J. Ellis Cosby, O.D., P.C.

Please complete the following information.

Date_____Birthdate_____ Male / Female Single/Married/Divorced/Widowed
Name_____Parents name if patient is a minor_____
Address_____City_____State_____Zip_____
Home phone_____ Work phone_____ Cell phone_____
EMAIL: (REQUIRED FOR PATIENT PORTAL):_____
SSN_____ Occupation_____ Employer_____
Insurance information: Vision Insurance: _____I.D.#_____
Major Medical Insurance_____
When was your last eye exam?_____Doctor?_____
Do you wear glasses? Y /N Do you wear Contact lenses? Y / N
When was your last physical exam? _____Doctor?_____
Are you currently taking any medications? Y / N If yes, please list_____
_____

List medication allergies:_____

Have you ever had any eye injuries/surgeries? Y / N

Do you have any of the following conditions?

Diabetes	Y / N	High blood Pressure	Y / N	Arthritis	Y / N
Glaucoma	Y / N	Fever	Y / N	Respiratory	Y / N
Heart Tbl	Y / N	Blood disorder	Y / N	Skin Tbl	Y / N
Muscle/skin	Y / N	Genitourinary Tbl	Y / N	Gastrointestinal	Y / N
Neurological	Y / N	Ear/Nose/Throat Tbl	Y / N	Psychological Tbl	Y / N
Sleep Apnea	Y / N				

Please list any medical conditions not listed above_____
_____
Please list any family member with the following conditions:
Diabetes_____ Hypertension_____
Heart Problems_____ Cataracts_____
Blindness_____ Glaucoma_____
Crossed eyes_____ Other_____

Do you use tobacco products? Y / N (if yes, indicate type and amount)_____
Do you drink alcohol? Y / N (if yes, indicate amount/how long)_____

If patient is less than 6 years, did he or she have any problems before, during, or just after birth? _____

WE WILL FILE INSURANCE CLAIMS FOR PLANS THAT WE PARTICIPATE IN AS A COURTESY.

I UNDERSTAND THAT ALL CHARGES ARE MY RESPONSIBILITY regardless of insurance coverage, and that payment is due when services are rendered. A deposit of 50% or more is required in order for materials to be ordered. Materials must be picked up within 45 days of notification. After 45 days, unless other arrangements have been approved, the materials will be returned to the manufacturer and the deposit will be forfeited.

I ALSO UNDERSTAND THAT ALL INSURANCE COPAYS ARE DUE AT THE TIME OF SERVICE.

REFRACTION is the process of determining if there is a need for corrective eyeglasses. It is NOT covered by Medicare or any other health insurance plan, however it is covered by most vision plans. Our office fee for refraction is $40.00 and this fee is collected at the time of service.

Please list the names of individuals that you will allow to have access to your financial information in regards to J. Ellis Cosby, O.D., P.C.

_____ _____

_____ _____

Please list the names of individuals that you will allow to have access to your medical info.

_____ _____

_____ _____

Emergency contact:_____

Please sign and date: Signature_____Date_____

Signature_____Date_____

Signature_____Date_____

Signature_____Date_____

FINANCIAL POLICY

J. ELLIS COSBY, O.D.,P.C. is committed to providing you and your family with the highest level of quality medical care and personal service. In our practice, we do everything possible to make our patients our first priority including working to hold down the costs of healthcare. We feel that it is the patient or guardian's responsibility to meet the financial obligations that you have made with both your insurance company and our practice. The following is a summary of our financial policies.

1. Each new patient must complete a registration form prior to or at the time of his or her appointment. Registration forms are updated annually.
1. Proof of insurance and identity must be provided on the date of service, otherwise the patient will be expected to pay in full for all services when services are rendered. **If we are unable to verify insurance benefits, the patient will be expected to pay at the time services are rendered.**
2. Payments for services may be made by Cash, Check, Money Order, VISA/MC, American Express, or Discover Card.
3. **If we are filing a claim for you, your contracted exam co-payments, coinsurance and deductible amounts will be collected at the time of service.**
4. **Patients with outstanding balances must make payment arrangements before their next appointment with the doctor.**

Insurance

5. It is each patient's responsibility to understand his or her insurance coverage. As your health care provider, our relationship is with you, **not with your insurance company.** While filing of insurance is a courtesy we extend to our patients, all charges are your responsibility from the date services are rendered.
6. Verification of your benefits is not a guarantee of payment. All payments are subject to the terms and allowances of your plan when services are rendered and claims are received and processed by your insurance company.
7. **If we have not received a payment or a denial from your insurance company within 45-days of submission, we reserve the right to bill you directly for the services**.
8. Statements will be generated when your claims are internally processed or the balance exceeds the 45-day maximum allowance for outstanding balances. ***Statement balance amounts will be due within 30-days of statement date.*** If you find an error on your statement or have any questions, please contact us immediately to clear up any confusion or concerns.
9. **All account balances listed under your account's guarantor will be due prior to services being rendered.** We will make every effort to notify your guarantor of any past due balances prior to your visit.

Credits & Overpayments / Returned Checks

10. Credits will remain on your account to be used for future visits unless you request those amounts be refunded to you. Overpayments will be refunded within 30-days upon written request to our practice.
11. Returned checks will incur a $30.00 service charge. Payment for return checks and services are due upon the notice of the returned check and are payable by cash, money order, VISA/MC, American Express, or Discover ONLY. **J. ELLIS COSBY, O.D.,P.C.** reserves the right to refuse payment by check if a history of returned checks is established.
12. Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24-hours prior to your appointment time. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read, understand and agree to comply with the Financial Policy as stated above. I agree to allow **J. ELLIS COSBY, O.D., P.C.** to file claims on my behalf and receive payment for those services as governed by contract. **I acknowledge that all previous balances owed as well as current amounts due will be paid prior to my receipt of services.**

All accounts not paid within 90-days of the due date may be subject to dismissal from the practice and will be turned over to The Credit Bureau and documented on your credit report. Accounts reported to The Credit Bureau are subject to a collection fee with a maximum of $20 that will be added to your total balance due and will be your responsibility. Past due balances of over $200.00 may be taken to small claims court.

_____

Patient Name (Print)

_____ _____

Patient Signature *Date*

_____ _____

Responsible Party Name Responsible Party Signature

NOTICE OF PRIVACY PRACTICES

J. ELLIS COSBY, O.D., P.C.

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY. Your "health information," for purposes of this Notice, is generally any information that identifies you and is created, received, maintained or transmitted by us in the course of providing health care items or services to you (referred to as "health information" in this Notice).

We are required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOUR AUTHORIZATION

The most common reasons why we use or disclose your health information are for treatment, payment or health care operations. Examples of how we use or disclose your health information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and faxing them to be filled; showing you low vision aids; referring you to another doctor or clinic for eye care or low vision aids or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we must carry out in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

OTHER DISCLOSURES AND USES WE MAY MAKE WITHOUT YOUR AUTHORIZATION OR CONSENT

In some limited situations, the law allows or requires us to use or disclose your health information without your consent or authorization. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;

- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPAA;
- [specify other uses and disclosures affected by state law].

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with your eye care. Upon your death, we may disclose to your family members or to other persons who were involved in your care or payment for heath care prior to your death (such as your personal representative) health information relevant to their involvement in your care unless doing so is inconsistent with your preferences as expressed to us prior to your death.

SPECIFIC USES AND DISCLOSURES OF INFORMATION REQUIRING YOUR AUTHORIZATION

The following are some specific uses and disclosures we may not make of your health information **without** your authorization:

Marketing activities. We must obtain your authorization prior to using or disclosing any of your health information for marketing purposes unless such marketing communications take the form of face-to-face communications we may make with individuals or promotional gifts of nominal value that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent to such payment.

Sale of health information. We do not currently sell or plan to sell your health information and we must seek your authorization prior to doing so.

Psychotherapy notes. Although we do not create or maintain psychotherapy notes on our patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosing any such notes.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES

- Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization.

- You may give us written authorization permitting us to use your health information or to disclose it to anyone for any purpose.

- We will obtain your written authorization for uses and disclosures of your health information that are not identified in this Notice or are not otherwise permitted by applicable law.

- We must agree to your request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and such information pertains solely to a health care item or service for which you have paid in full (or for which another person other than the health plan has paid in full on your behalf).

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information. You have the right:

- **To request restrictions on the health information we may use and disclose for treatment, payment and health care operations.** We are not required to agree to these requests. To request restrictions, please send a written request to us at the address below.

- **To receive confidential communications of health information about you in any manner other than described in our authorization request form**. You must make such requests in writing to the address below. However, we reserve the right to determine if we will be able to continue your treatment under such restrictive authorizations.

- **To inspect or copy your health information.** You must make such requests in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information, subject to applicable law.

- **To amend health information.** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the health information:

    - was not created by us, unless the person that created the information is no longer available to make the amendment,

    - is not part of the health information kept by or for us,

    - is not part of the information you would be permitted to inspect or copy, or

    - is accurate and complete.

- **To receive an accounting of disclosures of your health information.** You must make such requests in writing to the address below. Not all health information is subject to this request. Your request must state a time period for the information you would like to receive, no longer than 6 years prior to the date of your request and may not include dates before April 14, 2003. Your request must state how you would like to receive the report (paper, electronically).

- **To designate another party to receive your health information.** If your request for access of your health information directs us to transmit a copy of the health information directly to another person the request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send the copy of the health information.

Contact Person:

Our contact person for all questions, requests or for further information related to the privacy of your health information is:

Melissa Chatman (229) 435-7795
Dr. J. Ellis Cosby (229) 435-7795
2616 Pointe North Blvd.
Albany, GA 31721

Complaints:

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown above. If you prefer, you can discuss your complaint in person or by phone.

Changes to This Notice:

We reserve the right to change our privacy practices and to apply the revised practices to health information about you that we already have. Any revision to our privacy practices will be described in a revised Notice that will be posted prominently in our facility. Copies of this Notice are also available upon request at our reception area.

Notice Revised and Effective: August 22, 2013

Acknowledgement of Receipt of Notice of Privacy Practices

J. Ellis Cosby, O.D.,P.C.
2616 Pointe North Blvd.
Albany, Ga. 31721
229-435-7795

I acknowledge that I have received the *Notice of Privacy Practices* from J. Ellis Cosby, O.D., P.C.

Signature Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

Relationship to Patient Print Name