Cano & Manning Eye Center

Please complete the attached forms and bring them with you to your appointment on:

Additionally please bring the following information with you:

Photo ID

Insurance Cards

List of current Medications, vitamins & supplements with the strength and dosage

Pharmacy Name, telephone number and address

CANO & MANNING EYE CENTER, PLLC

David B. Cano, M.D. ***Lauree D. Manning, M.D.***
2068 Palm Beach Lakes Blvd. West Palm Beach FL 33409

Patient Information

Date: _____

Patient Last Name: _____
Patient First Name: _____
Patient Middle Initial: ____

Street Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____
Patient Sex: _____ Primary Care Doctor: _____
Patient Birthdate: ____/____/____
Patient Social Security Number: ____ -___-_____
Marital Status: _____

Employer Name: _____
Employer Phone: _____

Would you like to be able to access your Cano & Manning medical records through an internet-based Patient Portal? _____ Yes _____ No

Would you like to have an authorized representative access your Cano & Manning medical records through an internet based Patient Portal?
____ No
____ Yes Representative's First Name: _____
Representative's Last Name: _____

Physician Referral Information

Patient Referred by Doctor: _____
Patient is a previous patient of Dr. Louis Mark:
___ Yes ___ No

Race:

___ White ___ American Indian ___ Asian ___ African American
___ Other (Please specify)_____

Ethnicity:

___ Not Hispanic/Latino
___ Hispanic/Latino

Primary Language:

___ English ___ Spanish ___ Other (please specify) _____

(*Over Please to Page 2*)

Preferred Pharmacy:

Name: _____
Street: _____
City: _____
Pharmacy Phone Number: _____

Emergency Contact:

Name: _____ Relation: _____
Phone: _____

Insurance Policy Holder Information

Primary Insurance
Insurance Co. Name: _____ Pol. No.:_____
Policy Holder Name: _____ Birthdate: ___/___/___
Relationship to Patient: _____
Policy Holder Home Address: _____

Secondary Insurance (if any)
Insurance Co. Name: _____Pol_No.:_____
Policy Holder Name: _____

Notice of Privacy Practices – Acknowledgement

Please mark the appropriate response:

I acknowledge receipt of a copy of the Notice of Privacy Practices ("NOPP"):
___ Yes ___ No If no, the reason acknowledgement of NOPP not received: _____

Refraction

I understand that if a refraction is performed, it is a non-covered service and payment will be due on the date of service.

Payment Due at Time of Visit

PLEASE READ AND SIGN THE FOLLOWING INSURANCE AUTHORIZATION AND ASSIGNMENT:

I hereby authorize Cano & Manning Eye Center, PLLC to furnish information to insurance carriers concerning my illness and treatments. I understand that I am responsible for any amount not covered by insurance including any attorney fees and collection costs in the event of default.

Signature: _____ Date:_____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by **Cano & Manning Eye Center** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Cano & Manning Eye Center**. I understand that diagnosis or treatment of me by **David B. Cano, M.D. and Lauree D. Manning, M.D.** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Cano & Manning Eye Center** is not required to agree to the restrictions that I may request. However, if **Cano & Manning Eye Center** agrees to a restriction that I request, the restriction is binding on **Cano & Manning Eye Center** and **David B. Cano, M.D. and Lauree D. Manning, M.D.**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **David B. Cano, M.D. and Lauree D. Manning, M.D.** or **Cano & Manning Eye Center** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Cano & Manning Eye Center**'s Notice of Privacy Practices prior to signing this document. The **Cano & Manning Eye Center**'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Cano & Manning Eye Center**. The Notice of Privacy Practices for **Cano & Manning Eye Center** is also provided in the waiting room and on the **Cano & Manning Eye Center**'s website at www.canovision.com. This Notice of Privacy Practices also describes my rights and the **Cano & Manning Eye Center**'s duties with respect to my protected health information.

Cano & Manning Eye Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the **Cano & Manning Eye Center**'s website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

Notice of Privacy Practices

Cano & Manning Eye Center
2068 Palm Beach Lakes Blvd.
West Palm Beach, FL 33409
(561) 684-4773
Fax- (561) 684-9526

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.

If you have any questions about this Notice please contact: our Privacy Contact who is: Lauree D. Manning, M.D.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. " Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by accessing our website canovision.com, calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked by your physician to sign a consent form. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, your physician will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician' s practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician' s office is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided consent.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician' s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party " business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Contact and request that these fundraising materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician' s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your condition (in general terms), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Members of the clergy will be told your religious affiliation.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice' s premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A " designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.