Orion Eye Center 541-548-7170

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? ❒ No ❒ Yes E-mail _____

Age _____ Birthdate _____ SS# _____ Sex

Marital Status ❒ Single ❒ Married to: _____ ❒ Other: _____

Optometrist: _____ Primary Care Doctor: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

Emergency Contact
(you may list someone not in your household) Name: _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # City State Zip

Primary Health Insurance Company _____

Secondary Health Insurance Company _____

The State of Oregon would like you to tell us your racial/ethnic background so that the legislators can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. You have a choice if you would like to provide this information or, if you prefer, you may decline.

Ethnicity:
Do you consider yourself Hispanic/ Latino?
❒ Declined
❒ Unavailable/ Unknown
❒ Yes
❒ No

Race:
Which category best describes your race?
❒ Declined
❒ Unavailable/ Unknown
❒ American Indian / Alaska Native
❒ Asian
❒ Black or African American
❒ Native Hawaiian / Other Pacific Islander
❒ White
❒ Multiracial

I understand that office visit charges are payable on the day service is rendered. I authorize Orion Eye to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Orion Eye and myself.

Patient Name:
DOB:

Signature _____ **Date** _____

Orion Eye
Signature on File, Assignment of Benefits, Financial Agreement

Patient Name: DOB:
Primary Insurance: ID#:
Secondary Insurance: ID#:

1. Medicare - I request that payment of authorized Medicare benefits be made on my behalf to ORION EYE, for services furnished me by ORION EYE. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand 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 claim forms, my signature authorizes releasing the information to the insurer or agency shown. ORION EYE accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non covered services Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.
2. Medigap - I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to ORION EYE, if possible or otherwise to me.
3. Release of Information - ORION EYE may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to ORION EYE for reimbursement for services rendered and (2) any health care provider for continued patient care. ORION EYE may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.
4. Other Insurance - I understand that ORION EYE may contract with other insurance providers.. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by ORION EYE if I belong to a plan that ORION EYE does not contract with.
5. Non-Covered Services - I understand that ORION EYE's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with ORION EYE to obtain necessary health care service plan authorizations.
6. Financial Agreement - I agree that in return for the services provided to the patient by ORION EYE, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to ORION EYE for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to ORION EYE. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to ORION EYE. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Signature_____ Date_____

Orion Eye

HIPAA Acknowledgement and Consent

I understand that Orion Eye will use and disclose health information about me.

I understand that my health information may include information created by ORION EYE or received by another provider, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnosis, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that ORION EYE may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment.-Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies of others who may be responsible to pay for some or all of my health care, and
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how ORION EYE will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of ORION EYE, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of ORION EYE's Notice of Privacy Practices in effect will be posted in waiting/reception area and on the practice's website.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that ORION EYE is not required by law to agree to such request.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

Patient Name: DOB:

Signature: _____ Date: _____

- OR -

BY: _____

Authorized Representative Signature Relation Date

Orion Eye Medical History Form

Patient Name: **Date of Birth:**

Medical History:

Do you have allergies to any **prescription** medications? Yes No If yes, please explain:_____
_____
_____

Please list any medications you are currently taking, including oral contraceptives, aspirin, over-the counter, vitamins and herbal supplements:_____
_____
_____
_____
_____

Please list any past surgeries and when they were done:_____
_____
_____
_____

Do you have a personal history of any of the following (please circle):

Cataract(s): Yes No
Crossed Eye(s): Yes No
Glaucoma: Yes No
Macular Degeneration: Yes No
Retinal Detachment / Disease: Yes No

Cancer: Yes No
Diabetes: Yes No
Heart Disease: Yes No
High Blood Pressure: Yes No
Kidney Disease: Yes No

Other - Please Explain:_____
_____

Smoking status:
[] Never a smoker
[] Former smoker When did you quit?_____ How long did you smoke?_____
[] Current smoker How many cigarettes do you smoke a day?_____ How many years?_____

Do you drink alcohol? Yes No If yes, how many drinks per week?_____

Do you use recreational drugs? Yes No If yes, how often?_____

Height:_____

Weight:_____

Patient Signature:_____ Date:_____

Provider Signature:_____ Date:_____