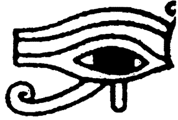

MICHAEL A. CALLAHAN, M.D. AND ASSOCIATES, P.C.

MICHAEL A. CALLAHAN, M.D.
JULIE H. GANNON, O.D.
TIMOTHY J. THOMPSON, O.D.

Dear New Patient:

Welcome to our practice and thank you for selecting our doctors for your care!

Because this is your first visit with us, there is specific information we must have from you. Enclosed you will find our new patient information forms that we would like you to complete prior to your appointment. Please present these forms to our receptionist upon your arrival at our office. Our receptionist will also ask for copies of your insurance cards, a photo ID and a list of the medications you are currently taking.

If our doctors participate in your insurance plan, we will file a claim for your visit. You will be expected to pay your copay and/or deductible when you check out after each visit.

If your insurance company requires that you get a referral before we can treat you, you are responsible for contacting your primary care physician before you come to our office. Please call your primary care physician as soon as the appointment date is set.

We hope this will make your first visit more comfortable and will save time once you are here for your appointment. Thank you for choosing our practice and be sure to call Cindy at (205) 933-6888 or (800) 348-8733 if you have any further questions. We look forward to seeing you!

Sincerely,

Michael A. Callahan, M.D.
Tim Thompson, O.D.
Julie H. Gannon, O.D.

700 18TH STREET SOUTH, SUITE 711 • BIRMINGHAM, AL 35233 • (205) 933-6888 • FAX (205) 933-6421 • E-MAIL: EYEDOCS@HIWAAY.NET

MICHAEL A. CALLAHAN, MD & ASSOCIATES

PATIENT INFORMATION (Print)

DATE: ____________ ☐ NEW ☐ UPDATE

NAME ______________________________ AGE ______ DATE OF BIRTH ____________
(Last / First / MI)

ADDRESS ____________________ CITY ____________ STATE ____ ZIP ________

HOME PHONE ____________ CELL PHONE ____________ EMAIL ____________

MARITAL STATUS (CIRCLE) S M W D RACE ______ SEX ______ DISABLED? N Y ____________

RETIRED? Y N IF NO; EMPLOYER ____________ OCCUPATION ____________ PHONE ____________

WHO REFERRED YOU TO THIS OFFICE? ______________________________

EMERGENCY CONTACT ____________________ RELATIONSHIP ____________ PHONE ____________

FINANCIAL RESPONSIBILITY

PATIENT IS FINANCIALLY RESPONSIBLE? (CIRCLE) Y N IF NO, PLEASE COMPLETE THE FOLLOWING:

RESPONSIBLE PARTY NAME ______________________________ RELATIONSHIP ____________
(Last / First / MI)

ADDRESS ____________________ CITY ____________ STATE ____ ZIP ________

HOME PHONE ____________ CELL PHONE ____________ DATE OF BIRTH ____________

RETIRED? Y N IF NO; EMPLOYER ____________ OCCUPATION ____________ PHONE ____________

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY ____________________

ID# ____________ GROUP # ____________

SUBSCRIBER ____________________

RELATIONSHIP ____________ DATE OF BIRTH ____________

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY ____________________

ID# ____________ GROUP # ____________

SUBSCRIBER ____________________

RELATIONSHIP ____________ DATE OF BIRTH ____________

ROUTINE SERVICES NOT COVERED BY YOUR INSURANCE

As my patient, I want to provide you the best care possible. There may be certain "routine" services that I feel are necessary for the maintenance of good health that are not covered by your insurance for various reasons. For example, I may order a refraction or other test that is generally not covered by insurance. Let me reassure you that I will order only tests that I feel are necessary for your treatment and care.

PATIENT OR RESPONSIBLE PARTY AGREEMENT AND ACCEPTANCE:

I understand that some procedures done by my physician are not covered or may be considered unnecessary by my insurance company. I also understand that in many cases my physician and staff will not know if these procedures will be covered until the claim is filed and a denial is received. I accept the responsibility for the immediate payment of the charges not covered by my contract and agree to pay attorney's fee, court cost , and other reasonable cost of collection should I fail to pay for these routine non-covered charges.

I have read your policy and agree to pay for services not covered by my contract as indicated below by my signature.

Patient (or Responsible Party) Signature ______________________________ Date ____________

Michael A Callahan, MD & Associates

NAME: ______________________________ DATE: ______/______/______

AGE: ________ DOB: ______/______/______ MALE / FEMALE

PRIMARY DOCTOR: ______________________ REFERRING DOCTOR: ______________________

PHARMACY NAME: ______________________ PHARMACY PHONE: ______________________

PLEASE CHECK ALL CONDITIONS WHICH APPLY (PRESENT OR PAST)

________ ACNE / ROSACEA
________ ALZHEIMERS
________ ANEMIA
________ ASTHMA
________ BLADDER PROBLEMS
________ BLOOD CLOTS
________ CANCER (TYPE) ______________
________ CHRON'S / COLITIS / DIVERTICULITIS
________ CONGESTIVE HEART FAILURE
________ COPD
________ DEPRESSION
________ DIABETES (INSULIN ____ ORAL MED____ DIET ____)
________ FIBROMYALGIA
________ HEARING LOSS / HEARING AID
________ HEART ATTACK
________ HEART BYPASS
________ HEART STENT (DATE) ______________
________ HEART VALVE PROBLEMS
________ HEPATITIS A / B / C
________ HERPES/SHINGLES
________ HIGH BLOOD PRESSURE
________ HIV
________ IRREGULAR HEART BEAT
________ JAW PAIN WHEN CHEWING
________ JOINT REPLACEMENT
________ KIDNEY DISEASE
________ LUPUS
________ OSTEOARTHRITIS
________ PACEMAKER / DEFIBRILATOR
________ PARKINSON'S
________ PROSTATE PROBLEMS
________ RACING PULSE
________ RHEUMETOID ARTHRITIS
________ SEIZURES / EPILEPSY
________ SINUS DISEASE
________ SJORGRENS
________ SKIN CANCER (LOCATION)______________
________ SLEEP APNEA / C-PAP
________ STROKE
________ THYROID DISEASE
________ VERTIGO

NO KNOWN MEDICAL PROBLEMS ____

DRUG ALLERGIES WITH SPECIFIC REACTION

PAST *EYE* SURGERIES/ INJURIES

ALL OTHER SURGERIES

MEDICATIONS (INCLUDE OVER THE COUNTER & SUPPLEMENTS)

OTHER CONDITIONS/ MEDICAL INFORMATION:

____

____

NAME:____

Please check all that apply. Explain if necessary.

SOCIAL HISTORY

________ SMOKE (PACKS/DAY _______ QUIT ________)
________ CHEWING TOBACCO / SNUFF
________ ALCOHOL (SOCIALLY ______ DAILY ______)
________ LEGALLY DISABLED
OCCUPATION ______________________________

COMPLICATIONS WITH ANESTHESIA

________ NO
________ YES (EXPLAIN) ____

FAMILY MEDICAL HISTORY

(Please check relationship)		MOTHER	FATHER	SIBLING
	LAZY EYE			
	CATARACT			
	MACULAR DEGENERATION			
	BLINDNESS			
	RETINAL DETACHMENT			
	GLAUCOMA			
	DIABETES			
	HYPERTENSION			
	STROKE			
	THYROID DISEASE			
	CANCER			

PERSONAL EYE HISTORY

_______ CATARACT CATARACT SURGERY: RIGHT _____ LEFT _____
_______ DIABETIC RETINOPATHY
_______ MACULAR DEGENERATION
_______ RETINAL DETACHMENT
_______ CORNEAL PROBLEMS
_______ GLAUCOMA
_______ LAZY EYE
_______ DOUBLE VISION
_______ RETINOPATHY OF PREMATURITY
_______ RETINITIS PIGMENTOSA

RETINA SPECIALIST __________________________ **PREVIOUS EYE DOCTOR** ______________________________

FOR OFFICE USE ONLY

Doctor's Signature (Initial Encounter)

___________________________________ ____________________

MAC TJT JHG Date

Subsequent History Reviews (check, sign & date) DATE

_______ No Change _______ Additions as noted above MAC TJT JHG __________
_______ No Change _______ Additions as noted above MAC TJT JHG __________
_______ No Change _______ Additions as noted above MAC TJT JHG __________
_______ No Change _______ Additions as noted above MAC TJT JHG __________
_______ No Change _______ Additions as noted above MAC TJT JHG __________

MICHAEL A. CALLAHAN, M.D. & ASSOCIATES, P.C. / OPTIMEYES
700 18th Street South, Suite 711 Birmingham, Alabama 35233
205-933-6888 FAX 205-933-6421 Email: eyedocs@callahanmd.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Michael A. Callahan, M.D. & Associates' Notice of Privacy Practices.

______________________ X______________________________ ____________

Patient Name (PLEASE PRINT) Signature Date

AUTHORIZATION TO DISCUSS MEDICAL CONDITION WITH FAMILY

On occasion it may be necessary for your doctor or other employees of this office to discuss your medical condition and/or your account with members of your family, thereby releasing Protected Health Information or "PHI".

I authorize my doctor or other employees of his/her office to speak or correspond with:

☐ **ALL** Family Members ☐ Medical Info ☐ Account Info ☐ Both

☐ **NO** Family Members ☐ Medical Info ☐ Account Info ☐ Both

☐ **ONLY** the Following Family Members: ☐ Medical Info ☐ Account Info ☐ Both

______________________ ______________________ ____________

Name Relationship Phone

______________________ ______________________ ____________

Name Relationship Phone

X______________________________ ____________

Signature of PATIENT Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign. ☐ Communication barriers prohibited obtaining acknowledgement.

☐ An emergency situation prevented us from obtaining acknowledgement.

☐ Other (Please Specify) ____

____

(If unable to obtain written acknowledgement, attach Notice Of Privacy Practices to this form and keep in patient record.)

FORM 2429

Original Effective Date: April 14, 2003

NOTICE OF PRIVACY PRACTICES

MICHAEL A. CALLAHAN, M.D. & ASSOCIATES, P.C. / OPTIMEYES
700 18th Street South, Suite 711 Birmingham, Alabama 35233
205-933-6888 FAX 205-933-6421 Email: eyedocs@callahanmd.com

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it. A federal regulation, known as the 'HIPAA Privacy Rule,' requires that we provide detailed notice in writing of our privacy practices. We know that this Notice is long, but the HIPAA Privacy Rule requires us to address many specific things in this Notice.

OUR COMMITMENT TO PROTECTING HEALTH INFORMATION ABOUT YOU

In this Notice, we describe the ways that we may use and disclose health information about our patients. The HIPAA Privacy Rule requires that we protect the privacy of health information that identifies a patient, or where there is a reasonable basis to believe the information can be used to identify a patient. This information is called "protected health information" or "PHI." This Notice describes your rights as our patient and our obligations regarding the use and disclosure of PHI. We are required by law to:

- Maintain the privacy of PHI about you;
- Give you this Notice of our legal duties and privacy practices with respect to PHI; and
- Comply with the terms of our Notice of Privacy Practices that is currently in effect.

We reserve the right to make changes to this Notice and to make such changes effective for all PHI we may already have about you. If and when this Notice is changed, we will post a copy in our office in a prominent location. We will also provide you with a copy of the revised Notice upon your request.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; testing or examining your eyes; prescribing glasses, contact lenses, or eye medications and taxing them to be filled; referring you to another doctor or clinic for eye care, services or surgery; or getting copies of your health information from another professional that you ay have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or vision care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use, or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for written permission.

We will not ask for written permission in the following situations; eyeglass, contact lens or medical prescription requests made from outside our office.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;

- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;
- Providing training programs for students, trainees, health care providers, or non-health care professionals (for example, billing personnel) to help them practice or improve their skills;
- Reviewing our activities and using or disclosing PHI in the event that we sell our practice to someone else or combine with another practice;

We may also disclose PHI for the health care operations of an 'organized health care arrangement' in which we participate. An example of an 'organized health care arrangement' is the joint care provided by a hospital and the doctors who see patients at the hospital.

INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE
We may disclose PHI about you to your family member, close friend, or any other person identified by you if that information is directly relevant to the person's involvement in your care or payment for your care. If you are present and able to consent or object (or if you are available in advance), then we may only use or disclose PHI if you do not object after you have been informed of your opportunity to object. If you are not present or you are unable to consent or object, we may exercise professional judgment in determining whether the use or disclosure of PHI is in your best interests.

APPOINTMENT REMINDERS
We may call or write to remind you of scheduled appointments, that it is time to make a routine appointment, to notify you of other treatments or services available at our office that might help you or to notify you that ordered items, such as contact lenses or eyeglasses, are ready to be picked up. We may also call or write to notify you concerning surgery or other scheduled medical procedures.

OTHER USES AND DISCLOSURES
We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

- If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing and sent to our office at the address shown at the beginning of this notice, marked "Attention: Authorization to Disclose".

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to our office at the address, fax or E Mail shown at the beginning of this Notice.

- Ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E-mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to our office at the address, fax or E-mail shown at the beginning of this Notice.

- Ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30-day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to our office at the address, fax or E-mail shown at the beginning of this Notice.

- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30-day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to our office at the address, fax or E mail shown at the beginning of this Notice.

- Get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30-day extension of time if we notify you of the extension in writing. If you want a list, send a written request to our office at the address, fax or E-mail shown at the beginning of this Notice.

- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to our office at the address, fax or E-mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. if we change our Notice of Privacy Practices, we will post the new notice in our office and have copies available in our office.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to our office at the address, fax or Email shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person (by appointment) or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit our office at the address or phone number shown at the beginning of this Notice.