

Piedmont Eye Surgical and Laser Center, P.L.L.C.

TIMOTHY R. BEVIS, M.D., FAAO

Glaucoma Treatment
Cataract Surgery

KARL G. STONECIPHER, M.D., FAAO

Cataract & Refractive Surgery

LISA L. SUN, M.D., FAAO

Glaucoma Treatment
Cataract Surgery

Welcome to Piedmont Eye!

**Please read all the information provided in this letter
BEFORE your next appointment.**

**We will gladly email your paperwork, OR you may
visit “mypatientvisit” and fill it out online OR visit our
website at “Piedmonteyedoctor.com” and print out
your paperwork. Bring your insurance cards, drivers
license, medication list and specialist copay. Plan
on being at your appointment for**

**2 ½-3 hours, you will be DILATED and we do
recommend a driver.**

**NEW CATARACT PATIENTS: if you wear contact
lenses, they MUST be removed 2 weeks prior to your
appointment. If you have any questions, please call
us at 336-854-4441 hit option 1.**

We look forward to seeing you!!!!

Piedmont Eye Surgical and Laser Center, P.L.L.C.

1002 N. Church Street, Suite 103
Greensboro, NC 27401
(336) 854-4441

1219 Lexington Ave., Suite C
Thomasville, NC 27360
(336) 854-4441

PATIENT INFORMATION

Patient Name (Last)		First		M.I.
Mailing Address		City	State	Zip
Home Phone (Area Code and Phone #) ()	Cell # () Fax #	Work Phone (Area Code and Phone #) ()		
Date of Birth	Sex	Social Security #	Marital Status	
Emergency Contact Name		Relationship	Area Code and Phone # ()	
Patient's Employer		Employer Address		
Name of Last Eye Doctor Seen Area Code and Phone # () Address		Name of Last Medical Doctor Seen Area Code and Phone # () Address		
Spouse Name		Patient's E-mail		

RESPONSIBLE PARTY INFORMATION (COMPLETE ONLY IF DIFFERENT FROM ABOVE)

Last		First		M.I.
Mailing Address		City	State	Zip
Home Phone (Area Code and Phone #) ()	Work Phone (Area Code and Phone #) ()	Relationship		

INSURANCE INFORMATION

Insurance Carrier	Name _____ Address _____ _____	Policy #
Secondary Insurance	Name _____ Address _____ _____	Policy #

HOW DID YOU HEAR ABOUT US (PLEASE CHECK ONE BELOW)

____ Optometrist / Ophthalmologist (Name _____)		
____ Medical Doctor (Name _____)		
____ Previous Patient	____ Yellow Pages	____ Insurance Company
____ Family Member	____ Newspaper	____ Seminar
____ Friend	____ Radio	
		Date _____

(over)

Piedmont Eye Surgical and Laser Center, P.L.L.C.

HEALTH INSURANCE CLAIM RELEASE AND TREATMENT AUTHORIZATION FORM

Please list your insurance company/companies below:

By signing this form, I authorize release of any medical information necessary to process my insurance claims. My signature means that I request Medicare, Medicaid or any other insurance company listed above to make payment directly to Dr. Timothy Bevis/Dr. Karl Stonecipher/Dr. Lisa Sun at Piedmont Eye Surgical and Laser Center, P.L.L.C.

The insurance information furnished here represents a full disclosure of the insurance/third party benefits to which I am entitled. I understand that failure to disclose pre-certification/second option requirements for any and all plans to which I subscribe, may cause me to incur full liability for professional charges, as a result of non-payment by any carrier.

Medicare Patients: The information that we obtain is used to identify you and determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare and to insure that proper payment is made. I authorize the holder of medical information about me to release to Medicare and or it's agents the information needed to determine benefits on my behalf. I do understand that Piedmont Eye Surgical and Laser Center, P.L.L.C.. does accept Medicare assignment and that I am responsible for any deductible, co-insurance and non covered services.

Treatment: I authorize Dr. Timothy Bevis/Dr. Karl Stonecipher/Dr. Lisa Sun to give me treatment according to proper medical care standards.

Sign

Date:

Sign

Date:

Sign

Date:

Sign

Date:

Sign

Date:

PIEDMONT EYE SURGICAL AND LASER(NOTICE OF PRIVACY—CONTINUED)

Right to Request Restrictions: You have the right to request restrictions or limitations on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. *We are not required to agree to your request.* If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

Right to Request Removal from Fundraising Communications: You have the right to opt out of receiving fundraising communications from the practice. **Right to Restrict Disclosures to Health Plan.** You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment of healthcare operations and pertains to a health care item or service for which the individual had paid out of pocket in full.

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. You must make your request in writing and you must specify how or where you wish to be contacted.

Right to an Accounting of Disclosures: You have the right to request and "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer. **CHANGES TO THIS NOTICE:** We reserve the right to change this notice. We will post a copy of the current notice in the Practice's waiting room. **COMPLAINTS:** If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Dept. of Health and Human Services. To file a complaint with the Practice, contact the Privacy Officer, 336-854-4441, 1002 N. Church St, Suite 103, Greensboro, NC 27401. All complaints must be submitted in writing. You will not be penalized for filing a complaint. **OTHER USES OF MEDICAL INFORMATION:** Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer.

I acknowledge by signing below that:

I have received the Notice of Privacy practices and Notice of Individual Rights

Sign: _____

Date: _____

Check below information you wish to share:

- ☐ Personal health information: demographics, medical record notes, etc.
☐ Billing information: statement information, balances, etc.
☐ All my information

1. _____

Name of person to share information with

Relationship to you

2. _____

Name of person to share information with

Relationship to you

By signing below: **I DO NOT** want my information shared with anyone.

Sign: _____

Date: _____

Piedmont Eye Surgical and Laser Center

NOTICE OF PRIVACY PRACTICES: 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

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU. The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. We must obtain your authorization before the use and disclosure of any psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosure that constitute a sale of PHI. Uses and disclosures not described in this notice of privacy practices will be made only with authorization from the individual.

For Payment: We may use and disclose medical information about you so that the treatment and services you receive at the practice may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we get paid for treating you.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the practice or the hospital. For example, we may disclose medical information about you to people outside the practice who may be involved in your medical care, such as family members, clergy, or other persons that are part of your care.

For Health Care Operations: We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the practice and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students, and other practice personnel for review and learning purposes. For example: we may review your record to assist our quality improvement efforts.

Who Will Follow This Notice: This notice describes our practice's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff, and other practice personnel.

Policy Regarding The Protection Of Personal Information: We create a record of the care and services you receive at the practice. We need this record in order 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 the practice, whether made by practice personnel or by your personal doctor. The law requires us to: make sure that medical information that identifies you is kept private; give you this notice of legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment for your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to or for: coroners, medical examiners, and funeral directors; health oversight activities; law enforcement; lawsuits and disputes; military and veterans; national and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the Practice. To request an amendment, your request must be made in writing and submitted to the privacy officer and you must provide a reason that supports your request. We may deny your request for an amendment.

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Pre-Operative Visual Function Assessment / Please place an "X" on your answer below

Do you have difficulty with the task listed below?				If yes, how much difficulty do you currently have?		
Yes	No	A little		Some	A great deal	Unable to do this activity

Question?

1. Problems reading small print, such as, labels on medicine bottles, telephone book, or food labels even w glasses?

☐
☐
☐
☐
☐
☐

2. Problems reading a newspaper or book, even with glasses?

☐
☐
☐
☐
☐
☐

3. Problems driving at night/day with glare or bright lights?

☐
☐
☐
☐
☐
☐

4. Problems reading traffic signs, street signs, or store signs even with glasses?

☐
☐
☐
☐
☐
☐

5. Problems w handwork like sewing, knitting, crocheting or carpentry, even with glasses?

☐
☐
☐
☐
☐
☐

6. Problems with writing a check or filling out forms, even w glasses?

☐
☐
☐
☐
☐
☐

7. Difficulty with depth perception or judging going up or down steps?

☐
☐
☐
☐
☐
☐

8. Problems with watching the TV, even w glasses on?

☐
☐
☐
☐
☐
☐

Signature: _____

Date: _____