Andrea V. Gray, MD, PC

Eye Physician and Surgeon

Welcome!

My staff and I are excited to welcome you into our practice. We enjoy providing the highest quality eye care in a warm personalized manner.

During your visit, I want to provide you with a very thorough eye examination that takes into account your other medical issues and medications. The process starts with you – included in this letter are health history and personal information forms. I would be grateful if you would please fill them out and bring them with you to your appointment. If you are currently wearing glasses, please bring them with you as well as any contact lens information you may have if you are wearing contact lenses. This will assist us with your eye care needs.

Your time is valuable, and we place importance on providing our patients with prompt, friendly service. Your promptness allows us to take the time to care for you properly.

Since we will be getting to know you, it is only fair that I tell you a little bit about myself. Roseburg is my hometown, and there is no place I would rather live and practice. I attended college at Oregon State University and then went to medical school at Oregon Health Sciences University. After obtaining my MD, I completed a general medical and surgical internship at Legacy Emmanuel Hospital in Portland. My residency in ophthalmology was done at UC Davis, where I also served as chief resident. I am a board-certified ophthalmologist and a fellow of the American Academy of Ophthalmology.

I appreciate your trust in allowing me to care for your eyes. My staff and I look forward to getting to know you and serving your eye care needs.

Sincerely,

Andrea V. Gray, MD

2995 NW Edenbower Blvd, Roseburg, OR 97471 P(541)957-5400 F(541)440-1010 www.roseburgeye.com

NAME:_____ DATE:_____
PRIMARY CARE PHYSICIAN:_____
REASON FOR TODAY'S VISIT:_____
ANY OTHER EYE PROBLEMS YOU ARE HAVING:_____
_____

EYE CONDITIONS (INDICATE ANY THAT APPLY, PAST OR PRESENT):

	YOU	BLOOD RELATIVES
GLAUCOMA	___	_____
MACULAR DEGENERATION	___	_____
RETINAL PROBLEMS	___	_____
PLEASE SPECIFY:_____		
BLINDNESS	___	_____
CAUSE:_____		
LAZY/CROSSED EYES	___	_____
EYE INJURY	___	
EYE SURGERY	___	
FOR WHAT?_____ WHEN?_____		
LASER PROCEDURES	___	
FOR WHAT?_____ WHEN?_____		

OTHER:_____
NONE APPLY___
CURRENT EYE MEDICATIONS:_____

MEDICAL CONDITIONS (INDICATE ANY THAT APPLY, PAST OR PRESENT):

	YOU	BLOOD RELATIVES
DIABETES	___	_____
HEART ATTACK	___	_____
HIGH BLOOD PRESSURE	___	_____
HIGH CHOLESTEROL	___	_____
THYROID PROBLEMS	___	_____
STROKE	___	_____
ANKLE SWELLING	___	
HIV/AIDS	___	
KIDNEY/BLADDER PROBLEMS	___	
ULCER	___	
BLEEDING TENDENCY	___	
ARTHRITIS	___	
SHORTNESS OF BREATH	___	
BREATHING DIFFICULTY	___	
EMPHYSEMA/ASTHMA	___	
HEART ARRHYTHMIA	___	
HEADACHES	___	
SEIZURES	___	
MIGRAINE	___	
NUMBNESS/TINGLING	___	
CANCER	___	
WEAKNESS	___	
SKIN PROBLEMS	___	

DO YOU SMOKE? Y N
DRINK ALCOHOL? Y N
ARE YOU PREGNANT? Y N

OTHER:_____
NONE APPLY___

PASTSURGERIES:_____
ALLERGIES TO MEDICINES:_____WHAT HAPPENS?_____
CURRENT MEDICATIONS:_____
_____

Patient Information

Patient's Name_____ Sex: Male / Female

Social Security #_____ Date of Birth_____ Primary Language_____

Mailing Address_____ City_____ State_____ Zip_____

Phone (H)_____ (W)_____ Email_____

Occupation_____ Employer_____ Primary Care Dr._____

Marital Status: S M D W Spouse's Name_____

Ethnicity: (circle one) **Hispanic/Latino** or **Non-Hispanic/Latino** Race_____

Mother's Maiden Name_____ Patient's **State** of Birth_____

Emergency Contact_____ Phone_____

UNDER AGE 18: Responsible Party_____ Phone_____

How did you hear of our office?

Doctor____ Our Website____ News Paper____ Phone Book____ Friend / Family____ Insurance Plan____

Sign____ TV Ad____ Lecture / Seminar____ Social Media____

May we communicate with you via phone, answering machine / voicemail regarding your appointments, test results, billing / insurance, or other medical information? (circle one) **YES** or **NO**

Who do you authorize to receive medical, billing / insurance, or appointment information on your behalf?

(Ex: spouse, friend, caregiver, etc.)_____

Signature_____ **Date**_____

If under 18, parent or guardian signature

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Patient Financial Responsibility Acknowledgement

Co-Payments are due each office visit prior to seeing the doctor. If you are unable to pay today, there will be an additional $10 billing fee.

Insurance will be billed as a courtesy. Your signature gives us permission to bill your insurance. Deductibles, patient balance responsibility beyond insurance, and all balances are due in full before the end of the month. If it is discovered that you are ineligible with your insurance plan, you will be responsible for all charges.

Managed Care Plans may require you to obtain a referral to be seen. If you do not have an authorization from your primary care physician, you are financially responsible for this office visit and services rendered.

Self Payment is due in full at the time of service. There is a $25 charge on all returned checks.

Patient Responsibility balances are due within 30 days of the date of service. There is a $10 finance charge per month for any balance past due.

Services Not Covered by insurance are the responsibility of the patient / guardian. Non-covered services vary between each insurance company.

Missed Appointments We reserve the right to impose, and you agree to pay, a fee of $25 for missed appointments not cancelled with 24 hours notice.

OHP / DCIPA patients without a 24 hour cancellation notice will not be rescheduled.

I have read the above Patient Financial Responsibility Acknowledgement and as a patient, or legal guardian of a minor or impaired patient, I understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand there is no fee accrued on accounts paid current; however, I am also aware that **delinquent accounts beyond 90days due are subject to other collection means at my own expense.**

I understand and agree to the above in accordance with the terms and conditions set forth in the policy of this office. I also hereby attest that I have given payment information to the best of my knowledge for complete and timely payment.

Printed Name & Signature _____ Patient Name _____

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Privacy Policy

- We will only use or disclose Protected Health Information we obtain from you or on your behalf (a) for purposes of providing medical services to you, (b) if needed for your internal management and administrative needs related to our provision of service to you, (c) if needed to fulfill our legal obligations, or (d) as required by your insurance provider for processing claims for your medical/vision services. We maintain technical, administrative and physical safeguards to comply with HIPAA regulations regarding your protected health information.
- We will not use or disclose Protected Health Information we obtain from you or on your behalf for any other activity or purpose unless you have authorized us to do so in writing and such use or disclosure is otherwise permitted by law.
- We will establish and maintain policies and procedures which are reasonably necessary to protect any Protected Health Information we obtain from you or on your behalf.
- If we become aware of any use or disclosure of your Protected Health Information which is not authorized under this policy, we will take such action as is reasonably necessary to stop such use or discloser, prevent its recurrence, and mitigate any harm it may have caused. We will also report any such unauthorized use or disclosure to you.
- If we contract with or otherwise use any other person to process, transmit, store or otherwise use or disclose Protected Health Information, we shall insure that person agrees to protect that information and not to use or disclose that information in any way which is not authorized as provided in this section.
- You have the right to access and/or copy your Protected Heath Information and to make amendments or corrections to the information. If you choose to amend or correct your Protected Heath Information, your amendment will be added to your Protected Health Information. We have the right to deny your request if you ask us to amend information that: we did not create, is not part of the health information we keep, you would not be permitted to inspect and copy, or that is accurate and complete.
- All regular employees will be trained in these privacy policies. Appropriate sections for failing to comply with privacy regulations will be administered and documented.
- You may make a complaint to this office regarding our handling of your Protected Health Information. We will retain a written record of any complaints and take appropriate action to rectify the situation according to these policies. There will be no intimidating or retaliatory actions against individuals choosing to make a complaint or exercise their rights according to these policies.
- You have a right to review our privacy policy at any time. You will be given opportunity to review our notice of privacy practices each time you visit our office.
- We may disclose health information about you to your family or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may determine that a disclosure to your family or friends is in your best interest. In that situation, we will disclose only health information relevant to that person's involvement in your care.

Signature_____ Date_____