Capital Eye Consultants, P.A.

2280 WEDNESDAY STREET
TALLAHASSEE, FLORIDA 32308
850-201-ISEE (4733) - OFFICE
850-201-4939 - FAX
www.capitaleyeconsultants.org

Aaron P. Appiah, M.D. Karen A. Young, M.D.

Patient Information

Full Name(including middle initial):_____

Address:_____

City/State/Zip Code:_____

Date of Birth: _____/_____/_____ Male/Female(circle one) Student:(Yes)(No)

Social Security Number:_____-_____-_____ Marital Status:_____

Email:_____ Minor: (Yes)(No)

Home Phone #: (____)_____ - _____ Cellular Phone #: (____)____ -_____

Work Phone #: (____)_____ - _____

Emergency Contact Information

Name:_____ Relationship:_____

Home Phone #: (____)_____ - _____ Cellular Phone #: (____)____ -_____

Work Phone #: (____)_____ - _____

Physician Information

Referred by:_____

Primary Care Doctor:_____

Address:_____

Contact Number:_____

CAPITAL EYE CONSULTANTS, PA

Informed Consent:

COVID-19

I understand that I am consenting to an elective treatment/procedure/surgery that is not urgent or emergent.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact, and as a result, federal and state health agencies recommend social distancing. I understand that my doctor listed below has put in place reasonable safety measures to help reduce the spread of COVID-19.

I understand that even if I have received a negative COVID-19 test result, the test may have failed to detect the virus, or I may have become infected after I took the test. I understand that even if I do not have any symptoms, I may have a COVID-19 infection, and that having the elective treatment/procedure/surgery can lead to a higher chance of complication and death.

I understand that exposure to COVID-19 before, during, and after my treatment/procedure/surgery may result in the following: a positive COVID-19 diagnosis, extended isolation, additional tests, and hospitalization, up to and including: the need for treatment in intensive care (ICU), short-term or long-term intubation, other complications, and death. After my elective surgery I may need additional care that may require that I go to an emergency department or hospital.

I understand that COVID-19 may cause additional risks, some of which may not be known at this time.

I understand that this elective procedure may put me at increased risk for becoming infected with COVID-19. By signing this consent form I accept that risk and give my permission to proceed with the treatment/procedure/surgery listed below.

I have been given the choice to have my treatment/procedure/surgery at a later date. I understand the potential risks of delaying and want to proceed.

I have read this consent or someone has read it to me.

Name of patient:

Patient date of birth:

Name of provider:

Treatment/procedure/surgery:

Signatures:

Patient:

Date:

Provider:

Date:

HIPAA NOTICE OF PRIVACY PRACTICES
As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our President in person or by phone at 252-744-2426.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

CAPITAL EYE CONSULTANTS IS REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF, AND PROVIDE INDIVIUALS WITH THIS NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION. IF YOU HAVE ANY OBJECTIONS TO THIS FORM, PLEASE ASK TO SPEAK WITH OUR HIPAA COMPLIANCE OFFICERR IN PERSON OR BY PHONE AT OUR MAIN NUMBER.

YOU SIGNATIRE BELOW WOULD ONLY BE AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THIS NOTICE OF OUR PRIVACY PRACTICES.

SIGNATURE: _____

PRINT: _____

DATE: _____

BELOW, PLEASE LIST THE PERSON/PERSONS THAT PAY ACCOMPANY YOU INTO THE EXAM ROOM OR THAT MAY CALL INQUIRING ABOUT YOUR CARE:

1. _____ **REALTIONSHIP:** _____

2. _____ **REALTIONSHIP:** _____

3. _____ **RELATIONSHIP:** _____

4. _____ **RELATIONSHIP:** _____

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Aaron P. Appiah, M.D.
Vitreo-Retinal Specialist
Diabetic Retinopathy
Macular Degeneration
Uveitis
Board Certified

Karen A. Young, M.D.
Glaucoma Specialist
Comprehensive Ophthalmology
Routine Vision Care
Board Certified

FINANCIAL POLICY

The following is a statement of our financial policy, which we require that you read, initial in the spaces provided, and sign before treatment begins. The responsible party must also provide his/her driver's license and insurance card, if applicable.

____ FULL PAYMENT IS DUE WHEN SERVICES ARE RENDERED: For your convenience, we accept the following forms of payment: cash, personal checks, and all major credit cards. ALL PATIENTS are responsible for a FULL refund at the time of service. MINOR patients must be accompanied by a parent or guardian at all times. The accompanying adult is responsible for full payment at the time of service. Exceptions to this policy can only be made by the office manager.

____INSURANCE: All insurance coverage must be verified before treatment begins. As a service to you, we will complete and submit your medical insurance claims; however, we cannot bill your insurance unless you provide us with your correct and complete insurance information. Acceptance of insurance assignment by this office does not absolve the responsible party of full responsibility for the charges in full for treatment rendered. Your insurance policy is a contract between you and your insurance provider. We are not a party to that contract. If your insurance company has not paid your account in full with 60 days, the balance will be due and payable by the undersigned. In regards to insurance plans where we are participating providers, all co-pays and deductibles are payable at the time the service is rendered, in the event that your insurance coverage changes to where we are not participating provider, please refer to the above. Your payment responsibility may change if your medical insurance coverage varies. This office can make NO GUARANTEE of insurance payment as estimated.

_ RETURNED CHECKS: Florida law designates that a $40 fee shall become payable on every returned check. Account balance and payment must be paid by cash, cashier's check, or by money order within 7 days of return or account will be turned over to legal prosecution.

___MISSED APPOINTMENTS FEE: Capital Eye Consultants requires that all patients give 24-hour notice of canceling appointments unless there is an emergency. If you are unable to make your appointment, please contact our office to reschedule or leave a voicemail notifying us of your canceling. If you miss your appointment and no notification has been given, you will be charged a $25 no show fee.

I certify that I have read and accepted all terms as set forth above and have received a copy of this agreement as of this date.

_____ _____

Signature Date