Seattle Ophthalmology, PLLC

Glaucoma, Cataracts, & General Ophthalmology

www.SeattleOphthalmology.com

Appt Date: _____

Appt Time: _____ am / pm

Welcome to our Practice!

Enclosed is the pre-registration paperwork for your visit. Please fill out these forms and bring them with you to your appointment. Please plan to **check in 15 minutes before your scheduled appointment** time to allow for completion of the registration process.

Please **bring your insurance cards** with you to each appointment. We will bill your insurance as a courtesy only if we have complete and current information. Please be advised that it is the patient's responsibility to understand their insurance plan(s) and to initiate the referral process with their primary care physician if their plan requires one. Failure to provide accurate and updated insurance information will result in increased patient financial responsibility. If you do not present insurance or do not have an insurance plan, payment in full is due at time of service.

Please remember to take into account possible traffic delays or parking difficulties in order to arrive on time. For your convenience, we have included a map along with driving and parking directions.

Thank you in advance for your time and attention,

Seattle Ophthalmology

Agnes S. Huang, MD
206.328.7614
fax: 206.328.6280

Arnold Medical Pavilion
1221 Madison St, Ste 1415
Seattle, WA 98104

The Arnold Pavilion
1221 Madison, Suite 1415 ♦ Seattle, WA 98104

Driving Directions:
From I-5 Northbound:
Take Exit 164A towards James/Madison/Dearborn. Follow the signs to Madison St. Take the Madison ramp. Merge onto 7th Ave. Turn Right at Madison St. The Arnold Pavilion will be on your right hand side.

From I-5 Southbound:
Take Exit 165A towards James Street. Merge onto 6th Avenue. Turn Left at James. Turn Left at Boren. Turn Right at Madison. The Arnold Pavilion will be on your right hand side.
There are patient drop-off areas on Madison as well as in the U-Turn in front of the building before entering the garage.

Parking:
Hourly parking is available in the Madison Garage, located underneath the Nordstrom Tower/Arnold Pavilion Complex. The garage is accessible from the drop-off area in between the Nordstrom Tower and Arnold Pavilion on Madison or from Boylston Avenue. We regret that we are unable to validate parking.

Bus Directions:
Buses running near Madison include #2 & #12

Seattle Ophthalmology, PLLC
1221 Madison, Suite 1415 • Seattle, Washington 98104
TEL 206.328.7614 • FAX 206.328.6280

Statement of Privacy Practices

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. Each employee is committed to ensuring that your health information is never compromised. We may amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given to anyone without your written consent.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients. You can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), date of birth, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of Your Protected Health Information

We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We may use and/or disclose your health information to communicate reminders about your appointments. You may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Patient Rights

You have the right to request copies of your healthcare information and to request a list of instances in which we have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Seattle Ophthalmology, PLLC

1221 Madison Street, Suite 1415 • Seattle, Washington 98104
Tel 206.328.7614 • Fax 206.328.6280

PATIENT INFORMATION

Date: _____

Title: Dr. Mr. Mrs. Ms. Patient Name: _____

Sex: Male Female Marital Status: Single Married Widowed Other

Date of Birth: ____/____/_____ Social Security Number: _____-_____-_____

Parent / Guardian (if patient is a minor), Name & Contact: _____

Patient Address: _____
Street City State Zip

Billing Address (if different): _____

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____

Cell Phone: (_____)_____-_____ E-mail (optional): _____

Employer: _____ Occupation: _____

Spouse's (or Significant Other's) Name: _____

Referred by: _____ Name/Address of Pharmacy _____

Primary Care Physician: _____ Phone: (_____)_____-_____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone (_____)_____-_____

INSURANCE INFORMATION – *We must have a copy of your insurance card(s) at each visit in order to bill your insurance company(ies).*

Insurance Company: _____ Effective Date: _____

ID #_____ Group #_____ Co-Pay $_____

Is the patient the subscriber? Yes No If no, complete the following Subscriber Information:

Name _____ Date of Birth ____/____/_____ Patient's Relationship: _____

Insurance Company: _____ Effective Date: _____

ID #_____ Group #_____ Co-Pay $_____

Is the patient the subscriber? Yes No If no, complete the following Subscriber Information:

Name _____ Date of Birth ____/____/_____ Patient's Relationship: _____

Please Turn Over

Appointment Policies

We request all cancellations and appointment changes to be made 24 hours in advance of scheduled appointments. This allows other patients the opportunity to use the available time. If you continually fail to show for scheduled appointments without calling ahead, a fee may be assessed and treatment discontinued.

We value your time and do not wish to keep you waiting. However, on occasion, an unexpected event may occur. If you are delayed well past your scheduled appointment time, we will make every effort to meet your needs, but your appointment may need to be rescheduled. We appreciate your understanding.

Prescription Refill Policy

Please allow 2 business days for completing prescription refill requests. Please note that all non-emergent refill requests that come in after hours or on the weekend will not be processed until the next business day.

Financial Policy

As a courtesy, we will bill your insurance company if we are provided with accurate, complete, and current insurance information. Although we make every effort to assist you with general insurance questions, specific questions regarding benefits and eligibility need to be directed to your insurance company. It is your responsibility to know your insurance requirements and benefits. This includes initiating the referral process with your primary care physician, if required by your insurance plan. Co-pays are due at the time of service. A charge may be incurred if co-payment is not collected at time of office visit.

Please be aware that refractions (test to determine your glasses prescription) are never covered by Medicare and policy of payment varies between other insurance companies. Please contact your insurance company to see if this will be covered. Alert the technician at your appointment if you do not wish to have a refraction done at your appointment.

If you do not have insurance, we require payment at time of service; unless prior arrangements have been made. Payments may currently be made by Visa, MasterCard, Discover, American Express, cash or check.

If your personal check is returned by the bank due to *Insufficient Funds,* a $25.00 fee will be charged. If you have financial problems, please communicate them as soon as possible so that we may work out a mutually beneficial payment plan to prevent your credit from being jeopardized.

Patient Consent and Release

I hereby consent to treatment by Seattle Ophthalmology. I understand that I am financially responsible for all charges rendered regardless of insurance reimbursement. I authorize Seattle Ophthalmology to release any necessary information requested by my insurance carrier and authorize payment directly to Seattle Ophthalmology for any benefits available under my insurance plan. I will advise the receptionist if any address, employment, or insurance changes have occurred since my last visit.

Notice of Information Practices

We keep a record of the services we provide you. You have a right to know how we use and disclose information about you. Your signature below serves as an acknowledgement that you have read and understand this form, as well as the *Statement of Privacy Practices.*

Patient Signature _____ Date_____
(or legally authorized individual's signature)

Printed Name _____ Relationship to patient _____
(if signed on behalf of the patient)

SEATTLE OPHTHALMOLOGY
Medical History

Name: _____ **Today's Date:** _____

Date of birth: _____ **Referring physician:** _____

Primary Care Physician:

Do you have problems with, or are being treated for:

	NO	YES		NO	YES
Diabetes	◯	◯	Neurological/memory	◯	◯
High blood pressure	◯	◯	Skin, breast	◯	◯
Hearing Loss/Hearing Aid	◯	◯	Muscles/joint	◯	◯
Fever, weight loss	◯	◯	Urinary/kidney	◯	◯
Breathing/ asthma	◯	◯	Migraines/ headaches	◯	◯
Heart disease/blood vessels	◯	◯	Poor blood circulation	◯	◯
Thyroid disease/immune	◯	◯	Dizziness/blackouts	◯	◯
Ear, nose, throat, sinus	◯	◯	Double/blurry vision	◯	◯
Digestive, abdominal	◯	◯	Other:_____	◯	◯

Please explain any "yes" answers: _____

_____

_____

Please list any surgeries you may have had: _____

_____

_____

Please list any current medications: _____

_____

_____

Please list any drug allergies: _____

Family history

Do any of your family members have:

	NO	YES		NO	YES
Diabetes	◯	◯	Retinal Detachment	◯	◯
Cancer	◯	◯	Blindness	◯	◯
Heart Disease	◯	◯	Neurological Problems	◯	◯
Glaucoma	◯	◯	Other :_____	◯	◯
Macular Degeneration	◯	◯			

Social history

	NO	YES	Frequency and amount
Do you consume alcohol?	◯	◯	_____
Do you smoke or chew tobacco?	◯	◯	_____
Do you use recreational drugs?	◯	◯	_____
Do you drive?	◯	◯	_____

What is/was your occupation? _____ (current/retired)