Coe Family Vision Clinic
HIPPA Notice

Right to Notice As a patient: You have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPAA), Coe Family Vision Clinic can use your protected health information for treatment, payment and health care operations.
Treatment - We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide you.
Health care operations - We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
Your Authorization: Most uses and disclosures that do not fall under treatment, payment, health care operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.
Emergency Situations: In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your healthcare.
Marketing: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may also use or disclose your health information when we are required to do so by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your or other people's health or safety.
National Security: We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders via phone, e-mail or letter.
Your Rights as a Patient: You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or health care operations.
You have the right to receive confidential communications regarding your protected health information.
You have the right to inspect and copy your protected health information.
You have the right to amend your protected health information.
You have the right to receive an account of disclosures of your protected health information.
You have the right to a paper copy of this notice of privacy practices.
Legal Requirements: Coe Family Vision Clinic is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they are posted to this site, or are available within our office.
Complaints: If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint.
Contact Information For further information about Coe Family Vision Clinic's privacy policies, please contact our offices and Dr. Brian Eirik Coe at the following address or phone number: 629 Avenue D, Suite #2, Snohomish, WA 98290; Phone: (360) 568-1551-Fax: (360)568-9487; E-mail: tamara@coefamilyvisionclinic.com
Acknowledged and agreed to by Patient:

Sign: _____ Print Name: _____ Date:_____

OR ON BEHALF OF THE PATIENT BY:

Sign: _____ Print Name: _____ Date:_____

Relationship to Patient:_____

Coe Family Vision Clinic
Authorization for Release of Identifying Health Information

Patient Name: _____ DOB: _____

Requesting records from:

Dr. /Clinic: _____

Address: _____

Phone #: _____ Fax #: _____

Sending records to:

Dr. /Clinic: Coe Family Vision Clinic

Address: 629 Avenue D Suite # 2. Snohomish, WA 98290

Phone #: (360)568-1551 Fax #: (360)568-9487

I authorize the professional office of my doctor named above to **release health information or receive** health information identifying me or my child (including, if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

- It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization form.
- If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient/Parent Signature: _____ Date: _____

Coe Family Vision Clinic
Billing and Financial Policies

Insurance Authorization and Assignment: I request that payment of authorized private insurance company benefits, Medicare and Medicaid services or other applicable benefits be paid on my behalf to Dr. Brian Eirik Coe of Coe Family Vision Clinic for any furnished services. I authorize Coe Family Vision Clinic to release any medical or other information about me to any private insurance company, Medicare and Medicaid or other company and its agents which might provide coverage to me.

All Services are the Responsibility of the Patient: Coe Family Vision Clinic will gladly bill your primary insurance. I understand that insurance benefits must be determined prior to my exam. The quote obtained from the insurance company is **NOT** a guarantee that benefits will be paid as stated during the conversation. The information provided by the Insurance Companies' customer service associate may be inaccurate. For this reason The Coe Family Vision Clinic's staff will not be responsible for any inconsistencies in quotes versus benefits actually paid. If I become aware of insurance coverage after services have been rendered, I agree to personally submit the claim to my insurance company for reimbursement. I understand that when my insurance company requires a referral from my primary-care physician, and I do not furnish the correct referral at the time of service, I will be responsible for payment if my insurance company refuses my claim. I also understand and acknowledge that I am financially responsible for non-covered services and any unpaid insurance balance over 45 days past due.

Payments, Co-pays and Deductibles are Due at Time of Service: I understand that not all services and materials may be covered by my insurance or may exceed benefits or coverage. I agree to pay all payments, co-pays and deductibles at the time of service for all services and materials.

Returned Checks: There is a $25.00 fee for any check returned by the bank. This fee will be added to the unpaid balance and must be paid by cash or credit card.

Patient's Name: _____ (please print)

Responsible Party
(If not the patient): _____ (please print)

Signature: _____ Date: _____

ACKNOWLEDGEMENT RECEIPT
By initialing below, I acknowledge I have been offered a copy of Coe Family Vision Clinic's Notice of Privacy Practices.

____Yes, I would like to receive a copy of Coe Family Vision Clinic's Notice of Privacy Practices

____No, I do not wish to receive a copy of Coe Family Vision Clinic's Notice of Privacy Practices

Coe Family Vision Clinic
Late, Cancellation, and No-Show Policy

Late Policy

If a patient is late for an appointment we ask that you call and let us know you are on your way. However, if you are more than ***15 minutes late*** you will have to reschedule your appointment.

Cancellation of Appointment(s) / No-Shows

Patients wanting to cancel an appointment are asked to call the office 24 hours in advance. The charge for not canceling within a 24 hour notice is **$25.00**, which will be charged to your account and is not payable by any insurance company.
Patients who "No-Show" with no previous notification three times for scheduled appointments may be discharged from the practice.

Informed consent /Agreement:

□ I have been informed of and understand the Clinic's late policy.
□ I have been informed of and understand the Coe Family Vision Clinic's No Show/ Late Cancellation Policy. I understand that a no-show or late cancellation will result in a **$25.00** Charge that is not covered by any insurance. I understand that three consecutive no show or late Cancellations may result in dismissal from the Clinic.

Signature of Patient / Guardian: _____ Date:_____

Coe Family Vision Clinic
Return & Warranty Policy

Customer Satisfaction: Your eyeglass lenses are custom made for your prescription in the frame you chose. In the event that you are not satisfied with your frame, Coe Family Vision Clinic allows a one-time exchange into a new frame of your choosing. If the new frame is a different cost, the difference will be charged to you or credited as store credit to your account **(No cash refunds)**. You will pay an additional 50% of the new lenses. The original pair must be returned in the same condition as received, including all packaging.

Doctor's Change: If your doctor determines a change in your prescription is needed within 60 days of your original order, we'll provide a one-time lens replacement, same frame, for free! Any other re-makes you will have to pay 50% of the charges.

Progressive Non-adapts: In the event of progressive non-adapt, Coe Family Vision Clinic will replace your lenses with a lined bi-focal or single-vision lens at no additional charge to you. **NO** refunds or store credit for the cost difference of the lenses.

Kids will be kids: We're happy to provide free repairs and a one-time no-fault same frame replacement within the first year after purchase. We also provide a two (2) year lens replacement with the purchase of the kids lens package. **(This does not apply or include lost frames and lenses or new prescriptions)**.

Scratch Resistance: Scratch resistant does not mean scratch proof. Please use proper care when cleaning your lenses. Coe Family Vision Clinic will replace lenses with scratch coating one (1) time during the first year, if needed.

Anti-Reflective Coating: If your lenses scratch or the Anti-Reflective coating flakes and you need to replace the lenses, Coe Family Vision Clinic will replace your lenses for free for up to two (2) years from the date of purchasing the Anti-Reflective coating at no charge.

Frame Warranty: All frames are warranted for one (1) year against manufacturer defects. A manufacturer defect does not include mis-handling or abuse.

I have read, understand, and agree to follow the Coe Family Vision Clinic's Return Policy. I also understand that no cash payments will be made towards any refunds.

Signature of responsible party:_____ Date:_____

You are entitled to a copy of this agreement. Please let the office staff know if you would like a copy.

COE FAMILY VISION CLINIC - REGISTRATION FORM

PATIENT INFORMATION

Patient's last name: First: Middle	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / part / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	City:	State:	Zip Code:
Home phone # :( )	Cell# :( )	What is the Best way to reach you?	
E-mail Address:		When is the best time to reach you?	

Occupation:	Employer:	Employer phone no.: ( )

Referred to clinic by (please check one box):	❑ Dr.	❑Internet	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

INSURANCE INFORMATION

Medical Insurance

Person responsible for bill:	Sub scriber Birth date: / /	Address (if different):	Home phone no.: ( )
Occupation:	Employer:		Employer phone no.:

Please indicate primary Medical insurance	❑ Medicare	❑ Medicaid	❑ Regence Blue shield	❑ Premera Blue Cross	❑First Choice health

❑ United Health Care	❑ VSP	❑ Aetna	❑ Medical Coupon *(Please provide coupon)*	❑ Other

Subscriber's name:	Subscriber's S.S./ID #:	Birth date :mm/dd/year:
Group no.:	Policy no.:	

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

VISION INSURANCE IF DIFFERENT THEN MEDICAL INSURANCE.

Name of Vision Insurance (If other then Medical)?	Subscriber's name:	ID #:	Group #:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Coe Family Vision Clinic or insurance company to release any information required to process my claims.

Patient/Guardian Signature _____ Date:_____

HEALTH HISTORY QUESTIONNAIRE

All Information contained in this questionnaire are strictly confidential and will become part of your **medical record.**

Name(Last, First, M.I.)

CURRENT DOCTOR:	PHONE #:	DATE OF LAST PHYSICAL EXAM:

Date of Last Eye Exam:

Occupation:

PERSONAL HEALTH HISTORY

Do You Currently Have Or Had Any Of The Following Conditions?	☐Diabetes Type:	☐ Thyroid Problem	☐ Respiratory Problems	☐ Blood Disorders
	☐ Hypertension	☐ Anxiety	☐ Stroke/Neurological	☐ Hepatitis
	☐Cancer	☐ Depression	☐ Cardiovascular Problems	Other (Please Explain):
	☐Arthritis/Rheumatoid	☐Tuberculosis	☐HIV/AIDS	

Have You Ever Been Treated For Or Diagnosed With Any Of The Following?			**Do You Have A Family History Of The Following?**	
☐Cataracts	☐Strabismus/Crossed Eye	☐Eye Infection	☐Diabetes	☐Glaucoma
☐Amblyopia/Lazy Eye	☐Retinal Problems	☐Eye Surgery	☐Macular Degeneration	Other(Please Explain):
☐Glaucoma	☐Macular Degeneration	☐Eye Trauma	☐Blindness	

DO YOU EXPERIENCE ANY OF THE FOLLOWING?

☐Flashes of Light	☐Double Vision	☐Blurred Vision
☐Floaters	☐Light Sensitivity	☐Itching/ Burning/ Dryness
☐Eye Pain	☐Tearing	Other(Please Explain):
☐Redness	☐Unexplained Headaches	

SURGERIES	YEAR	REASON

LIST YOUR PRESCRIBED DRUGS. PLEASE INCLUDE OVER-THE-COUNTER MEDICATION AND SUPPLEMENTS THAT ARE TAKEN REGULARLY.

ALLERGIES TO MEDICATIONS

HEALTH HABITS AND PERSONAL SAFETY

Alcohol	Do you drink alcohol? ☐yes ☐No	How many drinks per week?
Tobacco	Do you use tobacco? ☐yes ☐No	☐ Cigarettes☐Chew ☐ Pipe ☐ Cigars #per day? _____#of years:_____ Or year quit____
Drugs	Do you currently use recreational or street drugs? ☐yes ☐No	Have you ever given yourself drugs with a needle?
Women Only	Are you pregnant or breastfeeding? ☐yes ☐No	