITH YOUR VERBAL AGREEMENT - INDIVIDUALS INVOLVED IN CARE/PAYMENT

We may disclose health information about you to a friend or family member, who is involved in your medical care, unless you tell us in advance not to do so. In addition, we may disclose health information about you to an entity assisting in disaster relief effort (such as Red Cross) so that your family can be notified about your condition, status and location.

WITH YOUR SPECIFIC WRITTEN AUTHORIZATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission (called authorization). If you authorize us to use or disclose health information about you, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you. Some typical disclosures that require your authorization are as follows.

WITH YOUR WRITTEN CONSENT – RESEARCH UNRELATED TO TREATMENT

When a research study does not involve any treatment, we may disclose your health information to researchers when an Institutional Review Board (IRB) has reviewed the research proposal, has established appropriate protocols to ensure the privacy of your health information, and has approved the research.

RESEARCH INVOLVING TREATMENT

When a research study involves your treatment, we may disclose your health information to researchers only after you have signed a specific written authorization. In addition, for any such research study, an Institutional Review Board (IRB) will already have reviewed the research proposal, established appropriate protocols to ensure the privacy of your health information, and approved the research. You do not have to sign the authorization in order to get treatment from Hunkeler Eye Institute, but if you do refuse to sign the authorization, you cannot be part of the research study.

DRUG & ALCOHOL ABUSE

We will disclose drug and alcohol treatment information about you only in accordance with the federal Privacy Act. In general, the Privacy Act requires your written authorization for such disclosures.

DISCLOSURE OF MENTAL HEALTH INFORMATION

We will disclose mental health treatment information about you only in accordance with state law. In most cases, state law requires your written authorization or the written authorization of your representative for such disclosures.

SPECIAL SITUATIONS THAT DO NOT REQUIRE YOUR INFORMATION CONSENT OR AUTHORIZATION
The following disclosures of your health information are permitted by law without any oral or written permission from you; **ORGAN AND TISSUE DONATION** – If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation. **MILITARY AND VETERANS** – If you are a member of the armed forces, we may release health information about you as required by military command authorities**. WORKERS COMPENSATION** – We may release health information about you for worker's compensation or similar programs if you have work related injuries. These programs provide benefits for work related injuries. **AVERTING SERIOUS THREAT** – We may disclose health information about you for public health activities. These generally include the following:

- To prevent or control disease, injury or disability.
- To report births or death.
- To report child abuse or neglect.
- To report reactions to medications, problems with products or other adverse events.
- To notify people of recall of product they may be using.
- To notify a person who may have been exposed to disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse (including elder abuse), neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

HEALTH OVERSIGHT ACTIVITIES
We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil right laws.
LAWSUITS AND DISPUTES
If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may disclose health information about you in response to a subpoena; discovery request or other lawful process by someone else involved in the dispute.
LAW ENFORCEMENT
We may disclose health information if asked to do so by law enforcement officials for the following reasons: 1. In response to a court order, subpoena, warrant, summons or similar process. 2. To identify or locate a suspect, fugitive, material witness or missing person. 3. About the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement. 4. About a death we believe may be the result of a criminal conduct. 5. About criminal conduct at our facility. 6. In emergency circumstances to report a crime, the location of the crime or victims, or the identity description or location of the person who committed the crime.
CORONERS & MEDICAL EXAMINERS
We may disclose health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death of a person. We may also release health information about patients at our facility to funeral home directors as necessary to carry out their duties.
NATIONAL SECURITY
We may disclose health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.
INMATES
If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose health information about you to the correctional institution or the law enforcement official. This is necessary for the correctional institution to provide you with health care, to protect your health and safety and the health and safety of others, or for the safety and security of the correctional institution.
REQUIRED BY LAW
We will disclose health information about you without your permission when required to do so by federal, state or local law.
YOUR HEALTH INFORMATION RIGHTS
Although your health record is the physical property of Hunkeler Eye Institute the information belongs to you.
YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES: The following uses and disclosures of your Protected Health Information will be made only with your written authorization: 1. Uses and disclosures of Protected Health Information for marketing purposes; and 2. Disclosures that constitute a sale of your Protected Health Information. Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made previously on your authorization before you revoked it will not be affected by the revocation.
YOU HAVE THE RIGHT TO: INSPECT AND COPY You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Hunkeler Eye Institute, 7950 College Boulevard, Suite B, Overland Park, Kansas 66210. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny
your request, you have the right to have the denial reviewed by a licensed healthcare professional that was
not directly involved in the denial of your request, and we will comply with the outcome of the review.
RIGHT TO AN ELECTRONIC COPY OF MEDICAL RECORDS. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a
reasonable, cost-based fee for the labor associated with transmitting the electronic medical record. **AMEND** – Request an amendment to your health record if you feel the information is incorrect or incomplete. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. Also, we may deny your request if the information was not created by our health care team, is not part of the information kept by our facility, is not part of the information which you would be permitted to inspect and copy, and if the information is accurate and complete. Please note that even if we accept your request, we are not required to delete any information from your health care. **ACCOUNTING** – Obtain an accounting of disclosures of your health information. The accounting will only provide information about disclosures made for purposes other than treatment, payment or health care operations or for anything you have already authorized **CONFIDENTIAL** – Request communication of your health information by alternative means or locations. **REVOCATION** – Revoke your authorization to use or disclose health information except to the extent that action has already been taken. **RIGHT TO REQUEST RESTRICTIONS -**. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your

spouse. To request a restriction, you must make your request, in writing, to Hunkeler Eye Institute, 7950 College Boulevard, Suite B, Overland Park, Kansas 66210. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

OUT OF POCKET PAYMENTS -. If you paid out-of-pocket for services and requested that we not bill your health plan in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS – You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you must make your request in writing to, Hunkeler Eye Institute, 7950 College Boulevard, Suite B, Overland Park, Kansas 66210.

Our Contact: If you have any questions about this notice, please contact our Privacy Officer at (913) 338-4733

Date: _____

Patient Name (Print): _____

Patient Name (Sign): _____

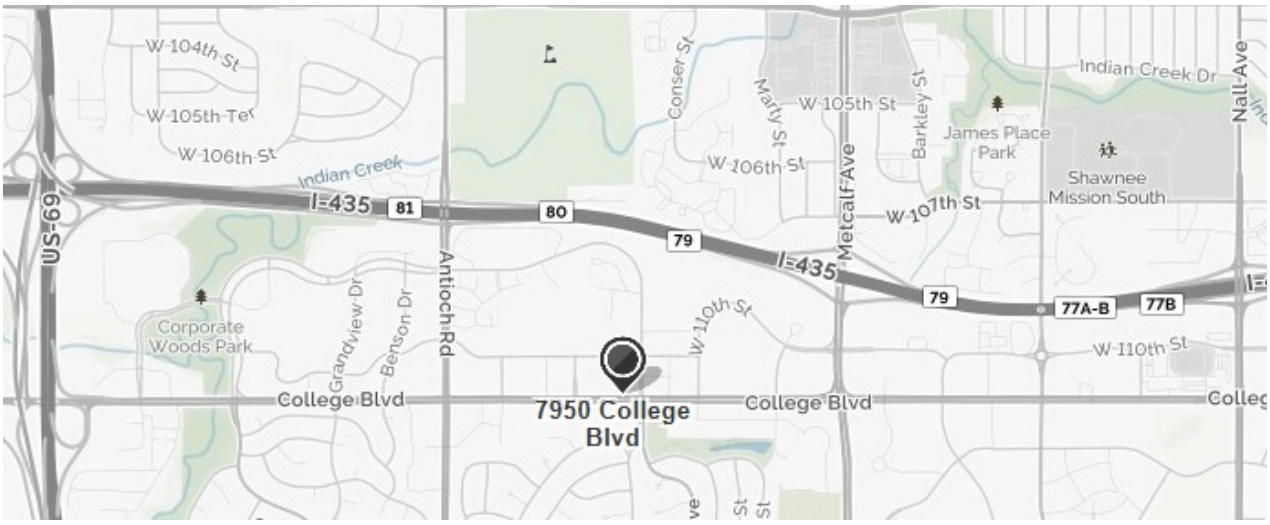
Patient Date of Birth: _____

Office building for Hunkeler Eye Institute

Hunkeler Eye Institute 7950 College Boulevard Suite B, Overland Park, KS 66210
(North Side of College Boulevard)

From the East, Northeast, or Southeast:
Follow 435West to the US-169/Metcalf exit; turn left (south) onto Metcalf Avenue (0.3) miles to College Boulevard. Turn right (west) onto College Boulevard one half mile to 7950 College Boulevard (north side of street). Turn right into parking lot.

From the North, Northwest, or Southwest:
At the I-35/I-435 intersection, go East on I-435 to US-169/Metcalf Avenue/Exit 79. Turn right (south) onto Metcalf Avenue (0.2 miles) to College Boulevard. Turn right (west) onto College Boulevard one half mile to 7950 College Boulevard (north side of street). Turn right into parking lot.



Please call if you have trouble finding the building – 913.338.4733