**Halifax Eye Care Center, Inc.**

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Mark. J. Morris, M.D.

*General Ophthalmology*

**Patient Information**

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

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_

Phone: (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F Marital Status: S M W D

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (Work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization for Use or Disclosure of Protected Health Information or In Case of Emergency**

I authorize my physician and/or administrative and clinical staff of Halifax Eye Care Center to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name and relationship of person(s) who you wish to allow access (e.g., your spouse, child, sibling, caretaker, or friend). Due to HIPAA Regulations, we can only discuss treatment with the person(s) listed on this form.

**Name of person or entity** **Relationship** **Phone Number**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**General Consent to Treat**

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

**Patient Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I, the undersigned, hereby consent to the following:

 Administration and performance of general treatments

 Use of prescribed medications

 Performance of diagnostic procedures/tests and cultures

Performance of other medically accepted diagnostic/laboratory tests that may be considered **medically necessary** or advisable based on the judgment of my physician or their assigned designees.

I fully understand that this consent is given in advance of any specific diagnosis or treatment.

I intend that this consent is continuing in nature even after specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

A photocopy or fax of this consent shall be considered as valid as the original.

I, the undersigned, authorize the practice to use and disclose my information for the purposes of:

Treatment, payment, and healthcare operations as described in the Notice of Privacy Acts.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

**Patient (or responsible party) Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If Responsible Party, Relation to Patient:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **Authorization to Leave Message**

I authorize Halifax Eye Care Center to communicate with me by the following means:

(Please check all that apply)

\_\_\_\_ Home

\_\_\_\_\_ Cell/Text

\_\_\_\_\_  Emergency Contact

\_\_\_\_\_  Email

I have read and had the opportunity to discuss and ask questions regarding the terms of this form, and I understand its contents.

I understand it is my responsibility to notify Halifax Eye Care Center, Inc. of any changes to the above authorizations.

Signature of Patient or Patient’s Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Representative Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Receipt of Patient Documents**

I have been provided a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) to read and understand, and I consent to use and disclosure of protected health information about myself for treatment, payment and health care operations.

I have been provided a copy of the Financial Policy to read. I understand, that I, the patient or the patient’s representative, am responsible for payment of all charges for service rendered. I also acknowledge that non-payment of my account may result in collection proceedings and dismissal from the practice.

I have been provided a copy of the Patients Rights and Responsibilities

I have been provided a copy of the Nondiscrimination Notice

I have been provided a copy of the Halifax Eye Care Center Grievance Policy

I been provided a copy of the Explanation of a Refraction

Signature of Patient or Patient’s Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_

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Patient Rights and Responsibilities

Patients have the right to…

* Be informed of their rights and responsibilities.
* Receive treatment and medical services without any type of discrimination.
* Be treated with privacy, consideration, respect and recognition of their individuality.
* Be informed of the names and functions of all physicians and other healthcare professionals providing their direct care.
* Receive the services of a translator or interpreter to facilitate the communication between the patient and the clinic’s healthcare professionals.
* Participate in the development and implementation of their plan of care.
* Make informed decisions regarding their care.
* Be informed of their health status, involved in care planning and treatment, and allowed to request or refuse treatment.
* Have physicians and other healthcare professionals comply with advance directives.
* Have their medical records kept confidential.
* Have access to their medical records within a reasonable time frame.
* Be free from all forms of abuse and harassment.
* Receive care in a safe setting.
* Examine and receive an explanation of their bill.
* Have an explanation if they are being discharged or transferred to another medical clinic.
* Be informed in writing about the clinics policies and procedures for initiation, review and resolution of patient complaints, including the address and telephone number of where to file complaints with Halifax Eye Care Center and the Virginia State Board of Medicine.

# Patients have the responsibility to…

* Provide accurate information
* Follow instructions
* Follow clinic rules and regulations
* Accept consequences of their decisions
* Meet financial obligations
* Show respect and consideration
* Ask questions

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 **Nondiscrimination Notice**

Halifax Eye Care Center, Inc. complies with applicable Federal Civil Rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex or gender orientation. Halifax Eye Care Center, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, sex or gender orientation.

Halifax Eye Care Center, Inc.:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

* Qualified sign language interpreters
* Written information in other formats

Provides free language services to people whose primary language is not English, such as:

* Qualified interpreters
* Information written in other languages

If you need these services, contact Debbie Morris, Grievance Officer

If you believe that Halifax Eye Care Center, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex or gender orientation, you can file a grievance with:

Deborah P. Morris

521 Webster Street

South Boston, VA 24592

(434) 572-9500

You can file a grievance in person, by mail or by phone. If you need help filing a grievance, Deborah Morris is available to help you.

You can also file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at [Https://ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf), or by mail or phone at:

US Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, DC 20201

1-800-868-1019 or 1-800-537-7697 (TDD)

Complain forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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**INTERPRETATION SERVICES AVAILABLE**

(TAGALOG) Pansin: Kung magsalita ka Tagalog, wika serbisyo ng tulong, nang walang bayad, ay magagamit sa iyo.

(URDU) توجہ: اگر آپ اردو زبان کی مدد کی خدمات، مفت کے انچارج بولتے ہیں تو، آپ کو دستیاب ہیں.

(YORUBA) Akiyesi: Ti o ba sọ Yorùbá, èdè iranlowo iṣẹ, free ti idiyele, ni o wa wa si o.

(BENGALI) দৃষ্টি আকর্ষণ: আপনি বাংলা, ভাষা সহায়তা সেবা, নিখরচা কথা বলতে পারেন, আপনার জন্য উপলব্ধ.

(AMHARIC) አዳምጥ: አማርኛ, ከክፍያ ነፃ የቋንቋ እርዳታ አገልግሎቶች, የሚናገሩ ከሆነ, ለእርስዎ የሚገኙ ናቸው.

(PERSIAN) توجه: اگر شما فارسی، خدمات کمک زبان، رایگان صحبت می کنند، در دسترس شما هستند.

(GERMAN) ACHTUNG: Wenn Sie Deutsch sprechen, Sprachassistenzdienste sind kostenlos, zur Verfügung.

(CHINESE) 注意：如果你说中国话，语言协助服务，免费的，都可以给你。

(ARABIC) تنبيه: إذا كنت تتكلم العربية، وخدمات المساعدة اللغوية، مجانا، تتوفر لك.

(FRENCH) ATTENTION : Si vous parlez Français, les services d’assistance de langue, sans frais, sont à votre disposition.

(IBO) Ntị: Ọ bụrụ na ị na-ekwu okwu Igbo, asụsụ aka ọrụ, n'efu, dị ka gị.

(KRU) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ [Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa.

(HINDI) ध्यान दें: यदि आप हाईटियन क्रियोल बात, भाषा सहायता सेवाओं, नि: शुल्क, आप के लिए उपलब्ध हैं।

(KOREAN) 주의: 당신이 말하는 한국어, 언어 지원 서비스를 무료로 사용할 수 있습니다 당신에 게.

(RUSSIAN) ВНИМАНИЕ: Если вы говорите России, переводческие услуги, бесплатно, доступны для вас.

(SPANISH) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted.

(VIETNAMESE) Chú ý: Nếu bạn nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn.

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Halifax Eye Care Center, Inc. – Grievance Policy

These procedures were developed to provide guidelines for the systematic receipt, documentation, evaluation, resolution and response to patient grievances.

# Definition

A grievance is defined by Halifax Eye Care Center, Inc. as:

Patient complaint or expression of dissatisfaction regarding service delivery.

**II. Procedures**

1. Patient expresses dissatisfaction verbally or in writing.
2. Halifax Eye Care Center, Inc. staff member will direct the patient to Grievance Officer. The Grievance Officer for 2016 is Deborah P Morris, Clinical Coordinator.
3. The Grievance Officer will document the complaint in the Grievance Log.

The Grievance Log shall include the following information.

Patient ID# (not name)

Nature of complaint

Identification of those involved

Date complaint received and by whom

Summary of follow-up activities

Date grievance referred to Dr. Mark Morris, if necessary

Date of resolution

1. The Grievance Officer will be responsible for collecting relevant information about the grievance, for taking action to resolve the grievance and for documenting all progress.
2. The Grievance Officer will attempt to resolve the complaint between the parties involved. If no satisfaction results, and disenrollment or termination of provider/patient relationship might be appropriate, the Grievance Officer will present the situation to Dr. Mark Morris, Medical Director of Halifax Eye Care Center.
3. Thirty days after expressing grievance, patients will receive in writing all grievance facts and decisions.
4. All information, including Grievance Log, will be provided to Dr. Mark Morris, Medical Director after the end of the month.
5. This procedure will be provided to each patient filing a grievance.

**If this procedure is not clear, or you have any questions, please call the Grievance Officer at (434) 572-9500.**

I have read the Grievance Policy and consent to the case management services of the practice.

Patient Signature Date

Grievance Officer’s Signature