

# Neuro-ophthalmic Consultants Northwest

*A division of Seattle Radiologists, A.P.C.*

## **NEW PATIENTS**

You have been referred to our office for a medical condition requiring the highly specialized services of our physicians.

Please complete this "New Patient Registration Packet" and **bring** them to your appointment. The documentation of evaluations done by other members of your care team are vital for the delivery of optimal care during your consultation. Your assistance in contacting those physicians which have seen you for your visual diagnosis is greatly appreciated, as some offices require your permission for records to be sent.

We have included an appointment card for you to use as a reminder of your appointment:

### Appointment Card

I have an appointment with Dr. \_\_\_\_\_

on \_\_\_\_\_ check in at \_\_\_\_\_

*missed or cancelled appointments without 24 hours advance notice will be rescheduled at the physician's discretion only*

*Neuro-ophthalmic Consultants Northwest*

*Seattle:  
Nordstrom Medical Tower  
1229 Madison St. Suite 615  
Seattle, WA 98104  
206-386-2700*

*Eastside:  
12600 SE 38<sup>th</sup> #108  
Bellevue, WA 98006  
206-386-2700*

**Website Available**

**[www.nocnw.org](http://www.nocnw.org)**

## Neuro-ophthalmic Consultants Northwest

Welcome to Neuro-ophthalmic Consultants Northwest. You have been referred to us by a member of your care team to investigate your specialized visual concerns. In order to do so, we will need to obtain and review the documentation of your medical workup pertinent to your diagnosis.

Please complete the *Patient Data Collection Form* with the names and phone numbers of the physicians you have seen in relation to this episode of visual disturbance. Your assistance in contacting these physicians to have them forward their notes, along with reports of any tests completed, (visual fields, visual evoked potentials, MRI, etc) is greatly appreciated. Some offices require your personal consent to release this information.

To enable our physicians to provide the most comprehensive care, please take note of the following instructions:

- Arrive with your completed registration forms and insurance card
- In consideration of patients with migraine and allergies, please do not wear any product with a strong scent (colognes, perfumes, aftershave)
- If you have had an MRI of the brain and/or orbits or retinal photography it will be necessary for you to arrange with the performing facility to pick up a copy of the images and bring them with you to your appointment. **We ask that you do not rely on the mail or courier systems.**
- Ensure that we are aware of all the members of your care team and that we have received the documentation from them in regards to your referral

The appointment time will have been reserved especially for you. It is imperative that you arrive at least 15 minutes prior to your first scheduled appointment time to complete your registration and prepare your paperwork. If you are late, we may have to re-schedule your appointment. Our physicians make every effort in allowing enough time with each patient for a comprehensive exam and to have every patient seen at their appointed time.

Due to the highly specialized nature of our practice, we have many patients being referred on an urgent basis and on our waiting list. Your cooperation in notifying us 24 hours in advance that you will not be able to keep your appointment will allow us to offer this time to another patient. If you do not show to your appointment you are subject to not being allowed to reschedule.

Insurance policy:

- If you do not have insurance, we ask that you pay for services at the time of your visit. If you are unable to pay the full amount, we require a **deposit**, determined by **estimating** the services you will receive during your visit. The receptionist will advise you on the amount required. Applications for hardship consideration on the remaining balance are available.
- With so many different insurance plans and benefits, we are unable to know of all the requirements for each plan. We do know that if you have Pac Med, Group Health, Regence Selections, TriWest, Molina, CHPW, or a Medicare Advantage plan **you will need a referral from your primary care physician in place before an appointment will be made**
- If you have an HMO insurance ie: Secure Horizons, Pac Med, Group Health, Regence Selections, TriWest, Molina or Community Health Plan of Washington, **you will need a referral from your primary care physician in place before an appointment will be made.**
- If your insurance requires a co-pay, we will be collecting the co-pay at the time of your visit. We apologize, but we do not bill for co-pays. We accept VISA and MASTERCARD.

We look forward to participating in your care. If you have any questions, please call our office at (206) 386-2700.

# Neuro-ophthalmic Consultants Northwest

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## New Patient Data Collection Form

Referred by: \_\_\_\_\_ Insurance: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone Numbers: daytime: \_\_\_\_\_ cell: \_\_\_\_\_

Documentation of my medical workup **pertinent to my eye diagnosis** can be found with:

PHYSICIAN	PHONE	DATE CONTACTED
Optometrist:		
Ophthalmologist:		
Neurologist:		

My visual field test was done with Dr. \_\_\_\_\_

My MRI of the brain was done at \_\_\_\_\_

Other tests performed are \_\_\_\_\_

**\*\*I GIVE NOCNW PERMISSION TO REQUEST CHART NOTES FROM THE ABOVE LISTED PHYSICIANS AND FACILITIES\*\***

**\*\*I understand that I will need to bring my MRI with me to my appointment**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Neuro-Ophthalmic Consultants Northwest  
MEDICAL HISTORY FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Referred by: \_\_\_\_\_ Primary Care MD: \_\_\_\_\_

Occupation: \_\_\_\_\_ Spouse/Partner Name: \_\_\_\_\_

Age: \_\_\_\_\_ Dominant Hand:  Right  Left  Ambidextrous

Reason for this visit: \_\_\_\_\_

Other Medical Problems	Past Surgeries

Medications and dose schedule:

- |          |          |          |
|----------|----------|----------|
| 1. _____ | 4. _____ | 7. _____ |
| 2. _____ | 5. _____ | 8. _____ |
| 3. _____ | 6. _____ | 9. _____ |

ALLERGIES: \_\_\_\_\_

Use of Tobacco: Never \_\_\_\_\_ Previously, but quit \_\_\_\_\_ Current packs per day \_\_\_\_\_  
Use of Alcohol: Never \_\_\_\_\_ Rarely \_\_\_\_\_ Moderately \_\_\_\_\_ Daily \_\_\_\_\_  
Recreational Drugs: Never \_\_\_\_\_ Yes \_\_\_\_\_ Type/Frequency \_\_\_\_\_

Review of Systems: *Do you currently have any of the following problems?*

	No	Yes	If yes, please explain:
Neurological problems (such as headaches, stroke, memory problems)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Disease (such as glaucoma, cataracts, wandering or lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic fever, unexpected weight loss, fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/Nose/Throat problems (e.g. hearing loss, sinus problems)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems (e.g. chest pain, irregular heart beat)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory problems (e.g. shortness of breath, wheezing, coughing)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary problems (e.g. pain, incontinence, blood in urine)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine problems (e.g. diabetes, thyroid disease, menstrual problems)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric problems (e.g. depression, anxiety, anger problems)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hematology problems (e.g. HIV, Hep C)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Family Medical History: *Any immediate family members with a history of either eye or neurological disease?*

No  Yes (if yes, please explain) \_\_\_\_\_

MD initials: \_\_\_\_\_

# REGISTRATION FORM

## PATIENT:

Name (Last, First, M.I.) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phones: home\_(\_\_\_\_) \_\_\_\_\_ work\_(\_\_\_\_) \_\_\_\_\_ cell\_(\_\_\_\_) \_\_\_\_\_

Date of Birth\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Social Security Number\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Gender  Male  Female Employment Status  Full time  Part time  Other\_\_\_\_\_

Employer\_\_\_\_\_

Address\_\_\_\_\_

Marital Status  Single  Married  Divorced  Domestic Partner/Life Partner  Widow(er)

## PERSON RESPONSIBLE FOR MEDICAL BILL:

Relation to patient  Self (Same as above)  Other\_\_\_\_\_

Name (Last, First, M.I.) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phones: home\_(\_\_\_\_) \_\_\_\_\_ work\_(\_\_\_\_) \_\_\_\_\_ cell\_(\_\_\_\_) \_\_\_\_\_

Date of Birth\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Social Security Number\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Gender  Male  Female Employment Status  Full time  Part time  Other\_\_\_\_\_

Employer\_\_\_\_\_

Address\_\_\_\_\_

SPOUSE/LEGAL NEXT OF KIN: Name:\_\_\_\_\_

Phone: home\_(\_\_\_\_) \_\_\_\_\_ work\_(\_\_\_\_) \_\_\_\_\_

REFERRING PHYSICIAN: Name:\_\_\_\_\_

Clinic:\_\_\_\_\_ phone\_\_\_\_\_

Primary Care Provider: Name:\_\_\_\_\_

Clinic:\_\_\_\_\_ phone\_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ phone: \_\_\_\_\_

# INSURANCE INFORMATION

**PRIMARY INSURANCE:** *please provide copy of card*

Insurance company \_\_\_\_\_

Insurance policy holder (**subscriber**) \_\_\_\_\_

Relationship to patient \_\_\_\_\_

**Subscriber's SSN** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Subscriber's Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_

Insurance claims address (found on back of card) \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**SECONDARY INSURANCE:** *please provide copy of card*

Insurance company \_\_\_\_\_

Insurance policy holder (**subscriber**) \_\_\_\_\_

Relationship to patient \_\_\_\_\_

**Subscriber's SSN** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Subscriber's Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer \_\_\_\_\_

Insurance claims address (found on back of card) \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

## MEDICARE QUESTIONNAIRE

I receive Medicare benefits  Part A  Part B  Both

I receive Medicare benefits due to being age 65 or older  Yes  No

I receive medical benefits as the result of my or my spouses current employment  Yes  No

Please note: Medicare may be your **secondary** coverage if you are receiving health benefits due to you or your spouse's current employment.

**SIGNED** \_\_\_\_\_

**DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_

# Neuro-ophthalmic Consultants Northwest

## FINANCIAL AGREEMENT WAIVER

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

I give permission to Neuro-ophthalmic Consultants Northwest for medical treatment, including laboratory and x-ray services. I accept financial responsibility for all services provided, including any laboratory, x-ray and other ancillary care provided by other providers that I am referred to by Neuro-ophthalmic Consultants Northwest. I understand that I am responsible for payment if my insurance does not pay or only pays a portion of the services I am provided by Neuro-ophthalmic Consultants Northwest and other contracted providers. I authorize release of medical records by Neuro-ophthalmic Consultants Northwest and other contacted providers. I authorize release of medical records to my insurance company as needed to process claims. I am aware that I will receive a separate bill for any lab or x-ray services.

My current insurance status is as follows:

- I have insurance and do not need a referral.
- I have insurance and require a referral for services provided by Neuro-ophthalmic Consultants Northwest. I have informed by primary care physician that a referral is needed and have obtained one.
- Although my insurance requires a referral to Neuro-ophthalmic Consultants Northwest, I do not have a referral from my primary care provider for services provided by Neuro-ophthalmic Consultants Northwest. I understand that the services I receive from Neuro-ophthalmic Consultants Northwest is entirely my financial responsibility until I obtain an official authorization from my primary care provider listed with my insurance for these services.
- I did not bring my medical insurance card/coupon and decline to reschedule my appointment with Neuro-ophthalmic Consultants Northwest. I understand that the fee for services provided by Neuro-ophthalmic Consultants Northwest is entirely my financial responsibility unless I can present my medical insurance card/coupon and/or authorization for services.
- I choose to be seen for services outside the scope of my insurance coverage, provided by Neuro-ophthalmic Consultants Northwest, and understand that I will be required to pay for these services in total. I will pay the pre determined amount of deposit at the time of service.
- I do not have insurance and will be paying for services provided by Neuro-ophthalmic Consultants Northwest at the time of my appointment. If I am unable to pay the entire amount, I will pay the pre determined amount of deposit at the time of service **with the remainder of the charges to be billed to me at a later date.**
- Other: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

## PATIENT INFORMATION SECURITY

HIPAA (Health Information Portability and Accountability Act) sets rules and limits on who can look at and receive your health information. We, as a medical practice, are under obligation to provide you with a copy of the regulations and adhere to rules stated therein.

To make sure that your information is protected in a way that does not interfere with your health care, your information can be used and shared:

- For your treatment and care coordination
- To pay doctors and hospitals for your health care
- With your family, relatives friends or others **YOU IDENTIFY** who are involved in your health care, or your health care bills

To assist us in knowing to whom and how you identify the communication of your medical information, please complete the following :

YES       NO      It is permissible to leave detailed information from this office regarding my medical care on my home or work voice mail.

YES       NO      It is permissible to contact the other members of my care team or diagnostic facilities for information pertaining to my current eye condition.

YES      Being over the age of 18, I understand that my medical information cannot be released to any family member, (including my parent, spouse, partner), or friend that I have not designated below.

I have been given a copy of the HIPAA policy. I authorize release of relevant medical information to the following persons/entities:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_

**I would like a copy of my chart note sent to the following physicians: (other than my referring doctor and primary care listed on registration sheet)**

\_\_\_\_\_ **Address** \_\_\_\_\_

\_\_\_\_\_ **Address** \_\_\_\_\_

\_\_\_\_\_ **Address** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Printed Patient's Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient's e-mail address (case sensitive) \_\_\_\_\_

**IN A MEDICAL EMERGENCY - DO NOT USE E-MAIL****1. RISK OF USING E-MAIL**

Neuro-ophthalmic Consultants Northwest (NOCNW) offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail, however, has a number of risks that patients should consider before using e-mail. These include, but are not limited to:

- E-mail can be circulated, forwarded and stored in numerous paper and electronic files
- E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients
- E-mail senders can easily misaddress an e-mail
- E-mail is easier to falsify than handwritten or signed documents
- Backup copies of e-mail may exist after the sender or the recipient has deleted his or her copy
- Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems
- E-mail can be intercepted, altered, forwarded or used without authorization or detection
- E-mail can be used to introduce viruses into computer systems
- E-mail can be used as evidence in court

**2. CONDITIONS FOR THE USE OF E-MAIL**

NOCNW will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, NOCNW cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper use and/or disclosure of confidential information (including Protected Health Information that is the subject of the federal Health Insurance Portability and Accountability Act of 1996) that is not caused by NOCNW's intentional misconduct. Thus, patients must consent to the use of e-mail for patient information. Consent to the use of e-mail includes agreement with the following conditions:

- NOCNW may forward e-mails internally to our staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. NOCNW will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
- Although NOCNW will endeavor to read and respond promptly to an e-mail from a patient, we cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus the patient shall not use e-mail for medical emergencies or other time sensitive matters.

- If the patient's e-mail requires or invites a response from NOCNW, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient will respond.
- The patient should not use e-mail for communication regarding sensitive medical information, such as sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse
- The patient is responsible for informing NOCNW of any types of information the patient does not want to be sent by e-mail, in addition to sensitive material previously described.
- The patient is responsible for protecting his/her password or other means of access to e-mail. NOCNW is not liable for breaches of confidentiality cause by the patient or any third party
- It is the patient's responsibility to follow up and / or schedule an appointment if warranted
- The patient or patient's designated caregiver must be 18 years or older before NOCNW can respond to an e-mail about the patient

**3. INSTRUCTIONS**

To communicate by e-mail, the patient shall:

- Inform NOCNW of changes in his / her e-mail
- Include the patient's name in the body of the e-mail
- Review the e-mail to make sure it is clear and that all relevant information is provided before sending
- Take precautions to preserve the confidentiality of your e-mail
- Withdraw consent to use e-mail only by written communication to NOCNW

**4. PATIENT ACKNOWLEDGEMENT AND AGREEMENT**

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between Neuro-ophthalmic Consultants Northwest (NOCNW) and me, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that Neuro-ophthalmic Consultants Northwest (NOCNW) may impose to communicate with patients by e-mail.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

# Neuro-Ophthalmic Consultants NW

## NOTICE OF PRIVACY PRACTICES

1. **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.** The notice is provided in two layers: This top layer briefly summarizes how we handle your health information, and the attached bottom layer provides further details of our privacy policies and procedures.
2. **How we may use and disclose your health information.** We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. For example, your health information may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose your health information without your authorization for several reasons. Beyond those situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information, you can later revoke it to stop any future uses and disclosures.
3. **Your rights.** In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about you. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.
4. **Our legal duty.** We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgment of receipt of this notice. We may change our privacy policies any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy policies, contact Sandra Benson, Administrator-HIPAA Officer.
5. **Privacy complaints.** If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact Privacy Officer. You also may send a written complaint to the U. S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact:

*Privacy Officer*

**Seattle Radiologists, APC  
1229 Madison Street, Suite 900  
Seattle, WA 98104  
Phone: 206-292-8517, Fax: 206-292-7764**